

**QUESTIONS AND EVIDENCED BASED ANSWERS**  
**TO ASK ANY OBSTETRICAL CARE PROVIDER**  
**TO SEE IF HE/SHE WILL ACTIVELY ENABLE A NATURAL BIRTH,**  
**RETURN A BIRTH THAT IS DEVIATING TO ABNORMAL BACK TO**  
**NORMAL,**  
**OR BE MORE LIKELY TO DO AN UNNECESSARY C/S**

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**ARE YOU THERE FOR THE DURATION OF MY ACTIVE LABOR, OR DO YOU COME ONLY AT THE END TO MY DELIVER BABY?**

**and,**

**IF YOU ARE NOT THERE DURING THE LABOR (either seeing other patients or doing office hours), THEN WHO WILL BE ABLE TO DIAGNOSE AND CORRECT A MAL-POSITIONED HEAD (I.E. POSTERIOR, EXTENDED, OR ASYNCLITIC HEAD) DURING THE LABOR AT THE RIGHT TIME TO HELP ME PROGRESS NORMALLY TOWARD A NATURAL BIRTH?**

If they answer, which they might, “the posteriors turn in labor all by themselves to anterior due to the contractions,” they are partially right; they do turn, unless they don’t. And the “don’t’s” account for the extra 25% unnecessary c/s rate. Fetal mal-position accounts for the majority of “failure to progress /failure to descend” diagnoses that require a Cesarean birth. These fetal mal-positions can easily be corrected during labor by a birth attendant who is familiar with diagnosing and correcting these mal-positioned babies with a whole repertoire of remedial techniques to rotate/turn these babies DURING LABOR to progress to a normal, natural vaginal birth (i.e. Rebozzo techniques, creating a false pelvic floor as a fulcrum against which the fetal head can rotate, internal rotation of the baby’s head, and specific positioning of the mother as per position of the baby to encourage and enable an optimal position as per the level of the baby in the pelvis and the relationship to placental location, etc).

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  - *Recommended resource: The fetal occiput posterior position: state of the science and a new perspective <http://www.ncbi.nlm.nih.gov/pubmed?term=simkin%202010%20posterior> by Penny Simkin.*
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**WHAT IS YOUR PRIMARY C/S RATE?** For first time moms, The World Health Organization states that for the average risk population, **the primary Cesarean birth rate should be no higher than 10-15%.** Currently in the United States, the average C/S rate (primary plus repeat C/S) is approximately 30%. In New Jersey, it ranges from 30-40%. If the care provider's primary rate is near 15%, but the total C/S rate still approaches 30%, this means that he/she has a practically 0% VBAC rate (the successful VBAC rate should be between 60-80%). The American College of Nurse Midwives (ACNM) 2013 average C/S rate was 13%. Midwives deliver approximately 8% of the babies born in the USA.

**Source:**

- *WHO statement on caesarean section rates, Executive summary; April 2015; WHO reference number: WHO/RHR/15.02*
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**HOW WILL I (THE BABY) BE MONITORED DURING ACTIVE LABOR (4-6 cms until 10 cms)?**

**(THE ANSWERS TO THIS QUESTION ARE KEY TO THE LIKELIHOOD OF THE "CASCADE OF MEDICAL INTERVENTIONS" THAT LEAD TO UNNECESSARY CESAREAN BIRTHS)**

Unfortunately, most women who deliver in busy hospitals where the nurses primarily care for you during labor and report your progress to your OBGYN care provider are monitored with Continuous Fetal Monitoring (CFM) for low risk births, even though this has been proven to **unequivocally increase the C/S rates, with no better outcomes for babies and mothers compared to Intermittent Fetal Monitoring (IFM) that is safer and more appropriate for low risk births** (*Alfirevic Z, et al, 2006, Bix E., 2005*). [As per the World Health Organization: These two methods of fetal surveillance have been compared in a number of trials (*Haverkamp et al 1976, 1979, Kelso et al 1978, MacDonald et al 1985, Wood et al 1981, Neldam et al 1986*). Cesarean section rate and operative vaginal delivery rates were both higher in all the electronically monitored groups. There is little evidence that the increased number of interventions in the electronically monitored groups led to substantive benefits for the infants. Perinatal deaths and low Apgar scores were not reduced in the groups with electronic monitoring. Only one measure of neonatal outcome was improved by electronic monitoring, in the largest trial: neonatal seizures (*MacDonald et al 1985*). A further analysis of this trial suggested that the excess risk of neonatal seizures in the auscultation group was mainly limited to labors that were induced or augmented with oxytocin. The follow-up data of the infants with seizures showed an equal incidence of major neurological disabilities in the groups monitored electronically and by auscultation.]

