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# Pregnant in Pediatrics in a Pandemic

By Rukiayah Warner-Moxley

When COVID-19 started making waves in the U.S., my mother asked me to re-consider going into medicine and enroll in law school. I was a 3rd-year medical student at this time, and I told her it was too late for me to go to law school. Through the remainder of medical school, I assured her that I would be fine. As I started residency, I continued to assure her of this. I had received both doses of the COVID-19 vaccine and was taking all precautions to protect myself from the virus and remain healthy. I wrote off my mother's concerns as paranoia, as I had with her other worries she voiced throughout medical school. It wasn't until I found out I was pregnant 2 months into my intern year that I began to understand that my mother's "paranoia" consisted of encompassed maternal fears. As I began to have my own concerns over my unborn baby, those fears began battling with my desire to prioritize becoming a proficient pediatrician.

During my first trimester, I was on high alert. I knew these first weeks were the most crucial for fetal development and that the risk of miscarriage would be the highest. While trying to be careful around patients, I was also trying to keep my pregnancy a secret. I wasn't ready to reveal this information to the world yet. Keeping my secret was easier on some days and seemed impossible on others. Attempting to pay attention during rounds while swallowing down my nausea was a skill that I never mastered. Some of my attendings mistook my looks of anguish for disinterest. Even if my nauseous face was confused for disinterest in rounds, this was the price I had to pay while trying to avoid vomiting in the middle of the floor of 6 Children's. Navigating around patients with COVID-19 was harder than I expected. I no longer had the medical student privilege of declining to see COVID-positive patients based on my comfort level. As a resident, my only way to avoid seeing COVID-positive was to have a medical exemption, which would be public to my team. I didn't want to announce my pregnancy to anyone yet, so I made excuses as to why I couldn't see these patients. *There were too many other physicians in the room. The patient and family were asleep. The patient was going through dialysis in the room.* These excuses got me through the first trimester, only having to see about one COVID patient a month. After I announced my pregnancy at the beginning of my second trimester, it became easier to get exempted from seeing these patients. This doesn't mean, however, that I was able to stay away from COVID in the hospital throughout the rest of my pregnancy.

I experienced this rampage while working in the children's ED. Every third patient was a child with a fever or upper respiratory symptom. In the first few days of my ED rotation, when a child came in with a fever, I asked my co-resident if they could see the kid, worried that they may have COVID. Soon, there were too many febrile and sneezing children to avoid, so I put on an N95 mask with a surgical mask over it, threw on a gown and gloves, found some eyewear, and went to figure out why these children were febrile. Rapid COVID/Flu/RSV nasal swabs kept coming back negative for all 3 viruses. Expanded respiratory viral panels revealed adenovirus, rhinovirus/enterovirus, and types of coronaviruses that weren't causing global panic. I soon became more at ease with children with fevers and respiratory symptoms. As my nerves eased, the amount of PPE I dawned lessened. Gowns were becoming too hot to wear. Eyewear kept fogging up. It was too hard for my patients' parents to hear me through the N95. A regular surgical mask was enough for me until we figured out what non-COVID virus the child had.

One day, a one-year-old came into the ED with yet another fever. I put on a fresh surgical mask and walked into the room. The child didn't even appear sick. Rather, the child was playing in the room, laughing with their grandmother and older cousin, with a nose that was barely running. In my head, I was already telling myself that I was going to save this family a fair amount of money and not nasal swab this child, preemptively diagnosing the toddler with rhinovirus. The child's grandmother gave me a run-down of what had been occurring with the patient and answered each question. Finally, I asked, "Has the patient been in contact with anyone who had COVID?" and heard the same "No" that every other parent told me. Having the answers I needed, I asked if either relative had any other concerns. The cousin asked me if I could talk to the grandmother about the importance of getting vaccinated against COVID, which started a small back-and-forth between the family members. I left the room with the grandmother and cousin bickering and went to staff the patient with my attending. When the attending asked me what my plan was, I told them that, despite what I previously thought, I wanted to get a nasal swab on the child, just for due diligence and to ease the family's mind. I ordered the swab and waited.

