(introductory music)

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MARYN: Welcome to Indie Birth's podcast, *Taking Back Birth*, here on iTunes. Hi, everyone. Maryn here, of course. And I am back with the first podcast after Cove's birth. And maybe I'll link to that at the end, but today I'm here with a special guest. And as many of my listeners know, special guests are rare. This podcast is a bit of a monotone thing a lot of the time. So I am so thrilled today to welcome Dr. Nathan Riley, and we're going to hear from him. He is a birth and death physician. So I'll talk more about how we met online. But go ahead and introduce yourself. I'm so glad you're here.

NATHAN: Hi, Maryn.

MARYN: Hi.

NATHAN: I'm happy to be here. You got my name right which is easy because it's a pretty standard American name.

MARYN: I was going to be sad if I messed that one up.

NATHAN: Yeah. I'm Nathan Riley. We got to—I'll guess I'll let you kind of elaborate on how you found me. But I'm an OB/GYN. I live in San Diego. I practice obstetrics up in Encinitas, which is like the happiest place on earth outside of Disneyland. And I also am completing my fellowship training in hospice and palliative medicine, which is what many people would say is the other side of the spectrum. So I have kind of the luckiest job in the world. It's pretty great.

MARYN: Wow. So how does that look for you on a given day or a given week? How do you kind of manage both of those things? That's pretty intense.

NATHAN: That's a good question. I'm not doing obstetrics every day. Most of my time is actually spent with—in the palliative medicine world and hospice world. So a typical day for me could look like going to people's houses who are on hospice, meaning that they have—maybe, at most, six months to live. And we're doing symptom management. And then generally one day or week or more, I'll have to go to the hospital, and I'll be on call in hospital managing laboring patients and doing C-sections, doing operative vaginal deliveries, et cetera. We work with a lot of midwives.

MARYN: Awesome.

NATHAN: And they kind of support laboring patients. And then when I'm needed I will jump in and do something heroic, if needed. And then we manage the ED and that type

of stuff. So there are—there have been a couple cases—occasions when I've had to pronounce a death. And then I go to the hospital, and an hour or so later I'm delivering a baby. So it's kind of a—that's why I say I have the luckiest job in the world. It's the two most special, most mortal times in our life. I get to be intimately and directly a part of that for so many people. So it's a really privileged role I get to play.

MARYN: Hmm, yeah. That's so beautiful. Well, I want to talk more about all of that, but let's start with what is my first question which is why obstetrics. How did you find yourself there?

NATHAN: I don't know. I really don't. I don't know why I chose obstetrics. I think that what I thought in medical school—well, first of all, medical training, as I'm sure you know, is—it's just rot with problems. Like the way that we educate physicians. And one of those big problems is that they—it's kind of like when you exit high school and then they expect you to know what you want to be when you grow up.

MARYN: Right.

NATHAN: When you get done with medical school, they kind of expect you to pick a field to specialize in, and it's hard to know what that's like when you're stuck in the books all day. So in med school, you're covering a thick textbook roughly every two weeks. I mean it's a high volume, very high intensity sort of learning environment. And at the time—and what I continue to sort of—I don't know—aspire to is a life where I have a good work life balance. I have a lot of exercise and nutrition. And I have a meditation practice. And I have all these things that I hope are going to help me live a long, fruitful life. And I though in med school, "Wow. We don't really learn a lot about this." So I took on learning about nutrition and exercise and how those things play in, sleep, how those things play into our overall health. And I thought, "Wow. When I did my obstetrics rotation,"—OB/GYN rotation, I thought, "Wow. This is like a healthy group of people who are getting pregnant." I mean we're looking at the OB part of this, of course.

MARYN: Right.

NATHAN: Pregnant. And this is a great opportunity to talk to them about some of these things. And wow. If I can make a practice out of teaching people about the ins and outs of how human physiology and all of these lifestyle factors sort of interrelate, man, this is like—our world would be a better place. And so that was my—I think my initial motivation. Plus when you see a baby getting born for the first time, your mind is so blown that it' s like this is something magical. I don't know what this is. But this is—that—a human being was just made by another human being. And it's a really—it's a really cool thing. So an OB/GYN out there that says that they didn't go into it for that reason is—they're lying to you because there's, obviously, some magic there. But yeah. I found that maybe I would have time for—with the gatekeepers to the household, the

matriarchs of the world's households. And we could get some lifestyle education and some sort of lifestyle changes to help people get healthier. And so that was my motivation. But then in the reality of OB/GYN practice, you don't really have the time to do that.

MARYN: Right.

NATHAN: You maybe have ten minutes to do a full prenatal consult, and you're going to talk about all the ins and outs of nutrition and exercise. It's just far more complicated than that.

MARYN: Sure.

NATHAN: So I've been—so I enjoyed it, but I ended up finding that it wasn't fulfilling to me entirely. And as a physician, it's kind of a malicious environment unfortunately. The OB/GYN world. And you sort of have to live that—you're kind of a surgeon in the way you're trained. And that doesn't necessarily make for the healthiest living or learning environment. So that's why I started looking elsewhere. I do a much better job.

MARYN: Yeah. Well, gosh. That was a lot of my questions I think that you kind of answered a little bit. Or I guess we could go more into just how did you deal with the environment that I imagine most obstetricians work in and that lack of time and that really lack of focused on each woman as an individual just purely because you're trying to get people in and out. How did you do that while you were in there knowing that there was so much more for these women to have access to? It's hard.