## **Therefore routine use of CFM on low risk birthing women necessarily introduces more risks that are associated with surgical Cesarean births.**

### **First, what is Continuous Fetal Monitoring?**

CFM consists of a birthing woman wearing two tight belts around her belly, the top one toward the top of her uterus using a tocometer to monitor the frequency and length of each contraction (not intensity), and the lower belt near the lower part of her uterus recording the baby's heart beat with an electronic ultrasound doppler transducer or by an internal electrode screwed into the baby's scalp (which requires the "bag of waters" broken and can lead to an infection ascending into the uterus/baby) moment to moment in real time. In order to "get a good reading" on the monitor strip, CFM requires continuous and constant contact of these two "probes" which is achieved by tightening the belts on the pregnant woman's abdomen.

### **Why is this a problem?**

In order to maintain adequate contact with both probes to obtain an adequate reading on the monitor, the mobility of the birthing woman is often restricted. The instinctive, most comfortable positions that laboring women naturally assume when unencumbered and which are the best positions to promote optimal fetal positioning to help their baby through the pelvis to have a vaginal birth (i.e. leaning forward, standing, walking, squatting, lunging, laboring on hands on knees, or in the tub) are prevented. The adequate contact of the probes is hard to maintain when women are in these positions, and it is more difficult for the nurses to keep the monitoring strips on tight enough to "get a good reading for the strip." Even when trying to accommodate different positions and ambulation, most often the patient eventually needs to resort back to the supine position (lying on your back) of the woman semi-sitting or lying on the bed (which closes the pelvic outlet, making less room for the baby to come out). This position encourages babies to rotate to the more problematic posterior position, and closes the pelvis instead of allowing the pelvis to naturally open to help the baby come out (refer to How Will I be Born by Jean Sutton, and www.spinningbabies.com for more information about Optimal Fetal Positioning). In addition, the birthing surges are more painful lying on the bed on your back, side or semi sitting than in the more natural positions mentioned above (the minute you start having contractions you will immediately appreciate this!!). **Removing that ability of ambulation by confining the birthing woman to the bed in an unnatural and more painful position to get a "good reading" for the CFM removes one of her greatest coping skills to deal with the power of labor and to help the labor progress normally. This positional restriction and routine CFM monitoring begins the "cascade of medical interventions" that lead to increased pain of labor and the mal-positioned babies that these positional restrictions can create, the increased need to have an epidural due to this unnecessary increased pain, the subsequent risks of epidurals (see True Informed Consent For Epidurals) including low blood pressure in the mom and fetal distress in the baby, and the further sequela that includes slowing or arrest of labor, use of Pitocin to augment the arrested or slow labor (which is not addressing the true etiology of the arrest or slow progress of labor, namely a mal-positioned fetus, which would not have been created with natural laboring positions, adequate ambulation, and timely correction of mal-positioned babies), etc. Managing a low risk birth with CFM creates scenarios that create a "Necessary" Unnecessary Cesarean.** This CFM method has a high sensitivity (picks up a problem if it really exists), but has a low specificity (*Grant, 1989*), meaning that it has a high rate of false positive signals of assessments of fetal distress in low risk births and a concomitant high number of (unnecessary) interventions including C/S that may ultimately reveal a healthy, un-compromised fetus, especially if used in a group of low-risk pregnant women (*Curzen et al 1984, Borthen et al 1989*).

