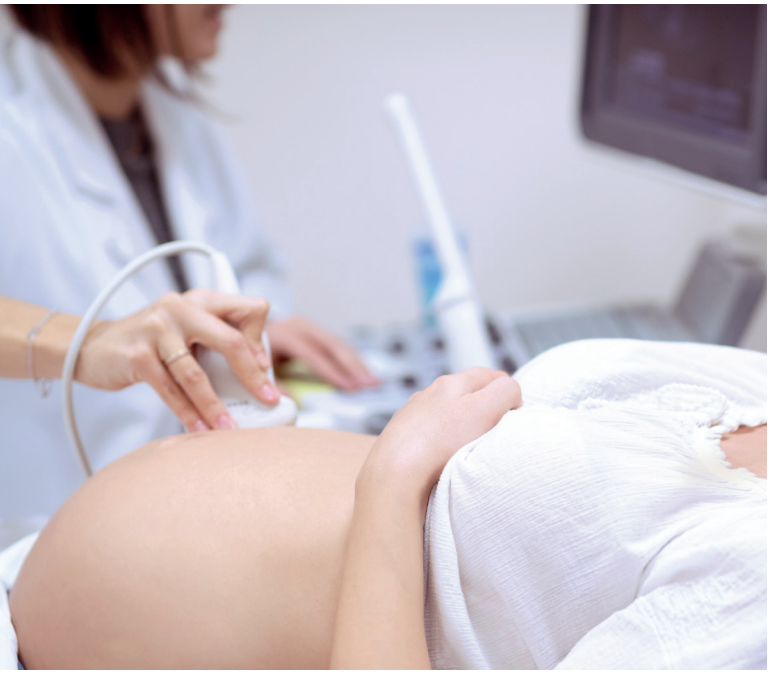
Jennifer Hawn

My journey to become a specialist in maternal–fetal medicine

By Jennifer Hawn, RDMS-OB/GYN, RN, WHNP-BC

Fifteen years ago, I became a nurse. I am now a women's health nurse practitioner (WHNP) who specializes in maternal–fetal medicine (MFM). I practice at Mercy Hospital, the largest delivering hospital in the St. Louis, Missouri, area, with 8,720 births in fiscal year 2018. This hospital serves greater St. Louis and several outlying communities in surrounding counties.

My journey from nurse to MFM-WHNP was not one I had planned to take. Instead, my career path was shaped by my own experience of high-risk pregnancy and caring for three *special* children of my own. I am sharing these personal moments and decision points with you because they may resonate with you—because of your own experiences, because you know someone who's been there, or because you're considering this field and want to read a healthcare provider's (HCP's) own take on it. In this commentary, I also describe aspects of my current position as an MFM-WHNP and explain why I think that WHNPs are particularly well suited to care for women who require the services of an MFM specialist.



The start of my journey: My role as a nurse

I earned my BSN degree from the University of Central Missouri in 2004, at age 21, and interviewed at Mercy Hospital for a position in the labor and birth department. Mercy was where I wanted to be. The hospital had a large volume of births, even back then, and a Level III neonatal intensive care unit (NICU).

During my undergraduate years, I had become interested in caring for expecting women, so when I was offered a position in labor and birth at Mercy, I was ecstatic. I was placed on the antepartum/postpartum floors for a 6-month term until the start of the next labor and birth fellowship. I didn't realize it at the time, but the 6 months I spent on those floors proved invaluable. I learned how to care for expecting and postpartum mothers, which I thought would enhance my compassion and skills as a labor nurse. During this time, my eyes were still on the prize of becoming a labor nurse.

At the beginning, the labor and birth fellowship was magical. I was fascinated by everything I learned and I was eager to assist my patients through labor and contribute to a wonderful birthing experience for them. Initially naïve, I soon learned that the labor and birth floor was not always a joyous place. Although it is one of the few *potentially* happy places in a hospital, hardship and tragedy occur there too, which I learned as I cared for women who gave birth to extremely preterm infants or who experienced fetal loss. At the same time, the experience sparked my interest in high-risk obstetrics (OB); I felt as though I was in the right place when I was caring for these women. I felt a bond with my patients during what may have been one of the most difficult moments of their lives.

Trying to start a family

As I began to try to have a child of my own, my appreciation for high-risk OB patients grew. My first two pregnancies ended in miscarriage. Even though miscarriage is common, I hadn't expected that it would happen to

me. I was deeply saddened by these losses and wondered if my husband and I would ever have a child of our own. On our third attempt, we conceived and I carried the pregnancy past the first trimester. Just when I began breathing a sigh of relief, at 23 weeks' gestation, my amniotic sac ruptured and I found my role in OB care reversed as I became a patient on the labor floor where I had worked that day. That night, I learned that my suspicion that I had been leaking amniotic fluid for the past few days was well founded. My husband came to the hospital. We remained awake all night, knowing we were facing another potential loss.