NATHAN: It's a—I guess it was complicated. Residency training is—somebody needs to make a documentary about what it means. What a person has to do to become a doctor because it generally has nothing to do with taking care of patients. And that's one of the big problems. And that is not—I'm not slamming medicine. You are going to find some of the best rounded human beings in the field of medicine, but that process of going through the process beats a lot of that sort of initiative out of you, right? Most of us want to save the world. We want to help people, and we want to solve really complex problems. And that's why it attracts a lot of smart people.

MARYN: Right.

NATHAN: That are not motivated by money because, believe me, there is much easier ways to get rich than to become a doctor. There are very few bleeding rich doctors anymore. And so when you're in this training program, you go in with the idea that, "Okay. You are here. You are the doctor. You are the one that's going to help this person," but there's so much red tape. And there's so many barriers to doing that. I mentioned the sort of malicious nature of OB/GYN training, but that's not unique to the

OB/GYN training though. Long residency, the training hours, the lack of sleep, and just the general emptying of your tank as a human being makes it very, very hard for you to walk into a room where a person is going through the most scary thing in their life—let's say labor—and their pain and anxiety are on a different level. They don't have the coping strategies to get through this, and they haven't been educated prior because the clinic or the physician in a clinic where you've been getting your prenatal care hasn't had the tools, the time, or the resources to provide you with some insight into what this experience might look like—or to even talk to you about your goals and your fears. And so when you can see there's all this stuff you want to do but you don't have the ability to do it to help these people that you signed up to help way back when you were 18 and you were picking what it is that you want to do with your life—when you decide to do pre med or whatever in college—when you run into this wall and there's really no way to get around it, it leads to the burn out, depression, and just overall compassion fatigue.

MARYN: Sure.

NATHAN: When you don't have the ability to actually do what you're there to do. And as soon as MD shows up after your name or DO for the osteopathic physicians—once that shows up after your name, you feel this immense responsibility to be diligent in how you take care of people. And so with those expectations for yourself and those expectations from a program standpoint or a system standpoint, you oftentimes aren't able to accomplish that. And that's very hard. So I'm going—I'm kind of rambling here because there's not an easy, I think, answer to that. So to your question, my wife has been a great witness. And she—and I don't have kids yet. But she has been a witness to the physical, emotional, and psychological pain that medical training has been for me over the years. And I think that that really helps. But the shorter answer is that I don't know what the answer—I don't know how people get through it because I block a lot of—I block a lot of it out. And there's a lot of coffee involved, and there's a lot of just trying to find some way to be happy. And whenever your tank is so empty, you just have no empathy left for other people and—including your wife, including your family, including your friends. And I mean it's a battle. It's a constant battle. Is that what you were—does that sort of answer your question?

MARYN: Right. Yeah. It answers it, and it gives me a million more and just things to talk about. I mean it's so fascinating hearing this coming from you. I don't talk to a lot of OBs. And I think as midwives we probably don't understand for sure what you've been through and perhaps a lot of the reasons that obstetrics is the way it is—so you're talking about—

NATHAN: Absolutely.

MARYN: - being burnt out—yeah. I mean that's not stuff that occurs to us even though we have our own burn out and that kind of thing. So that's really interesting to think about and gives me a lot more compassion for what you do and the field that you're trained in. So I'm kind of jumping around but not. The next thought that I was pondering while you were talking was when you and I talked you mentioned being influenced by midwifery. And so that, of course, is interesting to me. But hearing you talk, I mean you know you're not your average obstetrician, right? I mean for a million reasons. Right. I don't know all the reasons. But hearing you talk about wanting to spend those time—extra time with women and make sure they have nutritional knowledge and are educated and even having this understanding of labor being this life event, those aren't common thoughts. Or at least they're not so easily portrayed in western medicine. So was it the midwifery influence? Or can you talk more about that? Just why do you feel the way you do because it's not a common thing.

NATHAN: Wow. Yeah.

MARYN: I know.

NATHAN: Thank you for that. I definitely see that there are not too many people like me. I also am not the best doctor. I mean there's a lot of people out there that would describe the best doctor as being somebody who is the best surgeon or who can recite every paper with every number that's ever been published about X, Y, or Z. So when I say I'm not the best doctor, I guess I mean that based on our sort of objective criteria for what makes a best doctor, the test scores or the number of—I mean I've never had really ever any bad outcomes. But there's a lack of humility in medicine where we think in order to be the best you must be a perfectionist, and you must know all of these things. But the problem with that notion is that when you're focused on knowing every little detail of every study—and by the way, there hasn't been a truly great study ever done in medicine that proves anything. There's a lot of really good guesses we have. And there's a lot of good evidence to say, "I don't know. I guess for this particular person this is probably our best guess."

But that's why doctors get paid a lot of money. We've gone through so much training to do this stuff and to think about things critically and to know how to look at data. And we should be reading the data. We should be—and that's why I have a podcast. We should be looking into the—what are the recommendations and why? And does the data really support that for this particular patient? And that's what medicine—that's what a true medical scientist is supposed to do. But if you're going to focus 100% of your time on doing what you think is right for the patient, you miss out on the fact that there's a human being sitting there in front of you.

MARYN: Right. And I mean when that human being has another human being—

NATHAN: Right.

