An Intersectional Analysis of Experiencing A Maternal Near Miss

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Introduction

After giving birth, birthing people tend to forget all about the pains of their labour and the stress of their pregnancy the moment they lay eyes on their new baby. However, for my cousin – and later my family and I learned, many other women – there was not much forgetting to be done. With two children prior to the birth of her third, she thought she knew all the trials and tribulations of pregnancy and labour. The doctors and nurses warned of "normal" risks like miscarriage, gestational diabetes, postpartum depression. No one prepared her for a maternal near miss – but they could have.

"Maternal near miss" (MNM) is a phrase used to describe birthing people who experience complications during pregnancy, labour, or after terminating a pregnancy that nearly take their lives. In these situations, it is impossible to imagine what a birthing parent and their child go through, and even worse if these complications end with the loss of the child's parent. In many stories of women who have experienced a maternal near miss, or stories from the partner of a parent who has passed after such complications, they often express that they were not warned of this possible outcome. Surprisingly, even as the United States is one of the top 20 most developed countries, according to the United Nations Human Development Index, rates of mortality and maternal near miss are much higher than an OBGYN's warnings might make them seem. In this next section, I will be telling my cousin's story – using accounts from my cousin, as well as her partner, her parents, and my own parents.

My cousin's story

My cousin's experience began after her C-section, when she gave birth to her third child – a beautiful baby boy. She was discharged from the hospital two days post-op, and two days later, she began to feel pain around the area of the incision that should have been healing from her C-

section. During her post-partum follow up, she showed her OBGYN that her cut seemed to be open in some areas, as well as extensive and painful bruising all over her stomach, and much more bleeding than she had experienced with her first two C-sections. The doctor assured her that this was normal for someone during their third C-section, suggested a natural supplement for the bruising, and sent her home. At this point, she had been wearing adult diapers to contain her bleeding, and over the next ten days, she would pass thicker blood and much larger clots than she had ever before. On the tenth day, unsure what else she could do, she made her way to the Emergency Room of the hospital she had given birth in and was taken in for ultrasounds and a CAT scan. They noted that her uterine lining had thickened, and were able to diagnose her with endometritis – the inflammation/irritation of the lining of the uterus, or endometrium, caused by an infection - , which led to her being admitted to the women's center for two days. There she received antibiotics for the infection, as well as a drug which would induce labour-like contractions to help her pass any debris left in her uterus – sleeping pills and pain medication were of no use for her extreme pain, and it only wore off as the drug did.

By now, I am sure her body was worn and exhausted. Her bleeding continued to worsen after her visit to the ER, along with her pain, so she returned to her OBGYN yet again. She spoke to a nurse midwife, who, after consulting a doctor, prescribed another drug (Cytotec) that would help her to break down and pass her thick uterine lining, as well as told that if her ultrasound results had not improved, she would need to prep for a dilation and curettage procedure – where the cervix is dilated so the uterine lining can be scraped of abnormal tissues. After taking the medication, my cousin was in such great distress that her children would stay on and off with my family, as well as with her parents, because she was physically and mentally unable to take care of them herself, and her partner needed to be focused on her health concerns. While at her OBGYN, she was told by a nurse that her ultrasound had not changed, and that she should prep for the dilation and curettage procedure at the hospital. Moments later, the nurse told her that the doctor believed that her bleeding was normal and common for someone in their post-partum period.

Because of her pain and the initial reaction of the nurse, my cousin chose to go to the hospital anyway, and was admitted immediately upon explaining her situation and results of the ultrasound. The procedure was performed, and she was able to go home that night.

It is understandable to wonder at this point how, at 22 days post-C-section, she had not been properly taken care of or listened to. She had been bleeding heavily for 22 days (and for reference, normal postpartum bleeding, also known as lochia, should become light around 7-10 days, and can occur for 24-36 days). Now, on the last day of August, my cousin experienced something that felt like a rupture in her abdomen. Unable to stand or walk, bleeding heavily, and in much more pain, she called an ambulance. Upon learning that she had recently undergone a C-section, as well as the dilation and curettage procedure, they immediately decided to take her in as a "non-emergency" patient and chose not to hurry to the hospital. They informed her that they were simply "transportation to the hospital" and deemed her situation not immediate – even after she described the immense pain she was in and how heavily she was bleeding. This was around 3 in the morning. Not until 5:35am was she given an external pelvic ultrasound, and at 6:36am, a CAT scan. Her pain had escalated so much that morphine did not change her pain level, and when she was given Dilaudid (hydromorphone) – the strongest narcotic available to her – it made no difference. During her first and second pregnancies and labours, she did not complain about her pain (and thought to have a high pain tolerance); this time she described her pain as 200 on a scale of 1 to 10. She expressed to the nurse that she could feel her bleeding getting worse, and no one came to check the adult diaper she was still wearing – her nurse even informed her partner that they were considering sending her home. She laid in her hospital bed for over 20 minutes after asking to use the bathroom, because she felt lightheaded and was told she was a fall risk. The nurse continued to walk back and forth, daring to tell her she was "not ignoring" her in what my cousin described as a condescending tone, and when she finally brought the commode, with her partner's help moving to and from it, she was able to urinate what she described as only blood.

