BirthSpirit

Holistic Midwifery Services, LLC

PHILOSOPHY OF CARE

This midwifery practice is dedicated to these essential truths about childbirth:

The process of human childbirth is a normal physiological process perfectly designed by nature to bring babies into the world. It is an instinctive, primal experience that has its own rhythm and pace which should be respected and honored, and works best when interfered with as little as possible. Women should have as much control as possible in determining their care, and should be encouraged to be active participants in decision-making and self-care. When informed, supported and encouraged to follow their own instincts, women can be active givers of birth rather than passive receivers of birth technology. Childbirth, when experienced in this way, has the potential to be a transformative event; women who take responsibility for their births and give birth to their babies under their own power, emerge from the experience empowered, with a new sense of their own capabilities. This transformation benefits not only that mother and her children, but also the entire family unit, the community, the culture at large, and ultimately the world, as it encourages peaceful, loving, responsible relationships. As we birth, so we live.

Midwifery is both an art and a science. The art of midwifery consists of sensitivity to the needs of women and families, and being able to meet these needs in the most appropriate way. It involves knowing when and how to intervene to promote safety if it becomes necessary, and is grounded in scientific knowledge. The science of midwifery overlaps with that of other disciplines such as medicine and nursing.

The crux of the art and science of midwifery lies in the knowledge of and devotion to keeping birth and other related processes normal. As midwives, we act as guardians of natural childbirth and well women, providing birthing women with support and guidance to ensure a healthy pregnancy, labor and delivery with minimal intervention. We understand that pregnancy and birth are normal processes, and work to optimize the well-being of mothers and their babies as the foundation of our care-giving. We approach the experience of childbirth as far more than a physical event, perceiving it as a profound emotional, mental and spiritual Rite of Passage for both mother and child. We respect the dignity, integrity and response-ability of the women we serve, recognizing that the primary caretaker and most important determinant of a healthy pregnancy and positive birth experience is the woman herself. The emphasis of our care is on building partnership with mothers, their families and their communities, helping them to explore their options and make informed decisions based on their unique circumstances. We see our clients as whole, capable people for whom the processes of pregnancy, labor, delivery and parenting offer the opportunity for significant personal growth, and are committed to doing whatever we can to facilitate that growth.

A midwife's job is:

- *to help a woman discover what she is feeling ... not to make the feelings go away.*
- *to help a woman identify her options ... not to tell her which options to choose.*
- *to help a woman discover her own strength ... not to rescue her and leave her still vulnerable.*
- *to help a woman discover she can help herself ... not to take responsibility for her.*
- *to help a woman learn to choose ... not to make it unnecessary for her to make difficult decisions.*
- *to listen, guide, advise ... not work miracles.*
- *to provide support for change.*

INFORMED CONSENT AGREEMENT

The best health care is attained when individuals make informed decisions regarding their care. Responsibility for well-being rests not only with the providers of health care but also, and ultimately, with each individual. You have been provided with this information so that you will be clearly aware of the education, training, and experience of your midwife, as well as the services she provides. Your choice of a midwife should mean that you are confident with her judgment and skills.

WHAT IS A MIDWIFE?

Midwifery care is unlike medical obstetric care in many significant ways. These differences are not just in the superficial aspects. It is not that midwifery is more "touchy feely" - although it can be that - or that it provides more quality time to the client - although it certainly does that. The differences stem from a fundamental variance in the underlying belief systems that give birth to the two styles of practice.

The midwife sees pregnancy and childbirth as normal states for the healthy mother. Out of respect for the birth process and a woman's innate ability to bear a child, the midwife believes unnecessary interference is an unwise interruption of the body's functions. Like a lifeguard, she carefully watches and guides, assisting the woman to give birth, respecting the choices and values of the family. She is a skilled practitioner, giving care and advice to the mother during normal pregnancy, labor and birth, and caring for the mother and newborn following delivery. A midwife is trained to detect any abnormality in mother or child and refers to medical aid if necessary. In the absence of medical aid, a midwife is ready and willing to use emergency measures to the limit of her education and experience

TYPES OF MIDWIVES, AND THE STATUS OF MIDWIFERY IN Pennsylvania

There are essentially two types of midwives: Certified Nurse Midwives and direct-entry midwives.