MARYN: - doesn't it change where your direction comes from? I think it does.

NATHAN: Yes.

MARYN: I mean even in midwifery there are similar thoughts and issues for sure.

NATHAN: Yeah. Well, so yes. And to answer your question more directly, I think that—I'd say probably about 10 to 15% of my patient interaction was facilitated through the practice of a midwife versus an OB/GYN trained classically as I have been. And I have been trained very, very well as an obstetrician. So don't get me wrong. When I say I'm a bad doctor, I'm trying to separate myself from the notion of what a good doctor is versus a bad doctor. Because there's a lot of people that I see who would practice like a midwife, but they fear being perceived that they're a bad doctor because they don't know the confidence interval on that one study that was published 20 years ago that we still are basing our obstetrics practice on. Meanwhile, there's also a person here in this bed who has some anxieties and fears around this process, and you trying to medicate in some way or to treat through procedural means—like maybe their labor isn't fully digestible to you because you just simply haven't gone in and talked to the person.

And so in my practice with midwives, that 10 to 15% of my time, you learn about—and I hate the word holistic. I hate the word complementary and alternative and all this stuff. They're just these fancy words that people use on Instagram to sell products. What we mean by that is that this is a human being who has had an entire life of experience, and that is playing into the physiology that is driving this important, very unpredictable, vulnerable, sort of thing that they're going through. And once you—if you can grasp that, it makes you a better doctor without compromising the statistical analyses and the ability to stay up to date with the literature and the ability to operate surgically. You know what I mean? But that's not something that's emphasized. If you work with a midwife, you naturally see that, "Oh, you know this about this person. And by virtue of you knowing this, you can now take better care of them and this little person inside of them," and the guy who is cowering in the corner because he's so afraid of what's going to happen with his partner or the woman in the corner who is afraid of what is happening to her partner. There's this whole thing that we don't learn in medical school. And that's what I took from my practice with midwives. And it has made me a phenomenal doctor. It just may not be seen like that in the general notion of what we're taught in medical school about quote being an outstanding physician.

MARYN: Right. Yeah. I mean that makes total sense. And that is being a fabulous doctor. I mean what woman wouldn't want someone to pay attention to them? And especially in labor. I say all the time I've never been to two labors that are the same. Sure. The theme is the same and sort of the curve can be the same. But it's different

each time. And it's so humbling to be in that space and to have to use your brain to sort of analyze or kind of step back and see but to really be present. Your head isn't in the numbers. It isn't the textbook. So it's really beautiful and such a blessing that you can operate that way since you've never birthed yourself. It's a really cool thing that you think that.

NATHAN: Actually, I did birth myself.

MARYN: Yes. You did.

NATHAN: June 24, 1985. I birthed myself.

MARYN: That's awesome. You did birth yourself. And we're four days apart but a couple years apart.

NATHAN: Four days. Are you June 21st?

MARYN: I'm June 28th. We're Cancers.

NATHAN: Oh, the 28th. The other direction. Cancer. Cool. Very nice.

MARYN: Very cool. Wow. Well, where to go from there? Anything that comes to your mind that you want to add? Or little segues?

NATHAN: Well, I do think—yeah. I mean I do think that the palliative care thing also has really played a big part in where I've gone in my career.

MARYN: Yeah. Let's talk about that.

NATHAN: And yeah. So right now I'm at UC San Diego and sort of one of the more famous palliative care training programs. It was born out of the San Diego hospice program, which it closed down—shuttered their doors several years ago for complicated reasons. But out of that fellowship training program, UCSD and Scripps kind of pick up the ball from there. And palliative—do you know much about palliative medicine, Maryn?

MARYN: I don't know a lot.

NATHAN: Yeah. So palliative care is a specialty that—again, we don't really learn much about it in medical school because it's not—there's a lot of science backing what palliative doctors do. But it's—because it's actually seen as the opposite of—if you're not trying to cure it, then what are you trying to do, right? In medicine—in western medicine, we don't accommodate disease. We try to eradicate disease. And the reality is that if you have advanced cancer, let's say—which is a large portion of my patients, at some point that cancer is going to quote win, right? Which we emphasize this battle with

cancer, and if you emphasize battle, that means there's a whole bunch of losers out there. And that, to me, has never sounded appropriate. But let's say that the—once the cancer starts winning, then what can a doctor do if a doctor can't fix it? If they can't fix it, then we shrug our shoulders, and we say, "I don't know." And we start offering things that maybe not—aren't useful and potentially even harmful like additional chemotherapy when you failed chemotherapy multiple times. And the chemotherapy itself is making you sicker than the cancer. So palliative care emerged as a means of trying to meet the needs of patients with advance illness. And you have very, very complicated symptoms. And when a medical team kind of runs out of options and starts shrugging and loookign around, we're the ones that are hopefully going to be stepping in to help take care of a couple things.

So what we do is we take care of complicated symptoms like pain, nausea, constipation, anxiety, depression, et cetera. We're kind of 80% experts on all of those things. And we also will talk to patients and their family members to sort of learn about who a person is and what their goals are and what their fears are about what's happening to them. And only after you ask those questions, are you able to really help coordinate their care in such a way that they're receiving maximum benefit without—with maximum reduction of harm. So I brought up cancer. Everybody that I know has been touched in some way by cancer for better or for worse. In most cases, it's a family member who had it, and they had to say goodbye to their mother or father or whoever. And I feel for people now that have been through this. I also lost my own father to multiple myeloma when I was in medical school. And he had a palliative care team that helped him with his pain and helped him with his nausea because he wanted to get more chemo because he was a fixer. And he wanted to fix this thing.