At 8:35 and 8:36am, my cousin sent texts to both her mother and sister, telling them that she knew she would die. When she felt the need to urinate again, her partner tried to help her up, only for her to begin feeling extremely dizzy and she reported not being able to see properly or hear properly. He then noticed that both her hospital gown and sheets were soaked through with blood, coming from her pelvic area. All this time the nurses coming in and out had done nothing. She began to shake and feel very cold, and only then was her partner able to get someone's attention to see what was happening to her. From this point on, she remembers a few key things, as she was in and out of consciousness and unable to see and hear very well. A doctor she had never met before told her they would be taking her back to surgery to try and stop the bleeding. The moment my mother and father arrived at the hospital, things slowly began to move forward. They noticed her clothes and sheets right away, as well as how much she was shaking, and that her face – normally a light brown – was losing colour, along with her lips. My mother describes seeing her go from her warm skin tone to almost grey. She spoke sternly to the staff, explaining to the nurse her own experience with a similar bleeding incident and that the way her own doctor had helped her was with a hysterectomy. My mother insisted they do something, as my cousin was looking more faint by the minute – and asked them when they planned to give her blood and get her into surgery, as well as demanding blankets because of how badly my cousin was shaking. She recalls that the nurse insisted they could not perform a hysterectomy on my cousin due to her recent C-section, however if my cousin herself insisted, she could sign a form and they would perform the procedure right away. My mother explained to my cousin, who was still slipping in and out of consciousness, that she should sign the form and allow them to perform the procedure. She agreed. My cousin listened to the voices around her as they spoke to each other, saying it would take 30 minutes to have blood ready for her from the blood bank (because trauma was out at the moment), and hearing another voice say, "she doesn't have 30 minutes." Hearing that alone would put most into absolute terror. Her last words were her whispers to the doctor who would save her life, pleading about her 3 very small children.

A note, along with some important information:

There may be some concern if this kind of interaction by a family member can truly persuade a medical professional to perform or ask for consent to perform a procedure they had not initially planned on. When my mother interacted with the nurse taking care of my cousin, she was firm and used her own personal experience with heavy and continuous bleeding (that was solved via a hysterectomy) to explain why she believed my cousin needed a hysterectomy to stop her excessive bleeding. I believe that my mother's words to the nurse may have been minorly persuasive, but the most important thing she did was point out my cousin's frail and sickly state – which motivated the nurse to find a better solution than leaving my cousin bleeding out on the hospital bed.

It is important to note that, while we should never invalidate the traumatic experiences of any party involved in something as high intensity as this, people may have different recollections of such a difficult event. Drawing from cognitive psychology research, there are two different kinds of long-term memory classifications: explicit and implicit memory. In a situation such as this, where someone is asked to recall information from an experience, we focus on explicit (or conscious) memory. These memories are further classified into facts and knowledge (or semantic memory) and personal events and experiences (or episodic memory). To share a recollection of an event such as these quick actions during a time of distress, episodic memory is accessed and the event is described by sharing details with others (this is also sometimes called declarative memory). Episodic memories require a kind of mental time travel, also known as self-knowing or remembering, which may also be key to understanding the significance of Post-Traumatic Stress Disorder and its related experiences regarding MNM.

In this specific instance, we can see that my mother is accessing an experience stored in her long-term memory, which calls for a deeper recollection of her own feelings during this time of extreme stress. She uses episodic memory through her conscious/explicit memory to describe what she felt, and semantic memory to describe the specific facts of the situation (e.g., that she explained a memory to the nurse, who ultimately gave my cousin a consent form and got her into surgery).

7 hours after being brought to the Emergency Room, she was finally brought into surgery. Her fight was still far from over. She was informed once she was awake in the Intensive Care Unit that her uterus had ruptured, she had to do an emergency hysterectomy, and she developed a condition during the surgery called disseminated intravascular coagulation (DIC), which affected her blood's ability to clot and stop further bleeding. In the end she received 6.5 litres of blood. In the days after, she had a lot of trouble urinating, and nurses who came in to talk to her assured her that her case would be reviewed and taken seriously. Four days later she was sent home from

the hospital, unable to go home and see her children because she could not risk further worsening her incision, being cared for by our grandmother in her house, as my cousin's own home also had stairs she could not climb. In the coming weeks, her incision would struggle to heal, become infected, and she would be instructed to irrigate and pack the wound twice a day – which our grandmother was able to do for her in the weeks she continued to stay at her house. Her children begged for their mother to come home day and night.