**But don't you have to monitor the baby in labor to make sure everything is safe and healthy?**  
YES!!!!

For low risk births, **Intermittent Fetal Monitoring (IFM) is the safest way to monitor the wellbeing of the fetus during labor (as per the most recent ACOG and ACNM standards).** To adequately and safely perform IFM, a nurse (or midwife) must listen at the bedside with the patient between and during contractions once every hour for latent (early labor), every half hour to 15 mins during active labor (6cm to 10 cm), and every 5 mins or after each push during the pushing stage. Each assessment consists of establishing a baseline between contractions, then listening through a whole contraction to detect any periodic changes in the heart rate during the contraction, and for a whole minute after the contraction has passed, to pick up any periodic decelerations that could signify that CFM would be required to more carefully investigate the status of the baby instead of IFM.

**So why is CFM done instead of IFM in hospitals for low risk births,** if it has been shown through high quality studies accepted by ACOG's Standards of Practice for low risk women that IFM is so much safer than CFM?

**The answer is two-fold:**

- 1) **IFM does require a higher nurse/patient ratio (more time per patient) than most hospitals can afford.** Due to budgetary restrictions that limit the number of nurses that can be hired, most women, regardless of risk, are put on CFM, because there are just not enough nurses on the floor to adequately perform IFM with the frequent level of direct patient contact that would be required for low risk women. It is easier for the nurses to assess all the babies on CFM on the unit from the TV screens in the nursing station (regardless of the increase in medical interventions and higher C/S rates that result.)
- 2) **The nurses are responsible for monitoring all the babies's heart rates and tolerances to labor on the busy labor unit, not the OBGYN** (most of whom are *not* present with you at the bedside during your whole labor because he/she may be doing office hours or seeing other patients until they are notified by the nurses about your status regarding the "fetal strip" generated by the CFM and the cervical dilation status assessed by the nurses). The OBGYN will then make certain labor management decisions from afar over the phone. **It is not the responsibility nor within the scope of practice of a Registered Nurse to diagnosis and correct mal-positioned babies as the labor progresses:** they can only report the cervical progress and the status of the patient. **It is only the responsibly of the obstetrical care provider (OBGYN or Midwife) to diagnose and treat this condition.** If the baby's head is mal-positioned (with the baby's head either in the posterior position —baby looking in front of you with his /her back on your back, or extended and not flexed, or asynclitic— meaning tipped), the baby's head is wider in those positions and may have difficulty fitting through the narrow part of the mid pelvis. This can cause a much longer and more painful "back labor," a slowing of labor, or an arrest of labor because the baby literally may just not fit out *in that position* (unless the mal-position is corrected by a practitioner who is familiar with how and when to diagnose and treat this deviation from normal labor).

On average, in NY and NJ where the use of CFM is extremely high for low risk women, 60% of women will become fully dilated and be ready to push, and their OBGYN will then be summoned to attend the birth. If, due to the sequela of CFM stated above, a mal-positioned baby is not diagnosed and corrected *at the correct time during labor* —when it can make a difference due to the birth attendant not being present during the whole labor as the baby's position is dynamically changing,—and this mal-position creates a “failure to progress or descend” diagnosis, the current statistics in NY and NJ indicate that 30-40% of these low risk women (who were inappropriately placed on CFM due to their risk status and became subjected to the negative sequela that cascade from it) ultimately will need to birth their babies by Cesarean Section. If the average primary C/S rate should be no higher than 15% in an average risk population, and if in fact the actual primary C/S rate approaches 30%, then 15% of these C/S could have been avoided by using a more physiological approach to birth, incorporating IFM as appropriate instead of automatically resorting to CFM as a mode for monitoring the babies in labor.

**If that same woman would have been supported to have a physiological birth with their birth attendant present for the entire labor, IFM used as appropriate for evaluation of fetal wellbeing, the ability to freely ambulate and have full mobility, the use of hydrotherapy, and techniques such as Rebozo, positional changes specific to fetal position to encourage optimal fetal position in labor, utilizing gravity and upright laboring and birthing positioning, she will have a lower need and use for analgesia and anesthesia, and she may not have needed to end with a birth that needed to be a Cesarean birth.** In fact, Intermittent monitoring (IFM) is most appropriate for low risk women as per ACOG guidelines.