Certified Nurse Midwives (CNMs) are medical professionals whose training included first getting a Bachelor's degree in Nursing, and then a Master's degree in Midwifery or Maternity Nursing. These degrees enable a person to be a state-licensed health care provider in any state. CNMs have some advantages: they can prescribe medication, attain hospital privileges, and file for insurance reimbursement. There are also disadvantages: in Pennsylvania, a CNM's license agreement requires that she work within a written practice agreement with a supervising physician. Her working relationship with this physician is part of what legitimizes her practice. This physician defines the scope of her practice – what she can and cannot do as a midwife – and she practices under the "umbrella" of the doctor's insurance policy (as well as her own). Therefore, her supervising doctor determines a lot about her services, including whether she can provide out-of-hospital birth services or not. Since most doctors (or their insurance carriers) are unwilling to support out-of-hospital birth, very few CNMs in Pennsylvania can offer out-of-hospital birth. For women desiring a hospital birth, however, a Certified Nurse Midwife is an excellent choice.

The term "Direct-entry midwife" (DEM) is the generic name for any midwife who entered the profession directly, without a nursing background. Such midwives are also known as Non-nurse Midwives or Traditional Midwives. DEMs get their training in two possible ways: First, they may attend a 2-3 year Direct-Entry Midwifery School; such schools exist in states where licensing of DEMs has been in place for a number of years. Women who attend these schools graduate with a certification that grants state licensing if they live in one of the 26 states that license such midwives.

In states where midwifery is unregulated or illegal, there are no formal schools to attend. Midwives in these states gain their skills by the apprenticeship method – learning in a hands-on way from another, more experienced midwife. An apprenticeship can last from 2–8 years, depending on the busyness of the practice, and the apprentice graduates into full midwife status when both she and her preceptor feel she is ready.

There is third credential that some midwives choose to obtain. Whether nurses or not, any midwife who desires can go through the certifying system of the North American Registry of Midwives, a lengthy process of documenting a requisite amount of experience and skills followed by a hands-on skills exam and an 8-hour written exam. Completion of this process grants the midwife the credential of Certified Professional Midwife (CPM). This certification is not the same as a state license, although several states use the CPM credentialing process as their own in granting licenses to non-nurse midwives.

In 33 states, Certified Professional Midwifery has become a licensed profession. In these states, which unfortunately do not include Pennsylvania, midwives who qualify earn the credential of Licensed Midwife (LM) and may practice legally, within the limits of the law, although without prescriptive or hospital privileges. I am a Direct-entry CPM, but since licensing for my credential is not available, my practice as a CPM is not recognized or regulated by the state of Pennsylvania.

PRENATAL CARE

Adequate prenatal care is required for each woman preparing for an out-of-hospital birth. This is a safeguard for her health, as it allows the midwife to watch for any risk factors that might make out-of-hospital birth unwise. It also offers the pregnant woman the opportunity to learn about the changes her body goes through as pregnancy advances.

I expect to see all clients at least once a month until the 28th week, then every second week until the 36th week and once a week thereafter. This is the same schedule that is followed during standard obstetric care. However, visits with a doctor statistically last less than 10 minutes each, while visits with your midwife routinely last 45 –60 minutes each. Prenatal care includes monitoring blood pressure, fetal growth, fetal heart rate and position; urinalysis; monitoring of the iron levels in your blood; and screening for complications. Equally important is the time spent discussing nutrition, exercise, breastfeeding, family changes in pregnancy, general information on childbearing, techniques for labor management, pregnancy and birth technology, and health care alternatives. If any complications developed in a previous pregnancy or delivery, I request that the medical records of that pregnancy be obtained from the previous caregiver.

In the ideal world, clients – especially first time mothers - would have the opportunity to work with a physician or Nurse Midwife, who would "consult" with them, as an adjunct to my care. This doctor would not be functioning as a midwife's "back up" doctor nor have any official or legal relationship with me. Rather, he/she would be someone who is willing to consult with families choosing out-of-hospital birth, to order any lab work or tests that I am unable to perform, and to assume their care in the event that hospital admission is necessary. Clients would see this provider a few times during their pregnancy, while seeing me for the bulk of their care. Unfortunately, at this time there are no providers in NEPA who are willing to provide this service. However, all clients are encouraged to talk to their own OB/GYN to see if they are willing to do this for them. We know that the best care for mothers and babies results when midwives have the option to collaborate on the care of the women/babies they work with, and we are always looking for providers who are willing to work with our clients.