To our surprise, our daughter held on in my womb for 3 more months while I remained hospitalized. My amniotic fluid level increased, but other problems ensued, including intrauterine growth restriction and a possibility that the posterior fossa of the fetal brain was not forming correctly. Fetal decelerations prompted cesarean delivery at 34 weeks 5 days. Charlotte Ann, our little fighter, weighed 3 lb 0 oz. After her birth, ultrasounds of the brain and heart confirmed the presence of cerebellar hypoplasia and an atrial septal defect. In addition, she had a shifted dimple near the sacrum, a tethered spinal cord, and strabismus. Because of the 3 months she remained *in utero* in the hospital, she spent only 3 weeks in the NICU and never needed to be ventilated. The congenital abnormalities discovered after birth were attributed to an unknown genetic defect.

Our miracle baby came home on October 20, 2006. She is now 12 years old and doing remarkably well. The rest of her story is complicated, but if you could see her now, you would never surmise what she has endured. Charlotte's situation, as heartbreaking and challenging as it was, ultimately led me to alter my career path.

A stepping stone on my journey: My work at an outpatient antenatal testing center

Charlotte needed me to be at home, coordinating her therapy and caring for her. With reluctance, I stopped working as a labor nurse and sought a position that would be less stressful and more predictable. At this point, my career veered from its original path; I applied for and accepted a position at the outpatient antenatal testing center at Mercy in spring 2008. This position enabled me to learn more about outpatient care of high-risk pregnant women, including how to perform limited ultrasounds to check amniotic fluid volumes and how to perform biophysical profiles.

Because of my experience with Charlotte, I gained a deeper understanding of the stress that high-risk pregnant women endure, and I cherished the relationships that formed as these women came into the unit for their weekly tests. I grew more comfortable in this role, and I also became pregnant again. Assured by genetic test findings indicating that our next child would not have Charlotte's congenital problems, we proceeded with cautious optimism. My only complications/concerns were preterm contractions, decreased fetal movement in the third trimester, and preterm labor at 34 weeks' gestation—again. However, I was reassured that this pregnancy did not share any of the problems that plagued my previous one.

Our son, Ryan, was born at 34 weeks 5 days, by cesarean section. He stayed in the NICU for 11 days, and the first month of his life was uneventful. But then he began to struggle to meet simple milestones such as holding up his head and eating proficiently from breast or bottle. When he was 3 months old, we were so concerned about his worsening symptoms of tachypnea and poor ability to eat that we brought him to the emergency department at Mercy, expecting to be told that he had a heart defect that had been missed. We were shocked to learn that he had a terminal illness, spinal muscular atrophy (SMA) type I. He was discharged from the hospital with the help of hospice nurses to prepare for the inevitable. In a short time, he grew too weak to breathe and died just after midnight, in my arms, in our home, on the day after he turned 6 months.

Losing Ryan changed me forever. Once again, I gained a more profound understanding of what many women for whom I was caring were enduring. I was even more determined to find a way to help other women deal with their struggles and sorrows.

The next step: Becoming an RDMS

I bravely returned to work once again, hoping that my experience of loss and heartache could somehow be applied to help others. While working in the outpatient testing center, I was offered an opportunity to learn how to perform OB/GYN ultrasound; once again, my career path swerved. I felt destined to do *more*, and I accepted the challenge, ready to focus on healing and on building my career. I completed my training, passed my board exams, and became a registered diagnostic medical sonographer (RDMS) in 2012. While in school, I felt a *calling* to go on and earn my master's degree in nursing and become an NP.

In the midst of all that, I gave birth to our third child, Grant, at 36 weeks 6 days' gestation, in June 2011. We

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had elected to use *in vitro* fertilization with preimplantation genetic diagnosis to ensure that this infant did not have SMA, the disease that had claimed Ryan's life. Grant was healthy and thriving; we were thankful to be able to care for a typically developing newborn.

And the next step: Becoming a WHNP

In fall 2012, when Grant turned 1 year old, I entered the WHNP program at the University of Missouri – St. Louis. I believed that my entire career thus far was leading to this point. School was difficult, now, with two children to care for, but my calling compelled me to attain my goal. I passed my WHNP certification exam in fall 2015.

Putting it all together: Becoming an MFM-WHNP

When I began interviewing for jobs, I had my heart set on working in MFM, although I feared that limiting my search would make it more difficult to find a job. At the same time, I felt strongly that my training and experience of the previous 11 years, including my certification as an RDMS in OB/GYN, would distinguish me from the other NP grads applying for the same positions. As it turns out, I was offered four different positions in MFM and was able to select the one that felt right for me.

As an aside, I highly recommend acquiring a broad variety of experiences for any NP considering specializing in MFM. Years of caring for high-risk expecting women provides a knowledge base that can't be replicated in the classroom.