If your care provider tells you that you will be monitored by CFM instead of IFM for a low risk birth, you may want to ask your care provider that **“If it has been definitively proven through high quality scientific studies that CFM for low risk births creates more harm than good, why is this harmful practice still used for low risk births?”**

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## HOW LONG POST TERM WILL YOU ALLOW ME TO GO?

As per ACOG guidelines, with proper fetal surveillance (including biweekly biophysical profiles, non stress tests, and tracking of fetal movement counting,), 42 WKS is the appropriate answer unless there are other risk factors.

### Sources:

- American College of Obstetricians and Gynecologists. Practice bulletin no. 146: Management of late-term and postterm pregnancies. *Obstet Gynecol.* 2014;124(2 Pt 1):390-6. doi: 10.1097/01.AOG.0000452744.06088.48.

## WILL YOU INDUCE ME PRIOR TO 42 WEEKS IF THE ESTIMATED FETAL WEIGHT IS “LARGE?”

If the baby is suspected to be “big” using ultrasound assessments in the 3rd trimester, and if your care provider is pressuring you to be induced because the baby is “big,” please be aware that the Practice Standards set forth by ACOG states that if the baby has an estimated fetal weight of less than 5000 grams (11.02 lb.) and the mother is not diabetic, or if the baby has an estimated fetal weight of less than 4500 grams (9.92 lb.) and the mother has diabetes, **induction only for “macrosomia” (big baby) is NOT indicated**, unless there are other factors that enter into the decision making, such as previous birth history, a previous shoulder dystocia, constitutional stature, etc. Many women can birth babies in the 9-11 lb. range vaginally with no problems if their babies are assisted into the correct fetal position during the birth. Also, be aware that the estimated fetal weight generated by ultrasound in the third trimester is *extremely inaccurate*, generating a weight plus or minus a pound and a half on either side. Often women are subjected to the medical risks of induction for an estimated fetal weight of an “expected” 9 lb. baby, and the baby ends up being 7 lb. 8 oz. You should discuss all risks and benefits of expectant management versus medical induction with your care provider.

### Sources:

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## WHAT DILATION DO YOU CONSIDER TO BE “ACTIVE LABOR?”

ACOG recently changed the guidelines that signify when “active labor” really begins, realizing that normal birth can take more time than previously thought: “Recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught,” so “*six is the new four*”--- the old guidelines defined active labor beginning at 4 centimeters dilated; the new guideline is that active labor does not technically begin until the cervix is dilated to 6 centimeters; **therefore now you cannot diagnose “failure to progress” in labor as an indication for a C/S if the woman has not even entered “active stage of labor,” i.e., being 6 centimeters.** See if your doctor is aware of these new guidelines and incorporates them into his/her practice.

### Source:

- March, 2014 American College of Obstetrics and Gynecology/ Society of Maternal Fetal Medicine Consensus Statement: Safe Prevention of the Primary Cesarean Delivery; *American Journal of Obstetrics and Gynecology*, March, 2014.

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## CAN I EAT LIGHTLY AND DRINK DURING LABOR?

If you are low risk (no meds, no inductions, fetal heart tones reassuring, no complications of pregnancy), you should be allowed to eat and drink; lighter foods in active labor are better tolerated— usually clears are preferred and better tolerated (teas, juices, soups, sports drinks, ice pops) because often there is vomiting if the stomach is full during transition (the blood supply to the stomach is preferentially shifted to where the activity is happening, mainly the uterus and pelvic areas, and stomach contents emptying is slowed down.) However, if the woman desires to eat, she should not be discouraged from doing so. Nothing by mouth (NPO) is indicated if there is an induction, Pitocin, or any other circumstance where there is a higher than normal risk of surgery. NPO is bad for low risk labors; women need calories, fluid and energy for the birthing marathon. The reason the medical community does not like laboring women to eat is due to the fear of *Mendelson's syndrome*—that if they need general anesthesia, they theoretically might vomit and aspirate stomach contents into their lungs. Keeping a restriction on the food and fluid intake during labor however, does not guarantee reduced stomach content (*Crawford 1956, Taylor and Pryse-Davies 1966, Roberts and Shirley 1976, Tettambel 1983, Mckay and Mahan 1988*). Routine administration of antacids during labor cannot be relied on to prevent Mendelson's syndrome, neither does it affect the volume of gastric contents. **So what is the risk of aspiration during general anesthesia for childbirth?** As per [evidencebasedbirth.com](http://evidencebasedbirth.com), in one study, authors examined 4097 maternal deaths that occurred in the U.S. from 1979 to 1990. The risk of aspiration during cesarean childbirth was 0.667 per million women, or approximately 7 events in 10 million births (*Hawkins, Koonin et al. 1997*). [Side note: The probability of this occurring is less likely than being struck by lightning!] In another study, researchers looked at 11,814 women who were given the freedom to eat and drink during labor, with some women requiring emergency C-sections. There were zero cases of morbidity or mortality reported from aspiration pneumonia, even though 22% of women had eaten solid food (*Rooks, Weatherby et al. 1989*). As there is no guarantee against Mendelson's syndrome, the correct approach for normal childbirth should include an assessment of the risk of general anesthesia. Based on the evidence, once categorized, the low risk birth can be managed without administration of antacids, and women should have the right to choose whether or not they would like to eat and drink during labor.

