To Kelly, whose fierce love of her family inspires all of us
Chapter 1. Fragile Beginnings

A vaulted ceiling rises five stories over the lobby of the Brigham and Women’s Hospital, its skylights illuminating the entrance to one of Harvard Medical School’s flagship institutions. Approximately twenty-five times every day, a small but joyous parade descends from one of the postpartum floors and crosses the two hundred feet of polished tile that stretches from the maternity wing to the hospital entrance.

First comes an orderly pushing a wheelchair bearing a new mother who holds her swaddled newborn in her arms. Next comes another aide driving a cart piled high with flowers, cards, assorted baby gifts, and the usual infant paraphernalia: diapers, formula, a blanket, pacifiers. Last comes the beaming father, suitcase in hand, carrying whatever doesn’t fit on the cart.

The procession pauses just before the revolving doors, and the father is dispatched to the parking garage. Soon the car pulls up, and the group moves out to the driveway; the new mother is lovingly strapped into the passenger seat and the baby carefully buckled into a car seat behind her. Quickly, luggage, gifts, and flowers are loaded, and the family drives away.

This is the way childbearing is supposed to happen.

Twice before, Kelly had ridden that wheelchair holding a healthy newborn. Understandably, she thought that having a child was a relatively uncomplicated affair: a couple tries to get pregnant and eventually succeeds. Nine months later, a healthy baby is born, and after a few days’ recuperation, they go home together.

But after Larissa was born, Kelly rode the wheelchair across the lobby alone.

January 10
Kelly steered her Ford Explorer through the slow curve as Storrow Drive swung under the Boston University Bridge and entered the stretch of highway that she liked best in the morning. Next to her, the Charles River widened, and up ahead, the sun bounced off the skyscrapers and shimmered across the ice. Behind her, three-year-old Hannah, her younger child, was cheerfully holding up her end of a conversation.

“We have turtles, Mommy. We have turtles in a box, Mommy. It’s my turn to feed the turtles, Mommy.”
“What do you feed the turtles, Hanni?”
“Food, Mommy.”
“What do turtles eat, Hanni?”
“They eat turtle food, Mommy.”
“Of course they do, Hanni. I’ll bet you are very good at feeding the turtles.”
Before long, they arrived at Hannah’s nursery school. Parking places were in short supply, so Kelly parked in the shopping plaza across the street. She had a long mental to-do list, and as she got Hannah out of the car, she added one more item—pick up some milk at the Stop & Shop before she left so she could get her ticket validated and exit for free.

“Hold my hand, love.” They carefully crossed two lanes of Cambridge Street, squeezing into the space on the median strip between two snowbanks. There was a break in the traffic and they dashed across to the other side.

Kelly had come to enjoy the daily trip into Boston. The buildings, the traffic, and the streets lined with restaurants, dry cleaners, and coffee shops gave her a dose of urban living that she sometimes missed amid the setback suburban homes in her neighborhood with clipped lawns now covered by un-mussed snow.

Wrapped in layers against the January weather, they made their way to Hannah’s classroom. At first, Hannah clung to Kelly’s leg and pushed her face into Kelly’s coat.

“Hello, Priscilla.” Kelly greeted one of Hannah’s favorite teachers warmly. “You have another boring day planned for the children? A whole lot of sitting around?”

“That’s what we’ll do today,” Priscilla said, smiling. “A whole lot of sitting and staring out the window. We will do our best to have no fun at all.”

Hannah’s face emerged. She looked up at Priscilla, then at Kelly, then back at Priscilla, and started to smile. She loosened her grip.

“Want to read a book, Mommy?”

“You know it.” They chose *Guess How Much I Love You* off the shelves and went to the reading area with its low couches and pillows. Awkwardly, Kelly lowered herself onto the couch. “Renee, Ella, Alex, do you want to read with us?” she asked some of Hannah’s friends whose parents had already departed. Ella came over and sat down.

When the story about the father hare and his son was over, Hannah and Ella wandered off to the sand table.

A mother dressed in a business suit came in with her son in tow. “Hi, Sarah,” said Kelly, and she couldn’t help comparing the woman’s perfectly tailored suit with the drab maternity dress from Target that she had hurriedly donned before hustling Hannah and ten-year-old Grace out the door and into the car. Between dropping Grace in front of the neighborhood elementary school and heading downtown, Kelly had managed to apply lipstick using the visor mirror, but her hair was still just hastily pulled back in a tight elastic.

“Hi, Kelly,” Sarah said, glancing at Kelly’s abdomen. “You look great.” Then she turned to her son and kissed him. “Bye, Sammy. Mommy’s got to run.” As she extricated herself from her son’s embrace, she said to Kelly, “God, I hate always rushing off.” And then she waved a carefully manicured hand at Kelly with the apologetic look of a working mother on a tight schedule.

“I know what you mean,” Kelly started to say, but Sarah was already too far away to hear.
Kelly stayed and watched the kids for a few more minutes; when the children were called to circle time, she quietly slipped out of the classroom, made a quick stop at the supermarket, and headed to her car.