While writing notes, I saw that the nasal swab for the one-year-old had resulted. When I read the results, I knew how I could convince the grandmother to get vaccinated against COVID. This toddler, who was the most well-appearing child in the ED, was positive for COVID. I walked over to the cart and started dawning full PPE, thinking it may be useless as I had already exposed myself just like every other worker in the ED. I walked back into the toddler's room, getting confused looks from the grandmother as to why I was now in a gown and new mask. Her hands went over her face when I told her that her young grandchild had the novel coronavirus that was causing a global pandemic. She immediately called the toddler's mother to let her know about her child's test results. The grandmother and the mother began asking worriedly what they should do now. I told them about COVID isolation guidelines for the toddler and anyone who had recently been in contact with her. I also mentioned how any caregiver for the toddler, like the grandmother, should get vaccinated as this was the main way to protect the toddler from getting COVID again. The family left the ED, and I quickly sanitized my stethoscope. As I finished my ED shift, I told myself there was no point in me avoiding COVID-positive patients anymore. I had exposed myself, and my unborn baby, to COVID with the minimal PPE and wasn't rushed to the ICU. This patient interaction set a new precedent for me for the remainder of the pregnancy; there was no reason in my mind to backtrack.

The third trimester of my pregnancy arrived. I was very obviously pregnant and the only patients I couldn't and wouldn't see were those with confirmed CMV infections. Attendings and co-interns kept asking me if I wanted to switch so I wasn't taking care of any COVID-positive patients, and I always told them that I was fine and didn't need to switch. It got to a point on some services where there were more COVID-positive patients than COVID-negative patients. It didn't seem fair to me for my co-interns to take on 1 or 2 more patients than me just so I didn't have to care for someone with COVID. I didn't want to be an inconvenience to my co-interns or make more work for them. I had been caring for COVID-positive patients for almost 3 months and hadn't gotten sick or tested positive yet, so I continued caring for them without hesitation. I would immediately claim COVID-positive patients that popped up on our census just to show that I no longer had any apprehensions. I didn't want it to seem like I was a slacker. The want and desire to be a competent intern that added value to the team was overpowering my need to not expose my baby to COVID-19. I was taking care of children with COVID who were having seizures that were likely connected to their viral infection and kids who had MIS-C following their infections, pushing the worries about what could happen to my unborn baby if I were to get COVID to the back of my mind for those moments. Being a pediatrician during a pandemic took priority over concerns related to impending motherhood. This hierarchy was present until I gave birth. Once my daughter was born, the guilt of exposing her to COVID while she was in utero slapped me in the face like a sopping wet rag. I felt like I had put my career over my baby and that guilt brought tears to my eyes. Even though the effects of having COVID while pregnant would have on a neonate were still being researched, I still considered how the worst could've happened to my baby. She was born as healthy as can be. However, I continue to think about how this could've been different if I hadn't felt selfish and worried about how my colleagues perceived me. I continue to think about this, but the guilt has started to lessen as I watch her grow and thrive. I've spoken to multiple mothers, those in the medical field and in different professions, and learned "mom guilt" is universal amongst most mothers. It's a, usually false, sense of inadequacy because you're striving to be a "perfect mother." If this experience hadn't made me feel guilty, then some other experience would. Mom guilt is like matter: it can't be fully destroyed, but it can change form and size. While I may always hold some form of guilt as a mother, my daughter's smile and food-covered face tells me that I'm a good Mama.

In their own respects, intern year and pregnancy are hard. Together, it seems like an impossible combination. With the added fun of doing both during a global pandemic, it seems like an implausible plot for a medical drama on TV. I have the staggering privilege of being able to say that I lived this plot. While I'm pleased that there were no plot twists and a happy ending, I'm aware that this could have very well not been the case. Part of me tells myself I properly dawned and doffed PPE and sanitized my equipment appropriately, so I never got COVID and gave my unborn baby COVID. Another part considers it utter luck. Either way, the pandemic continues, and I now worry about bringing COVID home to my baby; I pray she doesn't become a patient for one of my co-residents.

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