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## **CAN I SHOWER DURING ACTIVE LABOR, OR USE A TUB DURING LABOR?** (not necessarily birth in the tub).

Hydrotherapy—the use of showers or tubs in active labor—helps women to avoid an epidural. Being in the water reduces the perception of “pain” during your birthing waves, is soothing due to the feeling of buoyancy, can help to stimulate and progress your labor due to the lack of stress hormones released and the nipple stimulation that showers can provide to increase natural secretion of oxytocin. It also provides general relaxation and the ability to assume floating forward leaning positions in the tub that are ideal for the latter stages of labor (i.e. froggy leg position, which opens the pelvis and provides more space for baby to descend.) There is always an “ahhhhh” moment immersing into a warm tub, and really helps to bridge you toward the end of the latter active stage into being fully dilated and being ready to push. The tub is frequently referred to as the “aquadural” instead of the “epidural.”

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## **WILL I BE ABLE TO AMBULATE FREELY DURING LABOR OR WILL I BE CONFINED TO THE BED?**

Ambulation supports changing the shape of the pelvis during labor to assist with optimal fetal positioning and the normal movement and rotations of the baby through the pelvis, assists the descent of the baby with the help of gravity (instead of pushing baby “uphill”), feels much more instinctive and makes the birthing waves more tolerable which helps to avoid an epidural and its associated risks, and is associated with lower risk of C/S. Trials that have compared these positions to the supine (lying down position) have found that, on average, labor was experienced as less painful (there was less need for analgesia) and augmentation (Pitocin use) was used less frequently in the non-supine positions (*Chan 1963, Flynn et al 1978, McManus and Calder 1978, Diaz et al 1980, Williams et al 1980, Hemminki 1983, Melzack 1991*). No birthing woman, left to her own devices, would EVER assume a dorsal (laying down on her back) position to labor and birth in. Once you are in labor, you will immediately see why.....

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## **WILL I BE EXPECTED AND COACHED TO START PUSHING AS SOON AS I AM FULLY DILATED IF I HAVE NO URGE TO PUSH YET?**

There is a normal, physiological **plateau phase** that can occur once a woman reaches 10 cms (fully dilated), and the contractions may space out. The physiological model of birth recognizes this phase, the normality of it, and the important role it plays to achieve a natural birth. This phase may last about 20-30 minutes. Midwives call this the “rest and be thankful stage,” when the contractions space out more, and allows for her to regroup, ambulate, empty her bladder, eat, drink, shower or rest and gather strength for when the contractions resume a more frequent pattern again to begin the next pushing phase. This phase also **allows for the baby to find the optimal position** to realign his/her head to fit easily out of the pelvis. When this phase is normally completed, usually the baby will have assumed an optimal position for entering the pelvis, and as it descends it presses on the pelvic floor and produces a natural urge to push. If a woman is forced to push during the plateau phase, the baby’s head may be forced deeper into the pelvis in a misaligned or tipped (asynclitic) position and may make it more difficult to proceed normally with descent, sometimes necessitating a C/S for “failure to descend.” She may even be given Pitocin to “strengthen the contractions” because they have naturally spaced out during this plateau phase, and this normal physiological stage is not appreciated. The medical model may diagnose this normal plateau as “inadequate contractions,” and may put a woman on Pitocin to enhance the power and frequency of her contractions artificially, which requires CFM, restriction of mobility, confinement to the bed, inability to allow the coccyx bone to naturally flare out, increasing the need for an episiotomy to enlarge the pelvic outlet. If your doctor is unaware of this physiological plateau phase of labor, and starts intervening with requiring forced pushing without an urge to push and/or administering Pitocin, your chances of a vaginal birth are diminished.

