



A medical crisis and a series of what-ifs

By Rochaun Meadows-Fernandez | July 3, 2017

When our son was diagnosed with hydronephrosis in utero, the news triggered a series of events that made me question the entire medical system.

My birth experience was the opposite of what a patient hopes for. And things went downhill from there. My treatment from the medical professionals responsible for my well-being – and our son's – led to long-term health consequences and nearly cost me my life.

Maternal mortality is a striking problem in the United States. So, too often, is the disempowerment of the patient.

How did my situation get so bad? Tools that could have helped me amplify my voice and play an active role in my own treatment were not available to me: access to clinicians outside the emergency department, access to my own health data through a patient portal.

Unconscious bias may also have played a role. I am a young-appearing woman of color, so clinicians seemed to assume that I was unqualified to make good decisions. At every step along the way, there were missed opportunities to help me advocate for myself.

I began to truly realize how much my birth experience was out of my control when the attending physician, at a hospital in Colorado, ordered an episiotomy without my permission. "I had one with each of my children; you'll be fine," she said. I wasn't fine, though. The procedure caused me a great deal of pain.

But that was nothing compared to the gut-wrenching cramps and fatigue I started to feel around two weeks postpartum. When the pain began to interfere with my ability to care for myself and my newborn, I called the nurses' line at the hospital. I was told my symptoms sounded normal but to go to the ER if they worsened.

In hindsight, I could have insisted on consulting with another clinician or determining a timetable for checking in with the nurses' line if the pain persisted. But as far as I knew, my choices were to sit at home in pain or to visit the ER with a newborn in tow.

And my symptoms did worsen. On Valentine's Day, during our first family outing since our new addition, my pain skyrocketed to unbearable levels. I felt an immense amount of pressure, similar to what I had endured during labor. I ran to the restroom, bleeding. I told my husband we would have to leave for the hospital immediately.

The wait at the hospital was lengthy, but what frustrated me most was the disregard for my pain. I rated my pain a 7 out of 10, but the medical professionals assured me that I was experiencing “normal” postpartum recovery.

Several more blood clots, an ultrasound, and a cervical exam later, I was sent home with no further instructions. My doctor didn't believe anything was wrong. What could I do?

Again, I can't help but wonder about the ways the system failed me. In rural areas such as the one where I live, telehealth is gaining traction. Around the country, patient portals are proving indispensable in non-emergency situations – which, at this stage, mine still was. What if I had virtual access to medical providers?

My husband was due to return to work, so my mom thought it would be a good idea for me and the baby, who was then six weeks old, to spend time in Dallas. Being surrounded by family provided a distraction from the pain, but it never totally went away. A week after arriving, I was once again short of breath and barely able to walk. One day, I was in so much pain that I decided to take a warm bath. Before I knew it, huge blood clots were leaving my body.

In a panic, I tried my best to reach my ob-gyn. Unfortunately, my clinic didn't offer contact with doctors on a portal. A clinician familiar with my case might have provided reinforcement and perhaps even coaching on what to say and ask when I arrived at the ER. Instead, I was on my own, worrying about paying a portion of the resulting bills out of pocket. Once again, the nurses' line at my hospital back home was my only option. The staff advised me to go to the local ER.

My hospital wait was roughly four hours. During that time, I lost so much blood that my naturally pink lips turned white. I couldn't walk on my own. The wait seemed never-ending. Thankfully, a nurse noticed my struggles and promised me she would get help. She highlighted each of my symptoms and didn't quit until I got into a room. With her assistance, I made it to a hospital bed and was rushed for a diagnostic ultrasound.

The ultrasound technicians discovered what was wrong within the first five minutes of the checkup.

My uterus was filled with the leftover placenta – the cause of my weeks of postpartum agony and uncertainty. The tech couldn't believe that it had not been detected before.

Shortly after, I was rushed into surgery for an emergency dilation and curettage (D&C). Hours later, I was surrounded by relatives. The worst was finally over. My son was nearly 2 months old.

Misdiagnoses happen, but there were many opportunities along the way to remedy the consequences of a botched delivery. It took a third doctor in another region of the United States – and repeated urging by the nurse who made it her mission to help me – to save my life. Had other medical professionals cared for me the way that nurse did, my birth experience would have been completely different. I would have been saved a costly procedure and my peace of mind.

I will never forget the nurse who saw the signs I was in distress, listened to my concerns, and worked hard to ensure I got the care I deserved. It's no exaggeration to say that she saved my life and helped ensure that my son would not grow up without his mother.

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