Psychologically, my cousin was traumatized from what she had gone through – the neglect from her nurses and the refusal of her original OBGYN to take her seriously or admit her mistakes. Not to mention from the MNM she had experienced, along with the fear of leaving her children and family behind. Moving forward, she was unable to pass a depression screening, reporting to her new OBGYN that she needed help. She was struggling to sleep without medication, crying randomly during the day and night, having panic attacks, and experiencing night sweats. Her poor appetite only exacerbated her feelings of weakness and instability of her body. Along with this, because of the weeks spent in the hospital and the fragility of her body, she was unable to bond with her newborn son – her partner, along with my own family and her parents, had been taking care of her three children on shifts, and they stayed frequently at our respective households. She felt lonely, upset that she was unable to see and care for her children at home, reporting that she felt like an inferior mother, even as she had been through so much. Upon mention of what she went through in the hospital, she would relive those moments in terror and fear – leading her OBGYN to suggest she was also experiencing PTSD.

August/September of 2021 marks two years since this awful MNM experience, and it continues to affect her to this day. Sometimes through moments of intense emotion or fear of incorrect treatment by medical professionals for herself and her children, along with how severe a simple infection can be because of her previous conditions' impact on her immune system. If her doctors had warned her that any of this was possible – if she was treated properly and not

ignored continuously by nurses and have her symptoms dismissed by medical staff all throughout the hospital and OBGYN office – she may have had the opportunity to prepare, whether mentally, physically, or financially, for what was to come.

Literature Review

In the past, maternal near miss rates and maternal mortality rates have been extremely high due to many factors that may include lack of general education on the subject, as well as factors such as race, gender, and age. As years have passed, more has been done to decrease these rates, and in some countries the results have been significant. However, there are still concerns about how high the number of cases of MNM continue to be, especially in countries we consider to be developed. This review will view resources that present these problems, as well as working definitions of the phrase "maternal near miss" and thoughts on how we may be able to improve these conditions in the future.

Defining Maternal Near Miss and Other Terminology

Goffman et al. (2007) describe 'near-miss morbidity' as involving any of the following conditions: admission to the Intensive Care Unit, an emergency or unplanned return to the operating room for hemorrhage, eclampsia, emergent hysterectomy, cardiac arrest, cerebral anoxia, shock and embolism. These conditions are defined as follows:

Hemorrhage	A ruptured or broken blood vessel that causes a release of blood either in or outside the body	**Emergent hysterectomy**	Involves the removal of the uterus, potentially also including cervix, ovaries, and Fallopian tubes
Eclampsia	A complication of preeclampsia, or high blood pressure, that may result in seizures during pregnancy or labour	**Cardiac arrest**	Involves a sudden loss of blood flow via failure of the heart to pump
Cerebral anoxia	Occurs when the brain is entirely deprived of oxygen	**Shock**	A condition that results from the body's lack of blood flow, when cells and organs are not given

			enough oxygen to function
Embolism	A blockage in an artery, usually due to a blood clot or air bubble		

Knowing the meaning of these terms will be useful in understanding the specific conditions that increase the risk of maternal death or MNM.

Research and Statistics Surrounding Maternal Near Miss

Say et al. (2009) explains in their study that maternal morbidity, which is a more general term for health concerns that arise as a result of pregnancy or childbirth, may be a better indicator of the quality of obstetric care when compared to rates of mortality, or death. These instances of maternal morbidity, including MNM, can be much easier to study because they are not as rare as maternal mortality/death, but still a small enough number that is manageable to research, especially within a given facility (Say et al., 2009). In the article, a near miss, or severe acute maternal morbidity (SAMM) case is defined as a situation relating to pregnancy or someone who has recently delivered a child, and who experiences a severe complication that may result in death if not for the intervention of hospital care or by chance/luck.

To gain a better perspective, we should look at general statistics of maternal near miss and maternal death from around the world. Research done by Souza et al. (2009) based on the World Health Organization's global survey about maternal health (2005) reports that with approximately 15 thousand women dying each year in Latin America and the Caribbean, focusing on assessing cases of maternal near miss can be the key to understanding such a large number of maternal deaths in these regions. The results of this study found that a previous Caesarean section was positively associated with the probability of a maternal near miss occurring, meaning that having multiple children birthed via C-section increases your chances of having a MNM or maternal death (Souza et al., 2009).