HOME VISIT

Around the 37th week, at least one prenatal visit will take place in the client's home so that my assistant and I can become familiar with the location of the home and household layout, look over your birth supplies, and meet any others who expect to be present at the birth and answer their questions. Assistance will be given to arrange the home for birth, if necessary.

CLASSES

Childbirth education classes are not included in the prenatal services, but all clients, especially first-time parents, are encouraged to attend high-quality independent childbirth classes in their community. I can refer you to good independent childbirth educators in our area. I discourage clients from attending hospital classes only; although these classes are often quite inexpensive and/or covered by insurance, I find that they are not

appropriate for couples desiring natural birth, often failing to give vital information and encouraging the use of medical interventions as if they were normal and necessary.

LABOR & DELIVERY

Once you are in labor, my assistant and I will join you at in your home or at the birth center whenever you need us. Care throughout labor includes checking labor progress, monitoring the mother's vital signs and fetal heart rate and position, assistance during delivery of the infant and the placenta, examination of the newborn, and checking the mother's condition during the immediate postpartum period. Emotional support, information and guidance during the labor are also provided to the family and birthing woman.

You may labor and deliver in whatever room you like, in or out of the bed, presuming it is clean and safe and there is room enough for you and one other person! You may also assume whatever position you like. I have no restrictions or preferences about this, and have found that women in labor instinctively know how to move their bodies and what positions to assume to let their babies out. Of course, if you are having trouble and need assistance, I will provide guidance and suggestions to facilitate the delivery of your baby.

When your baby is born, unless it needs help breathing, it is handed immediately to you. Baby is dried off with a warm towel and kept warm on mother's chest, covered with more warm towels or blankets. If you are in the water for the delivery, baby stays warm by keeping most of its body in the water, but the towels are used once the mother/baby leaves the tub. The cord is not cut until long after the placenta is born in most cases. Any procedures that need to be done to baby are performed either in mother's arms or on the bed next to her. Until the placenta is born, we can't take the baby anywhere anyway, as baby is still attached to the placenta, which is still inside you! No medical procedures or tests are done without your express permission, and you have the right to waive any "routine" procedures.

Parents and baby are kept together to facilitate bonding and breastfeeding. About 2 hours after delivery, a full newborn exam is performed that includes weight and measurements. Perineal trauma is assessed and repair is done if necessary.

Risk factors are assessed throughout labor and postpartum to determine the need for physician consultation or emergency transport. In situations where hospital care is required or desired, I remain with the parents, providing them with information about their options and giving them support in making decisions. In the hospital, my role changes from primary attendant to labor coach and patient advocate.

I attend all births with one or two assistants. It is preferable to have an assistant at the birth for safety reasons; in the unlikely event of an emergency, having an extra person who is familiar with birth procedures can be critical. In most cases, I will function as the "primary" midwife, but we function as a team, doing whatever needs to be done. My assistants are sometimes students who are learning midwifery, and, with your permission, I will be allowing them to perform skills that are appropriate for their level of training.

DOULAS AT OUT-OF-HOSPITAL BIRTH

A "doula" is the name popularly used for a professional childbirth assistant and support person. Many women delivering in the hospital these days are choosing to have such a woman with them to help them avoid unnecessary interventions, provide physical and emotional support, and act as an advocate for them. In the out-of-hospital birth setting, doulas can also be useful. Although it is unlikely that a client birthing in the out-of-hospital setting would need a doula to help her avoid unnecessary intervention - since I already intervene so minimally - or to advocate for her – as I consider good communication a vital part of my care and we are likely already on the same page – a doula can be very helpful in providing physical and emotional support to the laboring woman and her family during the birth. While at a normal length labor, my assistant and I will be able to provide all of the assistance the woman might need, if the labor is long, we can all benefit from the presence

of a doula's energy and support. She can also act as an extra set of hands for me, take pictures, help with other children, run errands, prepare food, clean up, or do whatever else is needed. I strongly encourage every first-time mother to consider having a doula with her for her birth, and all other clients may wish to consider a doula as well.

