**Delivering Babies**

One of our rotations in the 4th year was obstetrics. We were all as students expected to deliver 20 babies.

Before doing the rotation to the maternity hospitals we were instructed by a midwife of how to examine a pregnant patient. We were shown how to estimate the weight of the fetus, the duration of the pregnancy and whether the presentation was breech of cephalic. We were taught how to determine how the foetus was lying – was the back on the left or right side? We were taught how to determine from palpation of the head of the fetus, the anterior fontanelle, or the junction between the frontal and parietal skull bones. This fontanelle was quadrangular and had four corners. The posterior fontanelle formed by the junction of the parietal and occiptal bones, was smaller than the anterior fontanelle and was triangular and had three corners. Most babies are born with the head facing backwards; if facing forward the birth is likely to be more difficult and prolonged.

The stages of delivery were stressed, and the midwife used a bony pelvis and doll to demonstrate how the head and shoulders rotated during delivery.

We were initially assigned for a month to Peninsular Maternity Home (PMH), situated in District Six, a colored area close to the city center. Our time spent in this institution predated the later demolishment by the apartheid government area, of this area, with the intention to make it a white. The demolition of this area became a symbol in the eyes of those suffering under apartheid and those against apartheid, as a reminder of the injustices of the system, such that for decades afterwards no one would build there. It was left as a largely rubble strewn area with scattered churches remaining (the churches were not torn down). At the time of the demolition of District Six PMH was left intact but unused. It was demolished in 2012 and a new hospital is to be built on the site. Thousands of colored babies were born in this hospital.

Our accommodation was in rooms on a second floor of a building close to the wards and delivery area. On looking out the windows at night we could see what was taking place on the streets; the bickering and the noise of the community, the skollies and drunks, the prostitutes and their customers; it had a vibrancy that was completely different from our sheltered white lifestyle. Our day was structured such that morning and afternoon lectures still needed to be attended at the main medical school campus. The period in between was spent at antenatal clinics and having tutorials (clinical discussions with the registrar or consultant.) The actual deliveries that we were to be involved in were those that took place from 7pm to 7am, the night shift. The daylight shifts, and deliveries were prioritized for student nurse midwives. Because our group of eight was doing the rotation, every eighth woman presenting to the hospital in labor at night was assigned to my care. I had to admit and examine the patient, do regular assessments and be involved with the delivery, if it happened at night. Some nights I had one delivery, some nights none and occasionally on some nights two. We had no difficulty filling the quota of 20 deliveries. Initially, one tended to stay up and become involved in what was happening to patients under the direction of our colleagues, but later as the lack of sleep made its effects known, we went early to bed and were awoken when necessary.

When a patient was admitted we had to take the history and do an examination. Pelvic examinations were done initially to determine the extent of cervical dilatation and the presentation of the fetus, determined by palpating the fontanelle, and then at regular intervals, or if indicated. We listened to the fetal heart by using a tubular fetal stethoscope of about 6 inches held against one’s ear and the abdominal wall. A sign of fetal distress was a slowing in the rate and could be a reason for caesarean section. The strength frequency and duration of contractions was also regularly documented. When the actual delivery took place this usually occurred quite rapidly, but in some patients an episiotomy or some form of assistance such as forceps or vacuum extraction was necessary. The neonate and the placenta had to be carefully examined. The placenta had to be examined to be certain all cotyledons are present, that there are two arteries and one vein and that the weight and thickness was not deficient or excessive; if deficient it may be associated with intrauterine growth retardation, if excessive with maternal diabetes or intrauterine fetal infections. I was taught initially how to repair an episiotomy wound and thereafter I was left on my own to do the repair.

Once a week, a consultant, Archie Michael took us for a tutorial and did rounds. He was somewhat uncouth and liked the dramatic. For example, when commenting on a new fetal monitoring device that was attached to the head of the fetus. “The device stated that the patient had fetal distress. Everyone was rushing around trying to arrange an emergency caesarean section, but nobody had looked to see that the baby was in the third stage!” He also, for some unknown reason, possible to demean the lowly student at the patient expense, asked us to do a rectal examination on the patients who were in labor. It is certainly possible to assess the stage of labor via this route, but it is unnecessary. We each did the procedure as instructed on a group of patients in labor: we felt uncomfortable as I am sure the patient did. It was demeaning for all in the area except for Dr Michael. One patient, rose her voice “Jy’s nie in die regte kant nie!” ‘You are not in the correct side’, but kant in Afrikaans, meaning side, pronounced in the same manner can be mistaken for an English derogatory word referring to another close anatomical structure. What she stated seemed amusing to all, but in retrospect the patient was correct – we were examining the wrong site.

Whenever something out of the ordinary occurred we were all awoken and became involved. Examples included forceps or vacuum deliveries, a breech delivery, multiple births, a retained placenta or cesarean sections.

There was obvious apprehension at the beginning but gradually over time we became more confident. Our relationship with the midwives also improved; we had the theoretical medical background, but they had the experience of years.

I remember the humor of the midwives. One midwife stated as the head was being crowned: “Daar’s nog a klonkie in the Kaap.” ‘There’s another colored (slang word) in the Cape.’

Another said to a very vocal young unmarried young woman who was yelling in pain during her contractions. “Ja, did gaan in soes a piesang en kom uit soos a pynappel!” ’Yes, it goes in like a banana and comes out like a pineapple.’

In my 6th year I spent a further month doing Obstetrics, but on this occasion, was assigned to Somerset Hospital, which was close to Cape Town docks. The highlight of this rotation was seeing the delivery of triplets.