## **FOR THE ACTIVE PUSHING STAGE, WILL I BE ABLE TO USE PHYSIOLOGICAL PUSHING OR WILL I BE “EXPECTED” AND COACHED TO USE DIRECTIVE PUSHING?**

**Physiological pushing** is when you push when you feel the urge to push, holding the push for as long as feels comfortable, (even if it seems shorter than what the nurses want), taking breaths when you need to instead of holding your breath for longer than feels right, and listening to your own body to tell you when and how to push (if no epidural). **Directive pushing** is counting to 10 during each push, and being expected to do 3 pushes per contraction, chin to your chest—“purple pushing” as they call it. Physiological pushing leads to better oxygenated babies (less acidosis in babies), less fetal distress, less perineal tearing, and only a 7 and ½ minute longer pushing stage, compared to directive pushing. Directive pushing should only be used if there is fetal distress and the baby’s birth needs to be expedited, or 2 hours of physiological pushing that has not brought the baby down.

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## **WILL I BE ABLE TO BIRTH IN ANY POSITION, INCLUDING SQUATTING, LEANING FORWARD, ON HANDS AND KNEELS, OR OFF THE BED WHILE STANDING?**

When women birth normally, physiologically, they instinctively assume forward leaning or hands/knees positions to birth to allow for the natural way of opening the pelvic outlet—the normal flaring outward of the coccyx bone to make more room for the baby to come out. Most physicians, and even some midwives insist on “performing” the birth on the bed, or even breaking the bed apart (removing the bottom portion of the bed) with your feet in stirrups, so you are pushing the baby uphill in the wrong direction, in the “stranded beetle position.” If you are forced to birth lying on your back, the bed will be in the way and will restrict the normal mechanism of flaring out of the coccyx bone to enlarge the pelvic outlet. Therefore, to compensate for this inability of enlarging the pelvic outlet normally to make more room for the baby to come out, your birth attendant may need to open the pelvic outlet surgically, by cutting an **episiotomy** (which is a deep second-degree cut through the main muscles of the perineum that is painful and can lead to extensions into the anus and other long standing pelvic floor problems), or needing a surgical vaginal birth by **vacuum extraction** or **forceps** with their associated risks to the baby and the mother’s tissues. A number of trials (*Stewart et al 1983, Liddell and Fisher 1985, Chen et al 1987, Johnstone et al 1987, Gardosi et al 1989ab, Stewart and Spiby 1989, Crowley et al 1991, Allahbadia and Vaidya 1992, Bhardwaj et al 1995*) suggest that an upright (vertical) position or a lateral tilt during the second stage of labor show greater advantages than a dorsal (lying down on back) position. The upright position gives less discomfort and difficulty in bearing down, less labor pain, less perineal/vaginal trauma and wound infections. In one trial a shorter duration of the second stage was observed in the upright position. With regard to the fetal outcome, in some trials there were fewer Apgar scores below 7 in the upright position. It is much easier and safer for the mother to birth standing, squatting, leaning forward, or to be on hands and knees to make more room in the pelvic outlet instead of cutting a woman deeply with an episiotomy to enlarge the pelvic outlet surgically. **In all of human recorded art history depicting birth, women are always represented as being upright with the birth attendant below her to receive the baby.**

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## **HOW DO YOU KEEP WOMEN FROM PERINEAL TEARING DURING BIRTH?**

The best way to support woman during birth to remain as intact as possible is to apply warm compresses to the perineum, olive oil to decrease the friction, to allow for natural physiological pushing instead of directed pushing, to allow for slow stretching with crowning of the baby's head as long as the fetal status is good, possible perineal massage, and allow a woman to spontaneously assume any position she desires to birth in that is safe.

