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Commentary

Pregnant during the pandemic: United in motherhood

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The cold hospital phone and fluorescent lights amplify the emptiness. “I am so sorry…we did everything we could.” The deafening stillness is interrupted by the distant sound of kids playing. Though hospital visitor restrictions are loosened at the end of life, he couldn’t come to say goodbye because he had no alternative childcare for their two young children. Tears begin to well, blurring everything around you. The momentary silence feels like an eternity. You search for words, but there are none. “I am so sorry,” you hopelessly offer again, trying and failing to steady your voice. As your own baby kicks, your heart sinks with guilt.

You run everything over and over in your head. You recall her laugh at the first pregnancy ultrasound, your shared fear in March when the seriousness of COVID-19 became clear, and how you bonded over what a strange time it was to be pregnant. If she was nervous when you admitted her to the hospital, she never let on. Her youth and her smile sustained us as much as it did her family, who didn’t realize that they would never again see her in person. She inspired us, consenting to participate in research because she wanted to make sure that pregnant Latinx people were included in clinical and translational studies aimed at understanding outcomes and biological effects of COVID-19 in pregnancy [1,2]. We’d tried everything: steroids, remdesivir, convalescent plasma, IL-6 modulators, proning, intubation, ECMO, hope. With the end near, you look into her dark brown eyes, willing the wrinkles around yours to relay your emotion, your gratitude for her life and her strength. At home that night, you think only of her. And the sweet baby in the neonatal ICU who would be discharged home without a mother.

Maternal death is heavy. Heavier as obstetricians and mothers. Heaviest while pregnant. The inexcusable maternal mortality rate in the U.S. was already on the rise prior to the pandemic [3]. Emerging data suggest that symptomatic COVID-19 may be yet another risk factor for maternal mortality which unequally affects minoritized patients of color [4-6], a frequent reminder of broken systems and enduring structural racism [7]. Death in the time of COVID-19 is particularly searing and tragic. There is an emptiness, a pervasive, cold new version of loneliness. The touch of loved ones, minimized, if allowed. Babies separated. And there is collateral damage; for everyone, the presence of supporters during birth is restricted. Some are birthing alone. *Will I be alone?*

As specialists in high-risk obstetrics, being pregnant is nerve-wracking. It is impossible for the mind not to venture into the “what ifs”. The experience of being pregnant during the COVID-19 pandemic is strange and injected with even more uncertainty. Comfort has been replaced by trepidation, joy shrouded by the suffering around us. Usually, Labor and Delivery is a hidden sanctuary, filled with the energy and laughter of families overjoyed at birth, and relieved staff – safe moms and babies. Obstetrics is a risky business to be sure. But before the pandemic, caring for multiple pregnant or postpartum patients in the ICU at a time was rare; now, it is unsurprising. In our daily work on the frontlines, our own pregnancies sharpen the highs and intensify the lows.

COVID-19 has also brought to the fore a longstanding neglect of women’s health research [8]. In our roles as physician-scientists, we live for evidence – data with which to guide our patients to the best decisions for themselves and their families. This past year, as we all tried to consume and integrate the rapidly evolving data on the science and outcomes of COVID-19, obstetric patients and providers were left in a data-free zone as pregnancy-related data were slow to emerge, and pregnant individuals were excluded from many trials of novel therapies. As a result, we’ve often felt unable to provide the meaningful counsel patients are seeking. Thus, we were compelled to do the research, in search of answers for our patients and ourselves [1,2]. We’ve been at the forefront, advocating for safety data for vaccines because pregnant and lactating women were left out (again) [9]. We’ve forged new collaborations both in and outside our specialties and made efforts to ensure our patients and our concerns are part of the discussion.

“What am I supposed to do now?” The desperation in his voice is apparent. Before you can process, you’re paged to a delivery. Just as you arrive, a member of the team shouts, “Happy birthday!” and the baby appears, crying her first breath. Family members cheer on the video screen as their new addition settles onto mom’s chest. Although she tested positive for SARS-CoV-2, your patient will be

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able to keep her baby with her because researchers – exasperated by early policies of automatic separation at birth – worked hard to show that asymptomatic mother-to-baby transmission is incredibly rare [10]. Despite a tough day, a flicker of hope shines through. You feel the familiar rumble of your baby kicking again, and are mindful of your gratitude for a safe and happy birth, and baby who will know her mother.

Declaration of Competing Interests

Drs. Afshar and Parchem have nothing to disclose.

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Author contributions

Drs. Afshar and Parchem wrote the manuscript.

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