And by getting palliative care involved, they were able to get his nausea controlled and his pain controlled such that he could tolerate higher doses of chemotherapy to buy him maybe some more time with us. And when you talk about the process of labor when a person goes into labor, a woman is in labor, she comes into the hospital. And this is a frightening thing. People started throwing things at her hoping something works, right? We have this way we do it. You come in. You're six centimeters. You're admitted. You maybe want an epidural. We recommend the epidural because you should relax. And there's all this stuff being said to you without anybody ever really sitting down and finding out who you are. There's no time for that sometimes. And fortunately, in palliative care in a lot of these diseases processes, you have time. You have time to sit down and get to know a person and get to know who they are and where they came from and how this cancer thing has been for them. And you're often surprised when you start asking them those questions because most people think cancer is very scary. And it is I'm sure for—me included—it would be. But a lot of people are like, "Yeah. It's just the way it is." And their spiritual beliefs permit them to live a life where they're fighting

the cancer, but they're also comfortable with the idea that maybe the end is coming near.

And, again, you don't know those things until you talk—until you ask them. So palliative care is sort of like one of those things that if it were combined with obstetrics you would sort of see midwifery. And so there's—I have a natural proclivity for leaning in that direction because getting to know the person is not a luxury. It's a requisite. It's requisite for me to take the best—to provide them the best care possible. And so when you're looking at something as scary as death and dying regardless of the reason that—those fears around death and dying, the only other place I've ever seen those fears is in the eyes of a woman who doesn't know what's happening with her pregnancy or what's happening with her labor or what's going to happen with the baby that's getting whisked away to the NICU. And so naturally, palliative care lends itself to the practice of obstetrics—and so yeah. So that's where I'm at in my training and my sort of understanding of everything. And I initially was hoping to bring palliative care back into OB/GYN to make OB/GYN better. But instead, I'm actually doing the majority of my time in my oncoming first real job in palliative medicine. I'm spending most of my time there and then doing part of my time in obstetrics as a real badass OB.

MARYN: That's so awesome. Yeah. I mean obviously there's so many similarities between birth and death and holding space, which is really what any of us do. I mean like you say wanting to fix things no matter who you are is a natural human way of reacting, I think. But in birth especially, I mean that's where I have more experience. That's really where you learn to—yeah. Let go whether you're the woman or the care provider. It's more about just holding that space and seeing what the person wants and which way they want to go. And in the end, I guess, I don't believe we necessarily control any of those outcomes in the bigger picture of things.

NATHAN: Of course. Of course. Yeah. I mean we don't. We really don't. We're powerless.

MARYN: No. Of course not.

NATHAN: It's one of those—it's also interesting that in our culture we somehow got to the point we—where we sterilized both death and birth to a point where it's—they're the two topics that you never bring up around the dinner table or with your grandparents. You don't really get at the details of your birth with grandma or the details of what death might look like with your grandfather. It just seems to intimate of a thing to talk about with people who have lived—like for your—my grandfather is 96 this year.

MARYN: Right.

NATHAN: He's lived 96 years. You don't think he can handle a story about birth? This guy was through probably six wars for all I know. And he's loved and had his heart broken. And he's gone through all of those normal human things. And for some reason, we feel like we can't talk about the quote gross stuff in life which, for us I guess as a culture, we see death as one of these—it's a little taboo. You just don't talk about it. And so we protect children from a very young age from these conversations and from the death process. The mortician make Grandpa (audio cuts out). In the same in obstetrics, it wasn't until recently that it was a common practice for fathers or other family members or little kids to be present during a birth. I mean unless, of course, you're a midwife, and you have an approach to childbirth that permits a woman to be on the floor or in the shower or in a tub or a stool or in the house or whatever. So that it's a part of life. It's just a part of the household. I had my baby over in that corner. It's like a pretty beautiful notion. But for some reason, we've medicalized it in such a way where this isn't something we talk about. Let alone is something you do in your house. Like ugh. That's despicable. And so these two topics just never come up. We never talk about them as a society. And so birth and death, I think—I think suffer from the same cultural stigmata. And it just makes our lives as birth educators and birth practitioners, for lack of better terms—it makes it a lot harder for us to provide quality care to those people that need it most.

MARYN: Yeah. Yeah. So true. So true. And I feel like it's getting worse in a way just with the younger generations becoming even stranger to consider these things.

NATHAN: Oh yeah.

MARYN: But yeah. I mean it's totally up to people like us. And you on both ends of the spectrum. I had that thought this past year. My grandpa was a hundred, and he died. But my relatives out in New York were looking for kind of how to make it okay for him in the hospital. And here I am on the other side of the country—not really involved enough to say anything. But why did he have to stay in the hospital? Bring the man home.

NATHAN: Right. Right. Right.

MARYN: But it's ingrained in us to just be in these institutions and let someone else take care of it when we're capable of all of these things. The beginning and the end.

NATHAN: Sure. No. Even the sort of expedited—what's the word I'm looking for? As soon as a baby is born, we go into action mode. And there's three or four people running around doing all this crazy shit. Can I say shit on your podcast?

MARYN: Yes. You totally can.