The next stop was across town at Brigham and Women’s Hospital; she had a long prenatal appointment during which she would have a blood test for gestational diabetes, a common condition she had had during her pregnancy with Hannah. Kelly was twenty-six weeks along in her pregnancy, and she was pretty sure she’d fail the test and be required to start the restrictive diabetic diet to control her blood-sugar levels and avoid insulin injections. She smiled as she recalled her carbohydrate binge of the previous day, which she’d relished in the full knowledge that it might be her last for several months.

Kelly pulled into the parking lot, checked in at the clinic, and had her first blood sample drawn. Then she drank the super-sweet cola that challenged her body’s ability to metabolize sugar and sat down to wait exactly one hour until the next blood sample was taken. She pulled a manila folder out of her bag and began to read through the information she’d printed out from the website of Boston Children’s Hospital, where she would interview the following week.

Before leaving Baltimore to move to Boston, Kelly had completed the coursework for a doctorate in psychology. As a student, she had excelled at working with children who suffered from chronic diseases such as kidney failure, cerebral palsy, and severe developmental delay. She was pleased when the best children’s hospital in Baltimore had aggressively recruited her for her required one-year internship, the last thing that stood between her and her degree. But instead of taking that coveted position, Kelly had put her own career on hold and moved to Boston—so I, her former-journalist husband who had just graduated from medical school, could do my residency in obstetrics and gynecology at Harvard-affiliated Brigham and Women’s Hospital.

Our plan was working perfectly—Kelly was helping our girls adjust to a new city and was pregnant with our third child during this year after our move to Boston and before her anticipated return to work. She had applied widely to internship programs in Boston and found that her success in Baltimore was opening doors in her new hometown. Leaders of the top programs in the city offered her interviews, and when the calls from internship directors eager to have her join them followed her visits to their hospitals, Kelly realized she would have her pick of jobs.

A young phlebotomist with a bored look on her face called Kelly in for her second blood draw. This one hurt, as the woman missed the vein on the first jab and had to reposition the needle. Kelly went back to her reading and waited for the third blood draw, an hour later.

At some point during the next hour, it occurred to her that she had not felt the baby move for some time. As the minutes ticked by, Kelly started to become anxious. Then there was a kick and a twitch as the baby shifted position. Kelly picked up her reading again, but her anxiety didn’t dissipate entirely. Perhaps it was the fact that she had been required to fast since the previous evening because of the blood test. After the
third blood draw, she paged me.

“Hey, what are you doing?” she said, trying to sound relaxed.

When she called, I’d just finished seeing a patient in the emergency room two floors below where Kelly was, so I was able to take a break.

“I’m just downstairs. I’ll be up in a minute.”

I found Kelly sitting forward in her chair trying to concentrate on the sheaf of papers in her hand.

“I’m sure it’s nothing,” she said. “It just doesn’t feel right.”

“What do you mean? Is the baby moving?”

“Yes, she just moved, but something doesn’t feel right.” She didn’t look all right.

“I’m sure it’s fine,” I said, still in my practiced reassuring-physician mode. “Let’s go have a look.” I took Kelly’s hand and led her through the reception area of the obstetrics clinic, past a few women who were waiting to be seen, and found an exam room that was unoccupied. Kelly climbed onto the table while I retrieved one of the portable ultrasound machines from the hallway. Then together, we looked at our baby happily ensconced in Kelly’s protuberant belly.

Larissa was moving intermittently, reaching out to touch the uterine wall, then touching her tiny face with fingers that were each perfectly formed but no larger than a piece of macaroni. As we watched, she brought her legs up and then kicked, which made Kelly smile as she felt the movement we could both see on the screen. We gazed for a few minutes at our oblivious child suspended in amniotic fluid, watching her reach and turn and make the other normal movements of a developing fetus that indicate a healthy pregnancy.

Kelly smiled and looked up at me. “I feel better.” The inexplicable stress that had been building since she arrived at Brigham and Women’s began to dissipate. She had her last blood draw and headed straight for the cafeteria. A few minutes later she was on her way back across town to the nursery school, eating a sandwich and listening to a National Public Radio call-in show featuring rescuers of a recent disaster. Yet somehow, inside her SUV with the heat on full blast, Kelly felt insulated from what was still raw.

January 11

Early the following morning, exactly three months and two days before her April due date, Kelly was awakened by an uncomfortable sensation. It began like dull menstrual cramps, and then her lower abdomen tightened to the point of pain before slowly relaxing, leaving a hollow ache behind.

This happened repeatedly, and for a long time, Kelly lay in the dark waiting for the cramps to go away, certain that this unusual sensation was just another in the catalog of pregnancy oddities. When my alarm rang, and I stumbled to the shower, she feigned sleep.