In my current position, I collaborate with five physicians in Mercy's MFM practice, one of whom cared for me when I "resided" at the hospital for 3 months with my own pregnancy and who observed my own professional growth and achievements firsthand. I also work with a kind and knowledgeable WHNP who mentored me in my first position as an NP. Another aside: Having a strong mentorship is a large part of the recipe for success for any new NP grad, no matter the practice or specialty.

This NP colleague and I have different strengths and backgrounds, which complement each other well as we care for the many patients we see in both the hospital and the office. This practice model, wherein the MFM-NPs work in both settings, is unusual. In most practices, NPs are either hospital based or office based. In our practice, when I am in the hospital, I participate in check-out rounds with the resident team and MFM specialist on call, round on patients independently or with our team when time allows, write H&Ps for new consults, and follow patients through their postpartum course if they have ongoing high-risk problems. In the office, I see patients for return visits, review labs, handle nurses' and medical assistants' questions, triage new outpatient consult referrals, and work with the physician scheduled in the office with me. Dual provision of hospital and office services provides continuity of care for our high-risk patients. It also provides professional satisfaction for me, enabling me to keep track of all our hospital admissions while coordinating care in the office.

One of the greatest surprises for me as an MFM-WHNP was the large proportion of patients in our practice—80%-90%—who have pre-diabetes, gestational diabetes, or hypertension. Caring for them has been another source of professional growth for me; I had not been intimately involved in managing these patients prior to my role as an MFM-WHNP. I did not have personal experience to rely on here, either. However, when you see the volume of patients that we do, both experience and confidence build quickly.

Another challenging but compelling part of my job is caring for expecting women with anxiety and/or depression—again, there are many more of them than I had previously assumed. I have relied on my education and my own experience with postpartum depression to aid me in caring for them. Their mood and anxiety disorders must be taken seriously; many women suffer in silence and do not ask for help. Many of our high-risk patients, who may not initially present with anxiety or depression, have major risk factors for both illnesses. I aim to create an open, nonjudgmental line of communication with

these women so they feel safe in sharing their feelings and concerns. Being the person who listens to them and explains their therapeutic options is gratifying.

I am proud to call myself a WHNP. Our unique training, focused on caring for women throughout the lifespan, is imperative for any nurse seeking an opportunity to work in MFM. In fact, WHNPs are ideally trained for a position in MFM. WHNPs take focused courses on reproduction, endocrine disorders, contraception, breast health, mood disorders, social determinants of health, and other specialty topics that many other education paths fit into one class session. This comprehensive coursework was the foundation, alongside my personal experience, that gave me the confidence I needed when I began practicing in MFM.

Another giant step: Joining the NPWH Board of Directors

After holding my current position for about a year, my professional goals continued to evolve, leading me to accept a position on the NPWH Board of Directors (BOD). During school, I was fortunate to have an instructor, Dr. Susan Kendig, who served as my first mentor and, at the time, as an NPWH BOD member. Dr. Kendig was gracious enough to continue mentoring me after graduation. When she asked me to get involved with projects related to caring for high-risk women, I said *yes*. She also encouraged me to pursue my goal to be on the board. To my surprise, after just 2 years of working in the field and working with NPWH on other projects related to MFM, I was asked in January 2018 to serve on the NPWH BOD. This position has sparked other opportunities for me to serve on state-level committees and boards that will be instrumental as Missouri addresses maternal mortality related to OB complications. Like other steps along my career path, serving on the NPWH BOD is something I feel called to do.

Concluding thoughts

I am fortunate to be able to apply my education and experiences to make a difference in my profession and in the lives of high-risk pregnant women. For WHNPs considering a career in MFM, keep in mind that the field is challenging. On many days, the weight and gravity of the job can take a heavy toll on HCPs with tender hearts—especially if they have already known tragedy in their lives. For me, some experiences hit so close to home that I must hold my breath and suppress much of what I'm feeling in order to function in my professional role.

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When my job challenges me in this way, I take a moment to reflect on my winding career path, taking a reverse trip down memory lane. I arrive at the same conclusion, and know that I am doing what I was destined to do. These feelings of deep connection with my patients shape how I care for them. I can't share my personal experiences with all my patients, but there are many with whom I do share my pain and sorrow, women who have benefitted from knowing that they are not alone. It is not a prerequisite for an MFM-WHNP to have suffered a tragedy to excel at this job. However, I believe that, in my case, my own experience has given me a humbling appreciation for the women I serve and has empowered me to be their advocate and pillar of strength when they need it most. If I could give any advice to NPs contemplating a career move, it would be to encourage them to seek a mentor in their desired specialty and grab an opportunity that may take them down a path they might not have originally contemplated navigating but that somehow now feels right. I'm pleased that I did.

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