If you are interested in having such a person at your birth, I am very open to this. I can direct you to doulas in the community who would be happy to attend your birth.

BIRTH TOOLS & EQUIPMENT

I carry with me the standard tools of the midwifery trade, including electronic Doppler, oxygen, and resuscitation equipment, and medications to prevent hemorrhage. I have portable labor/birthing tubs that are available for my client's use, as well as a Kaya birthing stool and a 65 cm birthing ball. I am a practicing homeopath, and am also familiar with the use of herbs and supplements for various conditions. I carry an extensive kit of homeopathic remedies for birthing, as well as some herbs and aroma-therapeutics.

POSTNATAL CARE

After the birth, I remain with the family until I am quite certain that both mother and infant are stable, a minimum of 2 hours but usually 4-5 hours. I examine the newborn, including performing weight and height measurements, and administer prophylactic eye treatment and vitamin K if desired. Postnatal instructions are given to parents after the birth and any "mess" from the birth is cleaned up.

I visit the new family 24 to 48 hours after the birth to see that the baby and mother are doing well, as well as staying in close phone contact in the interim. Another visit is often scheduled at 3-5 days postpartum. During these early days postpartum, I am watching both mother and baby carefully to make sure they are recovering normally, and assisting with breastfeeding.

Within the first week postpartum, a pediatric exam of the baby is encouraged; clients should retain the services of a pediatrician or family practitioner prior to delivery and inform him/her of their plans to birth outside the hospital, and to bring the baby in for an assessment shortly thereafter. Clients then visit me at 6-10 weeks postpartum for a follow-up exam to check for return of the woman's body to the non-pregnant state and to discuss contraception, if desired. Additionally, if the woman should desire a Pap test, I can perform this test at around 10 weeks postpartum. Should any problems arise, I am always available by phone and will not hesitate to make other visits to assess any potential problem in the postpartum period. I am available by phone throughout this period of time to answer any questions or concerns.

BIRTH CERTIFICATE AND NEWBORN SCREENING

Midwives are trained in filling out Birth Certificates Worksheets for the state of Pennsylvania and are REQUIRED to file this form for every client who delivers with them. I will complete your Birth Certificate worksheet at the first postpartum visit and file it with the state. You will receive a birth certificate from the state within a couple of months. If there are any errors on the form, you can make changes by contacting the Division of Vital Records within 6 months of the baby's birth. A new certificate will be issued with the corrected information. A Social Security number will also be ordered for your baby unless you decline one.

At the first postpartum visit, I will perform the Newborn Metabolic Screen for your baby. This involves collecting enough blood from your baby's foot to fill 5 dime-sized circles on a special card provided by the state. This blood is tested for many different metabolic diseases of the baby's metabolism. These are diseases that, if caught early, can be controlled with diet or medication, but if not discovered, can lead to brain damage or death. I am very gentle with your baby and the test is usually done in a parent's arms, where baby feels safe. The state does not charge for this test, so I can do the test free of charge. Hearing screening can also be done at this same visit.

MIDWIFERY BACKUP ARRANGEMENTS

Clients often ask, "What do you do if two births occur at once?" This is a legitimate question. My answer is that, first of all, I rarely take on more 6 births per month, usually less. This makes it unlikely that two labors would be occurring at once. However, since, even with due dates several weeks apart, it is possible for labors to occur simultaneously, my arrangements are that:

- If two women were laboring at once, I would go to be with the woman whose birth was most imminent. I would call on another experienced midwife from the community to be with the other mother and would call midwife's assistants to help each of us with the births that we were attending
- When the birth I was at was completed and I was confident that mother and baby were stable, I would leave my assistant with that mother/baby pair and go to be with the other laboring mother if possible.
- If I am unable to make it to the later delivery, the client would know that the midwife attending her has the same training and experience as I and is someone that I trust to care for her in my absence.