Contractions before the due date are not necessarily unusual; in fact, isolated contractions are common in the last months of pregnancy as the uterus prepares for
labor by tightening and relaxing the muscles that will be called on to push the baby through the birth canal. They generally dissipate quickly. But these contractions increased in strength to the point that Kelly was becoming uncomfortable. She struggled to stay calm as her abdomen kept tightening and relaxing, every six minutes, then every five minutes. Kelly had been in labor before, and these cramps felt more and more like labor and less like the occasional twinges of the third term. She called me out of the bathroom, where I was getting dressed for work.

“I’m having contractions,” Kelly said, with urgency bordering on panic in her voice. She scrunched her face up, and I wasn’t sure if she was in pain or just trying to keep the tears of disbelief from escaping.

“I’m sure it’s nothing,” I said, certain of my words. “They are probably Braxton Hicks,” I reasoned. This is the term for isolated contractions of late pregnancy that are not worrisome, named for the physician, John Braxton Hicks, who’d first described the benign phenomenon.

Nonetheless, I was concerned enough to call my parents, who lived in the next town, and ask them to come over quickly—we needed them to watch Hannah and Grace, who were asleep in their rooms. I wanted to get to the hospital as soon as possible so Kelly could be evaluated but also so that I wouldn’t be too late for work. I wasn’t terribly worried—I put on a tie while we waited for my parents so that I would be ready to start my day at the hospital once Kelly was sent home.

Twenty minutes later, my parents, still in their pajamas, arrived on our doorstep. Kelly was already in the car. I fumbled for my keys and dropped them; I bent down and felt the cold concrete as I reached across the dark driveway.

As Friday dawned, we drove through the winter streets of Boston, which were narrowed by the snow pushed to both sides by the plows. I drew up to the main doors and left the car outside the hospital with two sleepy valet attendants. Inside, a slightly more alert volunteer took us to Labor and Delivery.

Though it was barely dawn, the unit was humming. Machines beeped; the television attached to wall in the waiting room droned; a pair of soon-to-be grandparents dozed, leaning against each other; and harried nurses, getting ready for their change of shift, exchanged information. A slim nurse in her fifties escorted us to a room with a sliding glass door and expertly hooked Kelly up to two monitors. One sent ultrasound waves into Kelly’s uterus so we could hear the flow of blood through the fetal heart. This heart rate was plotted on a slowly moving strip of paper and it scrawled out the expected jagged line, reassuring us that our baby was healthy in the protective confines of the womb.

The other monitor contained a pressure sensor that measured uterine contractions; this information was also plotted on the strip of paper. I was looking for the flat line of uterine rest, which would tell us that the contractions were mild or absent. But instead, there were smooth bell-shaped hills coming regularly, every three minutes, again and again and again, plotting a pattern of contractions that looked more and more like labor.
In the vast majority of pregnancies, a perfectly timed cascade of hormonal signals between the developing fetus and the mother initiates labor after approximately forty weeks of pregnancy. Contractions develop, the cervix dilates, and the outcome is a well-developed healthy newborn.

True labor can also be triggered prematurely. Sometimes, labor is precipitated by chemicals released when the cervix gives way and dilates preemptively. Other times, the hormonal cascade is initiated by a stressed-out fetus that is unable to grow adequately within the womb. If the labor is caused by cervical failure or fetal stress, the best solution is to stop the contractions and fix the problem—attempt to reinforce the cervix or mitigate the fetal stressors.

Labor can be caused by more insidious factors as well, such as bleeding in the space between the placenta and the uterus, or an infection that breaches the membranes that protect the fetus and invades it and the surrounding amniotic fluid. In these cases, labor is an adaptive response, a way for the mother to get rid of the pregnancy before she bleeds to death or is overwhelmed by infection.

However, when a woman shows up on Labor and Delivery complaining of contractions far in advance of her due date, it is almost never clear why the patient is contracting. Aware of the potentially devastating consequences for the fetus of an early delivery, most obstetricians will try to stop preterm labor until they have evidence that a force of nature stronger than their medicine is at work.

Ultimately, it is the cervix—the conical structure that extends down from the uterus into the vagina—that is the arbiter of labor. Typically fibrous and strong, the cervix serves to protect the fetus from the outside world for nine months. At the very end of pregnancy, the composition of the cervix changes and it becomes receptive to the contractions that will cause it to dilate and shorten from a long and impassable canal to the ten-centimeter-wide aperture that’s big enough for a baby to pass through. Until the cervix shortens and dilates, contractions are essentially meaningless. Surely, I thought, these are Braxton Hicks contractions. It is only a matter of time before they resolve.

A senior resident came to examine Kelly. He was somewhat disheveled, and I knew he’d been up all night. Gently he placed a speculum in Kelly’s vagina so he could see her cervix. With the nurse angling a floor lamp over his shoulder, the young doctor adjusted the speculum to make sure of what he was seeing.

“She’s three and a hundred,” he finally said to me, using the shorthand of our field to describe Kelly’s cervix as three centimeters dilated and completely shortened. He looked scared, without the confidence he would [End of Sample]