NATHAN: So much crazy shit in the room. And it's like, "Guys, a freaking baby is—has just came out of her vagina. And he's sitting on her chest. And he's rooting around there."

MARYN: And he's fine.

NATHAN: And he's totally fine. He's just hanging out like, "What are you guys running around for?" Just let them have this moment. And they're like moving her arm around trying to get blood pressures and fixing the stirrups. It's like just relax. Just relax. If there was a shoulder, if I needed to do a vacuum assist, if the baby—we have—has a known fetal cardiac defect or what—there's a million reasons why you should be involved. This is not one of them.

MARYN: Right.

NATHAN: Let's just let this happen. In the same way when a person dies, we—let's call the morgue. Call the—the mortuary is going to come and pick them up, and we're going to get—there's this weird black body bag. And you put Grandpa in this body bag. And it's like oh my god. What is wrong with this picture? It's just—we're so uncomfortable with that space there that we don't even mourn.

MARYN: Sure.

NATHAN: We don't even allow ourselves to grieve. Or to celebrate in the—

MARYN: Right. Or to feel it. To feel any of it. And it's so rushed. And the intention is lost although whatever intention we have isn't the most important thing in the room anyway. Where's the space for that person? For that woman to receive her baby. And that baby. Who needs that? Who needs that stress? But it is just—again, you are very odd, as you know, because I don't think that's—I mean I know that's not the training. So I'm wondering how you even work in that setting like you do with people running around and having all their routines and maybe not stopping and thinking and feeling because they weren't taught to do that. And that's not the way it goes. I don't know that I'd be able to deal with that.

NATHAN: Yeah. And I think to add on to your question—the answer is I don't know. I don't know how—I don't know why I'm on this end of the tunnel.

MARYN: Right.

NATHAN: I have a wife, who is very emotionally intelligent. And when I think about her going through one of these experiences like in the birth world—which she will eventually. I think, "Gosh. I don't know how I would prefer to be spoken to by the nurses and what not," because that would stress me out if I was the partner of a woman who is

going through this very challenging thing. And somebody is speaking to me in that way. And granted, I don't have the—I'm not the perfect communicator in my own marriage. But we've known each other since high school. And it's like gosh. We've even talked about this stuff ahead of time. And I know exactly where she is. And she's a very strong, very intelligent, educated woman, who is going to still be so afraid when she's in that moment. Number one because she hasn't had any experience with other women. I mean apart from like her friend saying, "Oh yeah. The baby is out. Here is the baby." That was scary.

MARYN: Sure. Sure.

NATHAN: She's never really been a part of—well, she has with her nephew and niece. But it's not like it's a—she has a legacy of seeing all these births that you and I have. So she's going in with, "I hope it goes well."

MARYN: Well, most people haven't. That's a huge part of the problem. Women have no context for what they're about to go through.

NATHAN: Right. There's no red tent.

MARYN: No.

NATHAN: People are not getting together and actually talking. We could probably talk for another hour about that, in particular. But knowing what I know and what she knows and how we have this incredible cohesive relationship, going into that experience is still very scary. And I don't know—I don't know how we're going to handle it, right? So me, then being on the other side of that looking at my patient and her partner and this—maybe some kids in the room or whatever and seeing how—that we all interact as a big team, nurses and other physicians included—it's like you're constantly asking like, "Is this really the best we can do? Is this really what is going to work best for this scary situation?" And the answer resoundingly is no.

MARYN: Right.

NATHAN: Apart from those occasional great births that just—they just work. And everybody is just vibrant, and it feels great. And we feel like we've done everything we can to just provide this patient with the ultimate experience. And occasionally, that happens. Occasionally, it happens with death. But it's more—unfortunately, it's the exception versus the rule. At least whenever this—the birth experience takes place in a hospital.

MARYN: Right. Yeah. I was going to go there next actually. My first baby was born in a hospital. So, of course, I've seen it with transports and experienced it and never went

back as is probably obvious. And began midwifery training after our second baby. So I've been there, and it's really hard to respect the physiology process.

NATHAN: Yeah.

MARYN: So I mean it's just more of the same. I don't know how anyone does that. And even just personally, like are you guys ever on the home birth side? What is your experience with that? Have you gotten to attend any? Is that still pretty far outside of where you would go? But just based on what you've shared I have to ask.

NATHAN: So there's—that's a good question. I have. Yes. I have been involved in home births. And the first time I was in LA for my training. And I was probably half way through my training when there was a speaker at one of our didactic sessions who was an experienced OB/GYN. His name is Stu Fischbein.

MARYN: Yeah. He's been on this podcast.

NATHAN: Oh good. Okay. See? I would have known that had I—I've listened to like most of his interviews. But there's so many podcasts out there now that it's like oh my gosh.

MARYN: Totally.

NATHAN: So I feel embarrassed that I didn't know he was on yours. And I'll go back and listen to it.

MARYN: Oh no. It's all good.

NATHAN: So you know Stu. He came to our—one of our education sort of didactic sessions and gave a chat just about sort of what the data shows about breech delivery. And he's been on a quest to try to reteach—I think it's actually his sort of tag line is reteach breech. And he even does breech deliveries at home. That's a pretty scary place for people that are fresh out of OB/GYN training because we don't learn how to do breech deliveries adequately.

MARYN: Right. Right.