### **Sources:**

- [www.cochrane.org](http://www.cochrane.org): Aasheim V, Nilsen ABVika, Lukasse M, Reinar LM. *Perineal techniques during the second stage of labour for reducing perineal trauma.* 7 December 2011
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## **WHAT IS YOUR EPISIOTOMY RATE?**

Episiotomy should only be done if there is fetal distress while crowning, or it looks like the tissues will have a big blow-out. (Perineums heal, baby brain cells without oxygen don't; that is why we monitor so closely while pushing). Most spontaneous tears are first degree (only through the subcutaneous tissue). An episiotomy is a second degree tear through the beefiest part of the perineal muscle, and can frequently extend into a third or fourth degree tear right through the rectal sphincter or rectum itself. If crowning is allowed to go slowly, allowing your tissues to stretch and accommodate, and the birth is encouraged to go slowly at this point with the help of olive oil and warm compresses, good perineal support is given by your birth attendant, and physiological pushing is encouraged instead of directive pushing, tears are usually minimized, and if they occur are much less severe than episiotomy wounds. Left side lie is a good position to minimize tearing. Also birthing on all fours is helpful to reduce tearing and preventing shoulder dystocia (stuck shoulders). If women were meant to have episiotomies, women would have been born with zippers there. The vagina is like a fan. It normally is small, but has tremendous potential space to expand to birth our babies.

### **Sources:**

- *ACOG Recommends Restricted Use of Episiotomies, March 31, 2006*
  - *Practice Bulletin #71, "Episiotomy," April 2006 issue of Obstetrics & Gynecology.*
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## **DO YOU REQUIRE AN IV DURING LABOR? SALINE LOCK?**

It is not necessary to have an IV to birth a baby. However, in the hospital setting where nurses put IV's in everyone upon admission without urgency, if an IV is necessary in an emergent situation where the nurses are not skilled in inserting an IV quickly and easily, a saline lock (an IV access line established but not hooked up to a tube and fluid) is helpful. One of the benefits of having a saline lock even if you do not need IV fluids is that if there is fetal distress, the first things that are done for intrauterine resuscitation is to give the mother quickly a bolus of IV fluids, apply oxygen, and turn the mother on her left side. If a saline lock is in place, the ability to provide IV fluids is immediate. If there is no saline lock, it will take some time to insert an IV and prolong the time the mother does not receive this IV bolus. However, the low risk of fetal distress with a low risk birth, the risks of infection, restriction of total free and unimpaired movement of the arms/hands, and discomfort of having an intravenous line that might interfere with having a physiological birth must also be considered into the decision whether to insert a saline lock.

## **AFTER THE BABY’S HEAD AND SHOULDERS ARE OUT, WILL YOU INVITE ME TO REACH DOWN AND BRING MY BABY OUT AND ONTO MY CHEST MYSELF?**

This is a very empowering moment *if the mother chooses to do this*; it truly makes her feel as if “delivered” her own baby herself (which she did), right into her arms. The endorphins and euphoria that follow are good for both baby and mother. The initial steps of assisting a newborn to begin breathing, if necessary, may be done right on the mother’s chest if required.

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## **DO YOU DO IMMEDIATE CORD CLAMPING (BAD) OR DELAYED CORD CLAMPING (GOOD) AFTER THE PULSATION IN THE CORD CEASES (I.E. DELAYED CORD CLAMPING)?**

With delayed cord clamping, baby gets the extra 1/3 of its blood that belongs to her/him, not the placenta, and the baby has less anemia at 6 mos. of age. The baby also has more intravascular volume to help the transition from fetal non-air dependent oxygenation to the newborn circulation that requires the baby to breathe. Delayed cord clamping has become the standard of care when risks and benefits of both models are analyzed, and does mimic the natural, physiological model that has evolved during evolution. If there is meconium stained fluid AND/OR the baby is limp, not breathing, or gasping, the cord must be cut immediately to begin neonatal resuscitation that may require intubation for suction of the newborn’s airway to prevent the meconium from being aspirated. Any other scenario where the infant requires immediate resuscitation would require immediate cord clamping.

