Navigating the Medical Setting
What Parents Need to Know about Epidurals, Cesareans, Birth Plans & Informed Consent

Course Pack & Additional Resources

© 2015
Center for the Childbearing Year, LLC
www.center4cby.com
# Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine vs. Evidence-Based Maternity Care in the U.S.</td>
<td>3</td>
</tr>
<tr>
<td>The Birth Marathon: Food &amp; Drink for Labor &amp; Birth</td>
<td>7</td>
</tr>
<tr>
<td>Bishop’s Score for Induction of Labor</td>
<td>10</td>
</tr>
<tr>
<td>Fetal Movement Counting</td>
<td>12</td>
</tr>
<tr>
<td>Active Management of Third Stage of Labor</td>
<td>13</td>
</tr>
<tr>
<td>Steps for Reducing the Need for a Cesarean</td>
<td>16</td>
</tr>
<tr>
<td>Birth Plans</td>
<td>19</td>
</tr>
<tr>
<td>What is a birth plan?</td>
<td></td>
</tr>
<tr>
<td>How to write a birth plan</td>
<td></td>
</tr>
<tr>
<td>Birth Plan Checklist</td>
<td></td>
</tr>
<tr>
<td>Ideal Birth Worksheet</td>
<td></td>
</tr>
<tr>
<td>Birth Plans &amp; Care of the Newborn</td>
<td>24</td>
</tr>
<tr>
<td>Kangaroo Care</td>
<td>27</td>
</tr>
<tr>
<td>Additional Resources</td>
<td>28</td>
</tr>
</tbody>
</table>
## Routine vs. Evidence-Based Maternity Care in the U.S.

*From ImprovingBirth.org*  

<table>
<thead>
<tr>
<th>Labor and Delivery Procedures</th>
<th>U.S. Care</th>
<th>Evidence-Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical birth (C-section)</td>
<td>33% total¹</td>
<td>≤15% of low-risk women³</td>
</tr>
<tr>
<td></td>
<td>27% of low-risk women²</td>
<td></td>
</tr>
<tr>
<td>Vaginal birth after Cesarean (VBAC)</td>
<td>7-9%²</td>
<td>Every eligible woman should be offered a VBAC⁴ 74% will be successful⁵</td>
</tr>
<tr>
<td>Artificial induction of labor</td>
<td>42% of first-time mothers⁶ for whom this doubles the risk of C-section⁷</td>
<td>Induction should only be used for true medical indications⁸ suspected “big baby” is not a valid medical indication⁹</td>
</tr>
<tr>
<td>Artificial acceleration with Pitocin</td>
<td>47%¹⁰</td>
<td>Not supported by evidence¹¹</td>
</tr>
<tr>
<td>Artificial breaking of the waters</td>
<td>65%¹⁰</td>
<td>Not supported by evidence¹²,¹³</td>
</tr>
<tr>
<td>Routine electronic fetal monitoring</td>
<td>94%¹⁰</td>
<td>Not supported by evidence¹⁴</td>
</tr>
<tr>
<td>Routine intravenous fluids</td>
<td>80%¹⁰</td>
<td>Not supported by evidence¹⁵-¹⁸</td>
</tr>
<tr>
<td>Not allowed to eat or drink</td>
<td>60%¹⁰</td>
<td>Not supported by evidence¹⁹</td>
</tr>
<tr>
<td>Not allowed out of bed</td>
<td>76%¹⁰</td>
<td>Not supported by evidence²⁰</td>
</tr>
<tr>
<td>Back-lying positions during pushing and birth</td>
<td>92%¹⁰</td>
<td>Women should choose whatever position is most comfortable for them²¹</td>
</tr>
<tr>
<td>Water immersion during first-stage labor</td>
<td>6%¹⁰</td>
<td>This intervention has many benefits and no adverse effects²²</td>
</tr>
<tr>
<td>Continuous labor support from a doula</td>
<td>3%¹⁰</td>
<td>The use of doulas is supported by evidence²³</td>
</tr>
</tbody>
</table>

Table © 2012 by Rebecca Dekker, Phd, RN, APRN  
See footnote references at www.EvidenceBasedBirth.com
References


2. *In 2007, 27% of low-risk females with no prior cesarean birth had a C-section.* (The majority of this percentage consists of first-time mothers; however, because this includes a small number of women with prior children, this number may differ slightly from other data reported on the internet). Data accessed from September 2012 from HealthyPeople.gov. Click [here](#) to see the healthy people data set. Scroll down to MICH 7.1 and click on the link that says “Reduce cesarean births” to see the data.

