

“LOW TECHNOLOGY” APPROACH TO PREGNANCY & BIRTH HOW LOW CAN WE GO?

Many of our clients seek a very simple approach to pregnancy and birth health care, hoping to avoid technological interventions as much as possible. We support this approach to the best of our ability, while still maintaining our supportive connection with the hospital and medical community.

Midwives are guardians of normal birth, specializing in healthy, low-risk pregnancies. We are experts on normal events and complaints of pregnancy, and recognizing warning signs of trouble and possible complications. When problems occur, or our findings during prenatal care are questionable or abnormal, we definitely use technology to investigate, and ask your cooperation to do this. When all appears normal, here's a discussion of what we can and can't do.

In Pregnancy:

Other than the most basic and routine blood work and pap smear, all other prenatal blood tests are discussed with risks & benefits, and offered as optional at the appropriate windows of time.

Sonograms/ Ultrasounds: With a clear menstrual /conception history to determine due date, and no other clinical concerns, only one ultrasound is ordered, in the middle of the pregnancy. Our clients have had twins and even triplets (which require high-risk obstetrical care), discovered during this routine sonogram, therefore it is a required component of our care program.

Doppler/fetoscope: We have both hand-held Doppler and acoustic fetoscope for office checks of baby's heartbeat. Most mothers like to hear the baby's heartbeat during the exams, by Doppler, which uses about 5-10 seconds of ultrasound beam. In the second half of pregnancy, we can use the fetoscope instead, at client's request.

In Labor:

Upon admission to the hospital, a blood sample is drawn, and a 15-20 minute electronic fetal monitoring strip is done. If all appears normal at that time, we discontinue the continuous fetal monitoring, and encourage the mother to be out of bed, moving and choosing any positions that help her labor. We do listen electronically to the baby's heartbeat every 15 minutes thereafter, with a hand-held unit. We cannot use a fetoscope for labor; we find it is uncomfortable for the mother and impractical. If concerns arise that require continuous fetal monitoring, we try to arrange for wireless telemetry monitors to be used, which are also waterproof, allowing full mobility and use of the bathtub.

In normal situations: We don't require an IV. We don't limit the number of friends/family support people present. We don't routinely use Pitocin augmentation. We discuss pros and cons of all procedures, including rupturing membranes, prior to doing anything. We do vaginal exams when the information is useful for making management decisions or evaluating progress, and as infrequently as possible. We don't cut episiotomies. We do support the perineum and Dads can help catch the baby and/or cut the cord. We do place the baby directly on a warm towel on Mom's tummy. We can leave the cord pulsating if you request it.

When things are not going so normally: When a mother's bag of waters breaks at term, labor usually begins within a few hours. If no labor ensues, there is concern that infection risk may increase, both in the baby or mother, especially after 24 hours. If the mother has tested negative for Beta Strep ("GBS"), and fluid is clear, we are comfortable waiting up to 8 hours in first-time moms, and up to 12 hours, in mothers who have already had one or more babies, prior to inducing labor. If this 8-12 hour window is reached without labor starting, labor is induced with Pitocin, with a goal of achieving the birth within 24 hours. We recognize that infection is also minimized by performing as the few vaginal exams as possible, particularly before contractions have begun. For women who have tested positive for GBS, antibiotic treatment should begin as soon as possible after rupture of the membranes.

Other indications that intervention may be needed include: thick meconium noted in amniotic fluid, lack of progress in labor over many hours, dehydration, fever, vomiting, or rising blood pressure in the mother, or abnormal fetal heart rate changes. Sometimes we do recommend IV hydration, Pitocin augmentation, internal monitors, epidural anesthesia, or even, as a last resort, cesarean section. We can cut episiotomies, stitch up lacerations, manually remove stubborn placentas, resuscitate babies not breathing, give emergency drugs for bleeding, and participate in surgery if needed. None of this is routine, and your birth wishes are very important to us! We also believe that careful and judicious use of technology and interventions at times can help achieve a vaginal birth vs. a c-section, or in other ways preserve safety.

It is our heartfelt wish to be trusted, that if we discuss or do these things, they are based on long experience with many hundreds of normal births, in our best judgment, the safest and best management of the situation, to end the day with a healthy mother holding a healthy baby.

<u>What We Don't Do--</u>	<u>- What We Can Offer--</u>	<u>Comments-----</u>
Fetoscope monitoring in Labor	Intermittent Doppler or wireless, waterproof telemetry if needed	Practicality issues vs. importance of hearing baby's heartbeat
Oral Vitamin K	Vitamin K injection or sign waiver to defer.	Not available at Loudoun Hospital
Eating in Labor	Clear juices, Gatorade, Popsicles, Jello	Anesthesia Department policy
Waterbirth	Labor in Deep BathTub & Shower until birth	Not equipped for waterbirth
Oral GBS Rx	IV antibiotics if GBS+	CDC guidelines
VBAC, Vaginal Breech, Twins & Multiples, High-risk medical conditions.	Referrals to other providers Repeat C-section within our practice	We have many successes with encouraging breech presentations turn to head-down position for delivery.
Candles, incense	Dim lights, music, Hands-on, Bedside labor support, full mobility	Any flame= fire hazard
Routine Pitocin, episiotomy, amniotomy, or specific time limits on progress	Clear discussion & Informed consent on any procedures or interventions	Trusting relationship between midwife & family is key in good outcomes.