### **Sources:**

- [cochrane.org](http://cochrane.org): McDonald SJ, Middleton P, Dowswell T, Morris PS. *Effect of timing of umbilical cord clamping of term infants on mother and baby outcomes.* 11 July 2013.

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## **WILL THE NURSING STAFF RESPECT MY DESIRE TO HAVE UNINTERRUPTED SKIN TO SKIN CONTACT ON THE MOTHER’S CHEST AFTER BIRTH ASSUMING THERE IS NO NEED FOR RESUSCITATION FOR ONE HOUR BEFORE THE BABY IS TAKEN TO THE WARMER (FOR THE FOOTPRINTS, WEIGHING, MEASURING, ADMINISTRATION OF NEWBORN MEDICATIONS) OR NURSERY ASSUMING THE BABY IS FINE?**

That first crucial hour of skin to skin bonding between mother and baby have numerous benefits: immediately after birth the newborn is alert and primed to actively participate in the emotional bonding mediated by the physiological flow of oxytocin, the “love hormone.” Immediately after birth the infant is also primed to search for the nipple and begin spontaneous breastfeeding. (Babies can even self attach to the breast! Please refer to the You Tube video called “Delivery Self Attachment” based on a study published in The Lancet, 1990, Volume 336:1105-07, by Lennart Righard, MD, and Margaret Alade, RN, BSC, MS. The study compared the ability of newborns to breast crawl and self attach in two study groups: those who were separated at birth for cleaning, measuring, weighing, etc; and those who were allowed to remain on mother’s chest and breast crawl and self attach: both groups included both medicated and unmedicated in labor babies: the babies who were able to breast crawl and self attach were the ones who were unmedicated in labor AND not removed from the mother’s chest after birth.) Therefore immediately after birth is the perfect time to initiate breastfeeding and get nursing off to a good start, and have the baby get his/her first source of food/glucose before it begins its longer newborn sleep stage a few hours after birth when it is harder to awaken the baby to feed. It also is essential that the baby be on mom’s chest (assuming no resuscitation is required for baby) to help facilitate the natural expulsion of the placenta due to the natural surge of oxytocin immediately after birth, and to decrease blood loss.

And finally, the baby's access to the mother's micro-biome, the normal skin organisms that live on the mother's skin, is passed to the baby to increase the baby's immunity and decrease the incidence of infant morbidity.

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Donna Tabas, CNM, M.S., a Columbia University trained Certified Nurse Midwife with 33 years of experience with working with birthing families, has developed a new model of midwifery care that has resulted in faster labors in both first time and repeat birthing mothers, low Cesarean section rates, wonderful birth experiences and excellent outcomes.

Donna, the Owner and Founder of North Jersey Midwifery Care, L. L.C. that serves the women of northern New Jersey and surrounding areas is a solo “dedicated” midwife that offers women a **new five point model of midwifery care** that provides safe, positive, and empowering birth experiences in the safety of the hospital setting.

**These five points combines:**

- (1) Extraordinarily personalized, *unrushed home prenatal care*;
- (2) **Transforming expectations** of normal birth from that of fear, tension, and pain to that of power, relaxation, confidence, comfort, and even pleasure through multidisciplinary methods including exposure to hypnobirthing and other relaxation techniques.
- (3) *Doula care* in labor for all her women;
- (4) Guiding and maintaining the birth as normal using the natural *physiological model of birth*;
- (5) Having a **solo, “dedicated” midwife** with whom mutual trust has been developed, the guarantee of her being the midwife to attend the birth, and her **availability of continuous presence** during the active stage of labor to **adjust and correct problems** that might develop in birth, such as mal-positioned babies, to restore and maintain the birth as normal.

Some of these five components are utilized in other midwifery practices, *but the combination of all these components together* are what enables the excellent, safe, fast, and empowering birthing outcomes that the women under her care experience, with an extremely low Cesarean Section Rate.

This 5 point model of care is informed by her number one priority of a birth culminating in a healthy baby and a healthy mother, which she believes is represented by the motto, *“Natural facilitates safety, but safety always trumps natural.”*