Souza et al., (2012) expresses that, though the rates of maternal deaths and near misses have decreased since the 1990s, there is still work to be done to decrease this number much more, as it was estimated that as many as 287 thousand maternal deaths happened around the world in 2010 alone. The World Health Organization (2012) discussed that the initial target for the fifth Millennium Development Goal is to reduce the maternal mortality rate by at least 75%; while this difference can already be seen in some countries listed in the report, such as Lithuania, Islamic Republic of Iran, and Estonia, we have yet to see a difference like this in the United States.

Specific Risk Factors

Goffman et al. (2007) find that there are certain demographic factors that increase the risk of a maternal death or maternal near miss. These factors include race – where Black women experience the greatest risk, followed by Hispanic women, when compared to non-Hispanic White women – and age – where women experiencing MNM were likely to be older than 40 years, when compared to women 35 to 39 years old. Not among these factors were medical insurance status, differences in levels of education, as well as marital status (Goffman et al., 2007). Women who had more than one prior pregnancy also experienced a greater risk for maternal near miss, along with women who had previous C-section procedures (Goffman et al., 2007). Prior significant medical conditions as well as obesity (defined as body mass index of over 29) were also risk factors for MNM or maternal death. In this study, Goffman et al. (2007) discusses that racial disparities undoubtedly exist in maternal morbidity and mortality rates – it has not yet been determined whether these disparities come from a biological, social, or other background.

Furthering Knowledge

It is important when viewing a subject such as this to identify things we can begin to do in order to increase the likelihood that someone survives (maternal near miss) instead of passes away (maternal death), as well as to increase the likelihood that it does not happen at all. Goffman et al. (2007) also discuss the importance of the education of women who are pregnant or planning to be pregnant, as well as their health-care providers – such as hospital staff and OBGYN nurses and midwives. These mortalities may also be influenced by better education in the area of contraception and age at which you choose to have a child (or the age at which you become pregnant).

Overall, there is a lot more research that has to be done in the area of maternal mortality and maternal near miss. After this short review, we can now be more educated on obstetric terminology and their meanings when referring to these mortality and morbidity rates, as well as conditions that may cause these rates to rise and fall. Obstetrics in America as well as in other countries has a far way to go but raising awareness for maternal near miss is an important first step. Along with this, identifying problems that arise from demographic involvement as well as with malpractice within institutions may be extremely beneficial to decreasing the number of women unfortunate enough to fall into the maternal mortality and near miss statistics.

Main Body

Maternal near miss survivors

Survivors of maternal near miss are frequently nowhere near the end of their fight. These complications may be grounds for legal action against medical facilities or specific medical doctors, mental health complications as a result of extremely traumatic experiences, and many more that may not only involve the birthing person but their partner, child, and close relatives/friends. A birthing person who deals with maternal near miss experiences may, as my cousin did, require some form of therapy to assist with diagnoses of mental health conditions that arise as a result of the trauma – e.g., PTSD diagnoses based in the patient reliving their traumatic experiences upon mention of the experience or sounds they experienced in the hospital. There is a brief note in the introduction section which describes the process of recalling an emotional or personal memory or experience – which is an incredible insight into the reasons why PTSD may affect someone who has experienced MNM so greatly. Using a kind of "mental time travel" to recall and describe a memory can bring you back into the moment as if you were there. In normal circumstances (of non-traumatic memories), it may be common to feel a minor emotion connected to this memory, such as a small spark of joy or sadness. However, with such a traumatic memory, it would make sense that traveling back to something so intense would bring up such powerful emotions.

People who survive a maternal near miss are easily able to connect with others who have gone through, or are going through, something similar through Facebook groups. The most prominent one is called the "Maternal Near-Miss Survivors Support Group," which has over 1.1 thousand members. The group began in 2016 under the name "Maternal Near-Miss Survivors" and fosters a large community of birthing people who have experienced maternal near miss. These members all discuss their pain and difficulty with each other in hopes of gaining support from people from all walks of life who have experienced something as painful as they have.

Racial discrimination and maternal near miss

As with any field related to hospitality, there is possibility for racism and other prejudice, because there are many interactions between races, ethnicities and identities. As described in the Specific Risk Factors section of the Literature Review, there are racial disparities in the rate of mortality and maternal near miss. Specifically, there is an increased risk for experiencing MNM if you are Black or Hispanic when compared with Caucasian birthing people. Black women are noted as most likely to die or experience maternal near miss when compared to Hispanic and Caucasian women. Hispanic women are second most likely. These disparities come from the presence of racism and prejudice in places where the main concern should be the safety and wellbeing of a patient and their families and children. Unfortunately, as this issue of racism continues to push through fields of hospitality and take lives, we need to push back and make sure that our birthing people of colour are properly taken care of, believed, and validated in their experiences.