NATHAN: And if the baby is out and the butt is there, you hold the baby there. And I mean you move to the OR as quickly as possible because you don't want to get the head stuck and all this other stuff that they talk about.

MARYN: Wow. Yeah.

NATHAN: And his big point has been the risk of something bad happening in an appropriately selected patient is very, very low. And so he's developed skills over years

and years and years. And he probably does it better than the majority of people on planet Earth that he could actually safely deliver a breech baby. But anyways, I bring him up because as soon as I heard about him I said—and that he does this in the home. I said, "Hey, I want to learn how to do this."

MARYN: Yeah.

NATHAN: And he invited me to ride along with him on a delivery. And we went to a home in Temecula. And everything was set up. They kind of prepare the patient's home ahead of time. And they have all the supplies there, so that when they go into labor they can set up a tub. And they can—they have their whole process. And I was—it was amazing 'cause he had two midwives there with him. And one was a student at the time. His partner, Bliss. And then another midwife was there as well. And I—we just kind of hung out and just let her labor. And it was a lot of doing nothing which is so different from what I'm used to seeing in the hospital.

MARYN: Right.

NATHAN: It's like—and I remember Stu teaching me that night. He said, "You have to—if you're gonna do obstetrics, it's best if you learn to—the art of doing nothing." That has really stuck with me. It's been a—it was a real pleasure to see that in action because it really is very, very little that you're doing. And if there's a little tiny laceration at the end that might be a little bit—bleeding a little bit when the—when a woman is up in stirrups, it still bleeds 'cause there's no pressure on it. But as soon as her legs are back together and she's in bed breastfeeding her baby, suddenly it all kind of just comes back together. So there's little things like that that you don't learn unless you see it in action. And it's hard to imagine that outside of this—I'm using air quotes here. The sort of sterile hospital culture. And I remember leaving that birth, which was actually a very quick labor relatively speaking. We were there all night. But it was, I think, from start to finish it was probably like eight hours of action.

MARYN: Nice.

NATHAN: And we left probably around 8:00 a.m. after we made her—we made her a smoothie and left her in bed with the baby and her daughter was there. And the husband was there. It was just this beautiful scene at the end. And we left. and I remember—I remember on the ride home. Of course, I was tired. We really hadn't slept. But I remember feeling just as sleep deprived as I always had been in residency training. And we talk sleep deprived. We're talking six weeks straight never seeing sunshine because you're on nights.

MARYN: That's horrible.

NATHAN: Like the [cross talk], and it's just ridiculous hours. And you're not respected. You're just pissed off at everybody. They're all pissed off at you. It's just this crappy five to six week period of time where it's not—it's inhumane. But it's survivable. But you're just barely hanging on. And it's just miserable. And so when you're in the hospital seeing and you're doing that and you're sleep deprived, you're constantly—through this process of cognitive dissonance. You're like, "I guess it's okay that this thing happened. And I guess it's okay that we did that thing." But it wasn't the right thing to do. And you just have to keep telling yourself that it probably was the right thing to do because this data over here and this study over here. But it really wasn't.

MARYN: Oh gosh.

NATHAN: It really wasn't the right thing to do. I feel bad. And I'm going to internalize these feelings I have about not doing the right thing or saying the right thing to that poor woman or that poor partner and that—at that time. The contrast to going to the home delivery was oh, this whole thing just happened. And we were there in case something needed to be done.

MARYN: Yeah.

NATHAN: I went home to my wife. And I was beaming. I was just—I was glowing with whoa. This is what obstetrics should be like.

MARYN: Right.

NATHAN: Why is this not my everyday life?

MARYN: Right.

NATHAN: And so—yes. I have done it. I have been there for that. And the idea of something scary happening and having to transfer to the hospital rapidly is something that sounds like an ultimate nightmare for me.

MARYN: Right.

NATHAN: But it's also an ultimate nightmare when that happens in the hospital.

MARYN: Sure.

NATHAN: It's just when you're—when you are practicing and you're faced with four years of hard labor in a hospital environment, the idea of—you finally, after four years, you have it all figured out. A system there. Where you have medications you can call for and an operating room, and you can do all these great things with your hands and all these fancy instruments. When you get comfortable with that, it's very, very hard to break out of that mold.

MARYN: I'm sure.

NATHAN: And start doing it at home. So it's a—yeah. It's not that I think OB/GYNs are not open to it. It's that most OB/GYNs can't conceive of it.

MARYN: Right.

NATHAN: Right? Because they haven't sought out somebody like Stu Fischbein, who was happy to take you along and show you what a well trained, experience, confident OB can do.

MARYN: Yeah. That's so cool. I'm so glad that you know each other and you had that opportunity. I mean of all the people to tag along with that's a pretty awesome one.

NATHAN: Yeah.

MARYN: And yeah. You know obstetricians attending home births are also like unicorns. I can only think of a handful. And the ones I can think of probably—well, recently, aren't even doing it anymore. So that's sad. He's one of the only ones left. So yeah. That's really cool. Well, good. I thought I'd ask, and it's really nice to hear you've had that experience. It also makes you very odd but in a good way. So let's talk about your podcast.

NATHAN: I will say that even though—

MARYN: Yeah. Go ahead.