PARENT'S ROLE AND RESPONSIBLITY

As a midwife attending births outside the hospital, I believe planned out-of-hospital birth is a safe option for healthy mothers. I would not be in this business if out-of-hospital birth was inherently dangerous and fraught with hazards on a regular basis. However, birth, like the rest of life, carries some risks, and there are distinct risks and benefits to any place of birth. It is the responsibility of parents to become as informed as possible, to weigh those risks and to make decisions appropriate to themselves. It is also their responsibility to eat properly, take care of themselves emotionally and physically, including avoiding substances and situations that might jeopardize a positive outcome, and be diligent about coming for prenatal care.

Adequate prenatal care is the most important factor in detecting and avoiding possible complications that would make out-of-hospital birth unwise, and, thankfully, most complications can be detected prenatally. However, unforeseen difficulties can arise during labor and birth. Most of these are not life-threatening and can be dealt with outside the hospital or safely transported to the hospital. Nevertheless, you must be aware that there are some circumstances when use of the technology available only in the hospital may be essential for the safety of mother and/or baby. Your choice of place of birth - whether inside or outside the hospital - means the acceptance of certain risks which <u>may</u> be life-threatening. A good emergency care arrangement is essential for safe out-of-hospital birth, as is making informed decisions. I can provide you with information about some of the complications which can arise, and I encourage you to discuss with me my experience in dealing with them, as well as the supplies and equipment I bring to your birth for use in those situations. However, I expect you to consider the significance of the risk you are taking and be willing to take primary responsibility for the outcome of your birth. Like any other childbirth professional, I cannot offer you any guarantees other than that I will do my best, with the knowledge and skills I have, to provide you with a safe and rewarding birth experience.

I encourage you to realize that no midwife or doctor, regardless of degrees, diplomas, credentials or years of experience, can guarantee a perfect outcome. Listen to your instincts in choosing your midwife. Your sense of your midwife's commitment to you and to responsible childbearing and health care should form the basis of your decision to work with her. It is a determination best made both from your head and your heart.

RISK FACTORS

While I believe that every woman has the right to choose where and with whom she has her baby, my practice is limited to low-risk pregnancies and births. There are certain health factors that may make out-of-hospital delivery unwise. I screen for these possibilities by first asking questions about the client's health, reviewing their health history and blood work results, and then watching carefully for any problems throughout the prenatal period. Below are guidelines for my practice; these may be adapted to particular situations according to my judgment and experience.

Definite contraindications to out-of-hospital birth

- Placenta previa
- Pre-eclampsia
- Blood disorders
- Delivery before 37 weeks gestation
- Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations
- Other serious health problems:
  - Epilepsy
  - Tuberculosis
  - Renal disease
  - Cardiovascular disease
  - AIDS
  - Uncontrolled current serious psychiatric illness
  - Alcoholism
  - Drug dependency
  - Previous classical uterine incision
  - More than one previous c-section
  - Active syphilis or gonorrhea
  - Active herpes eruptions at time of labor
  - Active cancer
  - Insulin-requiring diabetes

Possible contraindications to out-of-hospital birth

- Smoking
- Sexually-transmitted diseases
- Poor nutritional status
- Hypertension
- Multiple gestation
- Breech presentation
- Abnormal fetal growth
- No labor by 42 weeks
- Too much amniotic fluid
- Rupture of membranes longer than 18 hours without established labor

Should your pregnancy fall outside the parameters for a safe birth, I out-of-hospital will refer you back into medical care. Should you so desire, I will be happy to continue to support you in the role of a doula (childbirth assistant) as you plan your hospital birth.

Complications which MAY require transport to hospital during labor, birth or postpartum (in order of frequency in which they have occurred my practice)

- Prolonged lack of progress in labor, usually caused by malposition of baby, leading to maternal exhaustion & need for pain relief – accounting for 75% of the hospital transports
- Irregular, depressed or accelerated fetal heart rate indicating fetal distress
- Maternal hemorrhage that cannot be controlled outside the hospital
- Thick meconium staining
- Maternal fever – which indicates infection and the need for antibiotics
- Extensive perineal or cervical lacerations
- Retained placenta
- Poor infant response after birth
- Infant abnormalities

In addition to these possible considerations, there are a few things that I require of my clients:

1. Breastfeeding – All mothers must be willing to breastfeed their babies. Formula feeding introduces a risk factor that could make out-of-hospital birth unsafe.
2. Circumcision – Families must be willing to read about and listen to information on the circumcision controversy in order to make a fully-informed decision.