Gender discrimination and maternal near miss

One disparity upon first glance of the issue of MNM is the current lack of inclusion of other genders of birthing people. While some articles and documents refer to MNM in terms of all possible genders of birthing people, others fail to recognize this development. In most peer-reviewed research, the use of only the word “women” to describe the gender of a birthing parent can be noted, with little to no use of gender neutral or non-discriminatory terms. There also seems to be a lack of research involving transgender birthing parents, who may experience different forms of discrimination to cisgender women during labour and delivery, as well as who may have different physical complications. These issues need to be addressed as soon as possible, because the first step to reducing maternal mortality for all birthing persons is to assure there is applicable research in all areas in order to formulate solutions to already present and newly discovered issues.

In discussion with a birthing person who has had a similar experience to my cousin during their own pregnancy, I learned more about the likelihood of having difficult or unusual symptoms be dismissed by medical staff before, during and after delivery. In my cousin's experience, she was visibly very unwell and (according to accounts from herself, her partner, and my mother) her sheets were so bloody that it would have been impossible not to notice if you had paid even minor attention to her physical state. She described a nurse coming in and out of the room, blatantly ignoring her concerns and cries for help as she struggled to stay conscious and fight. Her experiences with her two previous pregnancies allowed her to be more in touch with what she was feeling, what was normal, and what felt wrong. Other birthing people may not have these experiences, however, making it difficult for them to know if something is wrong simply based off of their current and prior symptoms.

In a postpartum unit, nurses are in charge of taking care of a few patients at a time. This means that in some cases, they will have to use their discretion and take care of one patient before another, given the right circumstances (e.g., a patient is having extreme pain and heavy bleeding versus another patient whose pain medication is beginning to wear off and requires another dose). Both patients in the example should be acknowledged and given what they need, however, the more time-sensitive emergency happening to the first patient should be dealt with as a first priority. My cousin has recalled privately that she heard her own nurse laughing outside in the hallway with some other medical staff in the ward, which allowed her to infer that they did not have another patient who needed tending to more than she did in the moment. She felt lost, confused and like the nurse did not care whether she lived or died – whether she would ever see her new baby or her other children again.

Birthing people and medical care providers

In environments such as hospitals and other medical care facilities, there are a myriad of factors that influence the treatment and outcome of patients. For example, in emergency rooms, patients are triaged and given treatment on basis of importance – if you come in with a minor cut, you will be prioritized underneath someone who was in a major car accident. In the postnatal ward of a hospital, a birthing person's opinion on the state of their own health may be ignored when other patients need to be tended to and the nurses on-call deem the situation to be stable enough to put off momentarily. Unfortunately, in some cases medical professionals may ignore signs that turn into much more life-threatening complications than anticipated. In maternity and postnatal wards, nurses and doctors have a greater potential to miss signs of a more serious issue due to the nature of the environment – they are constantly checking on people in the ward for signs of complications as well as if they are close to giving birth or if their baby is in need of emergency intervention.

The child and birthing person's partner

These are the stories we hear if, unfortunately, the birthing person does not make it. When we hear about these instances, they can give those who were fortunate enough to survive their pregnancy complications extreme survivor's guilt. A partner can be severely traumatized by the death and prior complications of their birthing partner, which may lead them to require therapy or other means of learning to cope. This can be especially difficult considering that this person now has to support their child alone – moving from co-parenting in one household to becoming a single parent before they could consider preparing for this possibility. The strain on birthing persons' partners is often overlooked as we delve into the depths of the birthing person's experiences, complications and trauma, however their partner's well-being is just as important (and impacted).