NATHAN: Sure. No. No. One last thing. The birth—the home birth experience I think is—I think it's—even more so than the fact that things for a lot of patients would happen completely naturally at home. Even more so than learning that when you see it in action, I think that what we can really learn—what we can really teach as a first step for OB/GYNs through the home birth experience or the birth center experience or whatever, just the involvement of midwives in general in whatever setting, is that even if—even if you wanted to argue that every birth should be in the hospital, which ACOG is pretty firm about—

MARYN: Right. We all know that.

NATHAN: There's so many things we could do in the hospital to make things better. The problem is not home versus hospital. The problem is that the hospital environment is completely—it's detrimental to the labor process because of all of those anti physiological things that we do to people without even realizing it.

MARYN: Right.

NATHAN: And so that's probably a whole separate conversation, but it's the fact that the whole thing is built around the comfort of a system that is built—has sort of found—has a foundation that is not patient centered. And so the fact that I walk into a labor and delivery room and I keep the bed—don't do the stirrups. Just keep the bed as it is. I put on some gloves. I don't put on the whole Darth Vader outfit. I probably will put goggle on because I don't want to be sprayed in the eyes with anything. But my mouth is closed. I've got intact skin, and I've got goggles on and a pair of sterile gloves. I can deliver a baby like that without putting anybody else through any sort of distress because like Darth Vader is looming over them trying to pull a baby out of them. I'm there to assist. I'm not there to do anything apart from be there in case they need me. If every OB/GYN did that and advocated for labor and delivery units to be a little bit more patient centered, we would have a very different looking obstetric practice in the United States that wouldn't necessitate a conversation that was so diametrically opposed between home birth and hospital birth. You know what I mean?

MARYN: Right.

NATHAN: And that's not me saying home birth is not safe. That's me saying that even—that's me saying that we're asking the wrong question.

MARYN: Right.

NATHAN: Hospital births are so medicalized. And that experience is so medicalized and so just dumb in so many ways that we can just do so much better without even talking about—without even taking that control piece away from people to say that this has to happen in the hospital otherwise you're doing—you're endangering yourself and your baby. Fine. Keep that. You can keep that. It has to be in the hospital. But if it's going to be in the hospital, let's just do this so much differently. And that's where I really feel like I'm most useful because I do appreciate the hospital environment. We have great nurses that do an amazing job. And we have great physicians that do an amazing job. And not every unit is like that.

MARYN: Right.

NATHAN: So I'll leave it at that.

MARYN: Right. Yeah. Well, you're right. We could talk for hours. And I always say it's not even personal. It's not even like home versus hospital. It's not doctors versus midwives. It's simply women, honestly I think—and that's a lot of the work we do is just education about undisturbed birth so that women can have that information. Families can it. They can see if that resonates with them. And then they go from there. And they don't wind up in a place they shouldn't be in. And if they have certain beliefs about birth

and even in—if they're in the hospital, then they might find a physician like you to support them.

NATHAN: Right.

MARYN: So it's just about transparency, I think, and full disclosure and having people reconnect with what's inside of them. And then they make their choices, right? There's no judgment on that, I don't think.

NATHAN: Yeah.

MARYN: We have to leave it open for people to choose what's best for them. But the majority of people just don't even know there are options or how birth works or the fact that a doctor isn't in control of their experience is. Or no one is. no one is.

NATHAN: Yeah. We wish we were. And we don't have any control.

MARYN: No. Likewise.

NATHAN: I'm with you. I'm with you on that. Yeah. Yeah. And I will—I'll also finish this part of the conversation by saying that if my wife was adamant about having a home birth, I would support her.

MARYN: Yeah. Yeah. That's awesome.

NATHAN: Yeah. And I don't mean adamant like she fought me on it. I mean if she said, "Hey, honey, can we talk about a home birth," I would be 100% on board. And we would be doing a lot of planning and everything. But as long as she didn't have any major medical issues or if I was concerned for some reason that maybe we would have something just based on my clinical gestalt, then I don't see why not. And I'm also—I'm an obstetrician. So maybe it's not fair that—I'm probably a little bit biased. But anyways, yeah. I am in support of that for a lot of people especially whenever they've been educated and they've seen so many things—as many of your patients probably have or they've had bad experiences before. It's like why not.

MARYN: Right. Right. Yeah. For sure. Obviously. And that takes a lot of work too.

NATHAN: Sure.

MARYN: It's not for everyone. And I think it's—yeah. Quite the journey for the woman herself and her partner and takes a lot of self reflection and talking about all of these things we've talked about actually. Talking about death is a huge part of birth. And we don't have to go down that road again.

NATHAN: [cross talk]. Yeah.

MARYN: Yeah. Just saying that—yeah. Often when people are in more medicalized birth situations, it's just—these kind of things aren't talked about because they assume this or that. So it's just different. They are different conversations and different care and all of that. So cool.

NATHAN: Absolutely. Yeah.

MARYN: Well, can we talk about your podcast for a few minutes? That way people know how I found you and where to find you if they want to hear you talk more. Yeah. Why don't you just tell us about it and how you came up with it and what you do over there on that podcast?

NATHAN: Yeah. Well, so the podcast is called *Obgyno Wino*. And the—so the reason—I mean this is legitimately when I have to sit down and read the—some of these practice guideline documents. They're up to 12, 15 pages long. Some of them. They're very long. Very dense. And I'm sure you've seen them. They're just packed full of info. There's no fluff. There is like—there's 100 citations. Here's what we need to know in order to stay up to date, right? On a specific topic. So do you remember which episode you found whenever you listened? You were listening to when you found me.