We also may forget about the significance of the child's experience in situations of maternal near miss. These complications, especially when occurring during pregnancy and labour, may not only impact the birthing person's health but the baby's health as well. When the birthing parent goes through such trauma, a baby can experience extreme and life-threatening effects like stillbirth, birth asphyxia, low birth weight, neonatal mortality, or admission to the NICU (Neonatal Intensive Care Unit) (Liyew et al., 2018). These severe effects are much more likely with birthing parents who experience maternal near miss when compared to those who do not. Alongside potential physical complications to the newborn, there are ones even further overlooked: developmental concerns when related to mental health. Child development, as studied in developmental psychology and related fields, begins the moment the newborn is born. This means that from their first parent contact, they are developing into who they will become. Harry Harlow, a psychologist best remembered for his experiments with rhesus monkeys, gave us vital information regarding the needs of newborns. Using a wire mother model who provided food and a soft, comforting mother model who provided no sustenance for the monkeys, he gave the baby monkeys an option of which mother they would prefer. Overwhelmingly, the monkeys chose the cloth mother who provided no food. This can attest to a human newborn's desire for skin-to-skin contact, and how important this is in a newborn baby's development. In situations of maternal near miss or maternal mortality, we see that children are tended to by nurses regarding feeding, changing diapers and keeping them warm and cared for. However, there is no replacement for skin-to-skin contact with a parent for these newborns. For example, in the case of my cousin, luckily her partner was able to care for her newborn – feeding him, changing him, and holding him close. Because of her trauma, she was unable to connect with her baby for months after his birth – especially as she associated him with what she had been through and felt distant from him, unlike how she felt with her two other children. In these scenarios, especially in cases where parents are too tired or traumatized by the birth experience to keep in physical contact with their newborn, these babies can suffer greatly from the lack of contact and love.

Suggestions for changes to research methods and improving post-MNM wellbeing

In many countries, employers provide from 14-weeks to a year of maternal leave. However, in the United States, many employers provide little to no allowance for birthing people to stay at home with their children for a period of time before returning to the workplace. This can be trivial especially for those who experience maternal near miss, because they may feel pressured to return to work too soon after a traumatic experience – before they truly feel ready to. Notably, my cousin tried to return to work in person much too soon and was hit with both physical and mental obstacles as a result.

More important notes in the future directions of maternal near miss research include allocating more resources to researching maternal near miss in gender neutral/nonconforming and gender minority people. There is not nearly enough done in these areas, and research frequently leaves out these terms altogether – meaning that solutions for reducing instances of maternal near miss are wholly tailored to the cisgender female body. In order for everyone who is impacted by maternal near miss to also benefit from maternal near miss research and intervention/prevention measures, there needs to be substantially more research directed to all potential victims of MNM and maternal mortality. While on this topic, it may also be wise to consider the names of these concepts – maternal near miss and maternal mortality. Using the word "maternal" implies a female cisgender parent, which is not always the case. In order to hear more stories about MNM and maternal mortality, there should be more gender inclusive language in the area of birth and pregnancy in order to allow members of gender nonconforming groups the comfort and safe space to share their story without judgement or feeling misgendered/misrepresented.

To continue bringing a more intersectional perspective to maternal near miss research, there needs to be more work done regarding Black and Hispanic birthing people, including focuses on Black and Hispanic transgender birthing people – who are generally underrepresented

in many areas. In order for us to continue working to save lives and prevent maternal near miss and maternal mortality experiences, we should involve every potential birthing parent. Without this integral research, we would not be able to push for prevention/intervention strategies that are tailored specifically to all birthing people. Similarly, we should include the experiences of birthing people who experience complications past the 42-day period that maternal near misses are considered. If a person experiences complications on the 43rd day post-partum, their experience should be validated and included, not cut out of research and prevention/intervention plans because their trauma did not happen in time. We must always remember, first and foremost, that this research and future prevention/intervention plans are to save lives of real people who are fighting to survive in a terrifying and life changing situation.

In situations of maltreatment by members of staff or medical professionals in hospitals or doctors' offices, it should also be less difficult to hold these participants accountable. A private account given to me revealed that an OBGYN who was caring for a victim of maternal near miss already had multiple maltreatment concerns on file from different pregnant people who all had similar experiences with this neglectful person. Unfortunately, because of the high protections given to people in medical careers (especially in large institutions), there was no way to 1) discover this information until something tragic had already occurred, and 2) to hold this person accountable for the many lives they could have taken while not giving the proper care to their patients.

Lastly, it is important to mention that there is a lot of work to be done regarding raising awareness of what maternal near miss is, its likelihood, and what birthing people and their families and partners can do to prepare for such an event. In any case, birthing people are much less aware of the possibility of maternal near miss than they are about other general pregnancy and labour complications – meaning that they are usually thrown into these experiences with little to no preparation or warning. Maria Corona, mentioned previously, was completely unaware of

the possibility she could pass away, as was her husband, until it was too late. Similarly, my cousin was unaware she could have entered her last moments while bleeding out in a hospital bed in front of trained medical professionals who refused to help. Nurses and doctors in hospitals should be a diverse group with multifarious backgrounds in order to lessen the possibility of racial or gender discrimination of patients. Nurses should also be more educated on the warning signs that something may be going wrong before, during, or after labour and delivery, as well as given refresher materials to keep on hand in case a situation arises. Patients should be given room to explain how they are feeling, be validated in their trauma and experiences, and treated with as much care and kindness as possible. Medical professionals in hospitals and other birthing locations should always be aware that their patient knows their body the best, and if they believe something is wrong, it should not immediately be dismissed or given a low priority.

Podcast Notes and Script

At the beginning of this podcast, there will be a trigger warning because I would like to give ample warning that the specifics in my cousin's story may be triggering for those who have been through or have family who have been through a maternal near miss or loss of life during pregnancy.

I would like to mention somewhere in this video/podcast that another mother, Maria Corona, experienced postnatal complications the same weekend that my cousin's uterus ruptured, but she didn't make it (and her husband shared her story). She was also ignored by hospital staff and was sent home, only to seek out help from another hospital where they told her partner he'd have to leave the room for an "intense procedure," where she died.

- Talk about how there was always room to save her – how insurance and healthcare are not supportive of pregnant people getting true help (as he said they turned his wife away due to the insurance not paying for her to stay any longer)

Insurance and healthcare providers in this country and many others do not have the best interest of the patient in mind. If it wasn't for her insurance, there is a possibility that Maria could have lived for days, weeks or years past the day she was taken from Sam and their baby so soon. My cousin had a similar experience with hospitals sending her home, when they were not over full and had enough staff to cover patients in the ward. It took her a ridiculous amount of time to get someone to help her, to believe her.

I believe, based on sheer luck and support from her partner and my family, my cousin was able to survive. If she didn't have her loved ones on her side, pushing for her to get help, I believe, just as much as she did as she texted her mother and sister goodbye, that she wouldn't have made it.

- And that some people survive out of sheer luck and support – how my cousin had the support of my mother and her partner in the moment that saved her life

I would also like to discuss a little bit about inclusivity and how, even though some articles and papers use gender inclusive language, they should (at the same time) be including these gender minorities in their research.

- There is no use using such language if you do not give these gender minority birthing people the same amount of care and effort when researching such an awful and traumatic experience – especially because people of gender minorities already receive less coverage with their experiences in general; they should always be involved in research efforts (especially because, as you can expect, gender minorities will likely receive even less care and attention in these settings where women are already overlooked, and may die more often relative to women's maternal mortality rates)
- People of gender minorities may also be afraid to tell their stories because of the overwhelming number of women who tell their stories – they may fear discrimination or being drowned out by people with a greater ability to reach larger audiences

Script

This podcast will discuss mental health issues, maternal near miss, and pregnancy trauma, as well as other difficult topics. Listener discretion is advised.

Imagine you've just had a beautiful baby. This should be one of the most glorious moments of your life, but you spend the next weeks in terror as you feel yourself drifting away. No one will listen.

Those moments you were supposed to love - to see your baby boy and hug him and kiss him for the first time - all of it taken away by ignorance and maltreatment. Every happy moment turned into one you wish you could just forget.

This is the story of one maternal near miss experience very close to my heart. A story I should have never had to tell.

<This is where I read out the full introduction of this written thesis to give my cousin's full story>

I am going to be honest here and say that it was extremely difficult emotionally just to get through telling my cousin's story – there are no words that could describe what she would have been feeling to the truest extent she was feeling it.

After describing her battle to you all, I would like to reference a story my cousin brought to me, of a woman who was in trouble just like she was, around the same time, but who wasn't so lucky.

I am going to, once again, restate the warning I gave at the beginning of this episode – in this next section, we will be discussing maternal death, pregnancy trauma, and other difficult topics. Listener discretion is advised.

<This is where I transition from my cousin's story to the story of the woman who was unable to make it>

I want to read a few short sections of Sam Volrie Jr.'s story, the partner of birthing person Maria Corona, as I don't think I could do their story justice without reading you his words directly.

"On September 1, 2019, in the early hours of the morning, Maria's water broke. The time was now! She was about to give birth to our daughter, Alina Victoria Volrie. We rushed to the hospital, where she would endure labor for hours and hours. But she took it on like a soldier! She was a little weary about the fact her doctor wasn't delivering though. She was on vacation, so there was a fill in. I wasn't too fond of this guy, and neither were his nurses. One even admitted to us he often overexerts his patients by making them push way too early. But we didn't have much of a choice at this point. Long story short, the situation was sketchy, but Alina was delivered alive and safe.

Due to 'hospital procedure,' she had to stay in the intensive care unit for reasons that made no sense (even more so now). So, we didn't get a chance to really spend quality time with our newborn baby. If we wanted to see her, we had to walk across the hospital floor to the ICU room. But this was an extremely difficult task for Maria. She was in pain and could hardly move. She needed help getting to the bathroom, which was no more than six feet away from her bed. She repeated, 'Something ain't right.' She just knew it.