MARYN: Yeah. I listened to—I think it was ectopic pregnancy.

NATHAN: Oh cool.

MARYN: Yeah. And I mean—right. They're all super helpful because I don't think any midwife is opposed to technology. We have harder access, of course, to that kind of thing. And maybe women that aren't as quick to utilize it, but I found it really helpful and topics that I'll go back to. And like we were talking about things for our students to have access to as they're learning just because the way you kind of make it pretty concise is helpful.

NATHAN: Yeah. And that's what I'm trying to do. So the—there's about a hundred of these guidelines documents, I'd say. Give or take. That are published through the American College of Obstetricians and Gynecologists. And the Green Journals are sort of governing journal. Every month they produce—they either reaffirm or they will replace one of these documents with updated guidelines. And so the practice bulletins and committee opinions between them, like I said, there's a hundred or so. And every time that's a new issue of the Green Journal comes out, I'll take those topics. And I'll digest them into—I try to do it within 30 minutes. But sometimes they're so dense that it's really hard. I have to even break them into two parts.

MARYN: Right.

NATHAN: But as busy professionals, well, reading and reviewing those documents every month or so, it's really time consuming. And I'm just not smart enough to read 15 pages and remember everything. It just doesn't work for my brain.

MARYN: Right.

NATHAN: So for me listening to podcasts, I find that I'm—I miraculously remember almost everything I hear. But I don't remember if I read it.

MARYN: Yeah. I'm that way too.

NATHAN: If I'm not doing or hearing—yeah. I think a lot of people are like that. And so I prepare it. I prepare some notes from the document, and I record it as a podcast. And it's a tool for me to help keep myself update and for anybody in the birthing or the gynecology world that wants to get the updated guidelines that's what it's there for. And even if I have ten listeners, I'm still getting the review that I need. It's just a resource that's out there in case people want to indulge. Oh, and I pair it with wine. That's why the name is *Obgyno Wino*. What better way to review than pop open some Merlot?

MARYN: That's so funny. Yeah. I have to say I definitely laughed the first time I listened. I was like, "What is this guy going to do? What is this? Is he going to talk about wine?" Or no. But yeah. It's very crafty of you to combine those things.

NATHAN: Oh, it's been fun. I have some microphones and all this cool podcasting gear now that—it's—I'm just sitting on my—at my table in my house. And I'm reading my notes. And cracking jokes about my dog that's running around. It's been a lot of fun.

MARYN: Yeah. It is fun. And yeah. It'll be fun to see where that goes for you or not, I guess, depending on life circumstance and time. Getting to hear you talk about other things like today would be really fun too. Just saying. If you branch outside of the practice guidelines, but I guess you'll see how it goes.

NATHAN: Yeah. Yeah. Yeah. Absolutely. Absolutely. Yeah. It's important to mention that there are guidelines. And for anybody out there who is going to base their entire practice on specifically what is recommended in guidelines, that's a safe way to practice. But it's not always the best way to practice because, like you said, every patient is individual. Every situation is—needs to be individualized. And you have to customize your approach using any of the various tools that you've picked up in your years of practice. And that goes for physicians, midwives, dentists, lawyers, whatever.

MARYN: Right. Right.

NATHAN: There's not a prescribed way to do things. So knowing the guidelines is helpful to keep you within safe parameters. But sometimes you end up outside of those

guidelines, and yeah. So you have to know the guidelines, I guess, to know where the safety, the parameters are.

MARYN: Sure. Yeah. That's definitely true because you don't know what you don't know. So you got to start with something.

NATHAN: Right.

MARYN: Yeah. Cool. Well, anything else you want to add or [cross talk]?

NATHAN: No. I'm looking—I'm glad you reached out. I'm glad we got to know each other because I love getting to know people in the birth world. I think we live in a special sacred place. And I'm looking forward to more conversations with you and to more years of fun within this community myself.

MARYN: Yeah. Awesome. Me too. And I'll add for any of our students listening or potential students of our Indie Birth midwifery school that I would love to get Dr. Nathan here to teach for us a little bit. So we're working on that. And hopefully, we'll utilize some of your wisdom as much as you have time to share with us. But just really grateful to have you here, grateful that you are such a cool, down-to-earth guy, and likewise. Looking forward to connecting more.

NATHAN: Absolutely.

MARYN: So people can find you. You mentioned your podcast. It's on iTunes, yeah?

NATHAN: Yeah. If you search—I want to make sure that I actually have it listed here correctly. So *Obgyno Wino.* So O B G Y N O W I N O podcast. And you'll see it. You'll find it right away. It comes up right away. If anybody out there likes it and would leave a review, I think it helps it come up more quickly on the search engine. But it's a pretty unique name. I don't think that anybody has had any issues with finding it. And then on Twitter, I'm beyondtheMD as in stuff outside of medical doctor. BeyondtheMD.

MARYN: Right.

NATHAN: On Twitter and Instagram. But I'm not super into social media. You can find me anywhere though.

MARYN: Awesome. Yeah. It's pretty easy. I found you quite easily. So give the podcast a listen. Highly recommend it, of course. And Indie Birth wise, check out the site for latest information. We are enrolling for Indie Birth Midwifery School July 2019 so check out indiebirthmidwiferyschool.org. And have a great day. Thanks for listening everyone.

(closing music)