Woman who had babies the same time as her were moving just fine. She even knew one of the ladies and had a discussion with her about how she felt. She said she felt fine, and you could tell in the way she was able to move. Not Maria. But, of course, she wanted to see Alina. So, she made every excuse to get down there. Despite not even being offered a wheelchair, she still got down there. She breastfed, so she would always go feed her whenever they said we could.

But she just got worse and worse, instead of better. A day and a half after the delivery, she was a wreck. But the nurse came in with the news it was time for us to pack up and go. I urged the doctor to keep us there. Maria wasn't well, and they were keeping our baby for another few days. We needed to be close. Maria NEEDED HELP. But her response was, 'Sorry sir, but insurance won't pay for her any longer.' And that was the beginning of the end.

The next day home from the hospital, Maria wanted to go back to the hospital to be with Alina. I had no type of paternity leave, so I had to work. I brought her while I worked my shift. She just hung around the hospital all day. She was literally, in that moment, dying on the inside. INSIDE A HOSPITAL. But I had no idea, and the hospital had no cares. We went back home that night, and it was the worst night of my life. She was out of it, sometimes even unresponsive.

The next day, we had to get help. We went to another hospital where they tried, but it didn't work. Her last words to me were, 'Don't cry baby.' I couldn't help it. I never cry, and she used to joke with me all the time about how I'm gonna cry one day — which is eerie to me. Seeing her hooked up to all those machines, my heart saw what was happening before my eyes could. The doctors told me I had to leave the room for a second for an intense procedure. I can still hear the alarm. I can still feel the wind from doctors running past me, responding to the 'code black' in Trauma 2. It haunts me. On September 5, 2019, my whole life took a different meaning."

I don't know if you could hear it in my voice, but that felt almost impossible. It is so incredibly unfair to birthing parents, partners, babies, friends and family to have to struggle to deal with a loss so great and so unexpected. To Sam and his baby girl, I am truly sorry. Those hospitals, doctors and nurses failed Maria. They failed you and your baby.

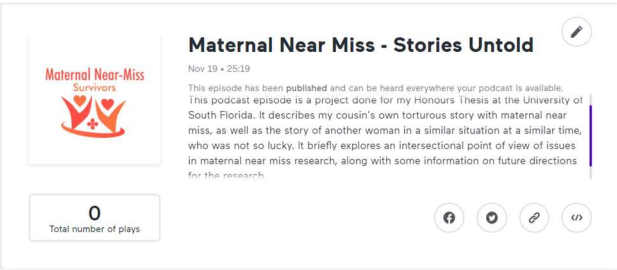
<This is where I speak shortly about research on maternal near miss, further directions, etc.>

<End of podcast>

The link to the podcast episode is here, along with a screenshot of the episode on Anchor for reference.

Spotify: https://open.spotify.com/show/0lK99RqvzPgmBgNMop1lfl

Anchor: https://anchor.fm/priya-collins



Conclusion and Reflection

Discussing a topic as intense as maternal near miss, especially with such personal implications regarding my cousin's experience, as well as those of her children, partner, and myself and my family, was extremely challenging. However, with these difficulties came a lot of learning and new directions to come in maternal near miss research. Through this thesis, I was able to review knowledge already explored about maternal mortality and near miss experiences, as well as stories of those who survived (such as my cousin) and stories of those who were not as lucky (like the story of Maria Corona). While researching this, I was able to get more detailed information about the severity of the conditions leading to maternal near miss experiences, alongside more elusive or trivial reasons for such a traumatic experience. This project opened up new avenues for research regarding intersectionality in maternal near miss experiences.

During my time researching and hearing my cousin's experience, as well as those of people she had met through Facebook groups and interviews, I was given an incredibly eye-opening opportunity to complete this thesis. It was nerve-wracking to say the least, considering the intensity of stories I presented during the podcast, as well as using new podcasting software – Anchor – to record and edit the episode. I feel as though I am closer to this issue than ever, and I will be continuing to research maternal near miss and aid in raising awareness for the issue behind the scenes as I pursue higher education. This podcast was slightly different from an experience I had with a podcast I recorded for Masculinities back in 2020, where I recorded the entire podcast in one take. I was able to snip sections and edit them to create a more cohesive experience for the listener, as well as using a partial script and bits and pieces of my already-written thesis report to enhance the content of the episode. Generally, this was an extremely rewarding and remarkable experience that I will be grateful for and that will help me to be a better writer and more cohesive speaker. There is still a long way to go with maternal near miss, but acknowledging these difficulties and areas for improvement is a great start to the movement.

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