3. National Quality Forum. NPP Maternity action team. 2012. This is a multi-disciplinary team (including representatives from ACOG, midwifery, nursing, and many other organizations) that joined together in 2012 to work on reducing the C-section rate in the U.S. Accessed November 25, 2012. Read more about the Maternity Action Team at this website.


8. *In this table, “artificial induction” refers to labor induction with medications. a. Artificial induction with Pitocin (Oxytocin): U.S. Food and Drug Administration. Oxytocin drug label. 2008. The BLACK BOX is the FDA’s strongest warning for drugs available on the U.S. market. Read the black box warning against elective induction with Oxytocin on this label [here](#). b. Artificial induction with Cytotec...*


14. Alfirevic Z, Devane D, Gyte GM. Continuous cardiotocography (ctg) as a form of electronic fetal monitoring (efm) for fetal assessment during labour. *Cochrane database of systematic reviews*. 2006:CD006066. Read the summary here. There is no reference for “intermittent” electronic monitoring because no studies have ever been conducted on this method of monitoring.


newborn weight loss. *International breastfeeding journal*. 2011; 6:9. Read the full text article [here](#).


The Birth Marathon—Food & Drink for Labor & Birth

Moms birthing in most hospitals are faced with instructions to not eat solid food, restricted to ingesting clear liquids only. If labor goes on longer than your blood sugar can hold out and contractions or your energy begin to wane, try the following options. Your overall strategy here is to achieve a stable blood sugar throughout labor. This can be challenging, not just due to restrictive hospital policies and the limitations of what is available on site, but because:

- some women feel nauseous from the onset of labor
- some women respond to pain with nausea and vomiting
- digestion does slow considerably during active labor because blood flow is concentrated to the uterus
- you may not have an appetite
- you may fear vomiting (remember, however, that nausea is one of the symptoms caused by low blood sugar!)

**Strategies**

- Some women experience an urge to load up on carbohydrates in the 24-hour period before the onset of active labor, similar to what an athlete may do in preparation for running a marathon on the following day. Go for it! (I had a bread, salad, and pasta dinner at a local restaurant 12 hours before my second child was born and never felt nauseated in labor, which started about 5 hours after the meal.) This strategy is especially recommended if you are facing a scheduled induction. You don’t want the hard work to hit after you’ve been essentially fasting for 24 hours or more.

- **EAT WHILE YOU ARE STILL AT HOME IN EARLY LABOR.** This is key and must be maintained throughout the day. Don’t just settle for breakfast and stop there. Eat every 2–3 hours, whatever appeals. You may want to avoid heavy, greasy foods such as pizza or fast foods (which don’t digest easily under the best of circumstances).

- Avoid substances that will spike your blood sugar such as pop and other forms of concentrated sugar (read your labels!). These will dehydrate you and ultimately lead to your blood sugar crashing.

- Eat a banana on the way to the birth center/hospital. Despite most TV depictions of how women go into labor (i.e., a sudden contraction alerts her to the need to rush to the hospital where she gives birth soon after on her back, typically involving various emergencies for dramatic effect), most women have plenty of time to take care of themselves at home and head to the birthing center/hospital with little need for high drama.

- During labor, try a variety of the suggestions below, alternating them. A little protein here, some electrolytes there, something sweet to boost your energy, the Pregnancy Tea … you get the idea. That will keep you going if your labor is long. This is especially important for women who might be admitted to the hospital early in labor or whose labor is being induced.
- Drink lots of water, at least 4 ounces per hour throughout your labor, more if it’s a hot day and you’re sweating a lot. Have your support team help you with this. (Note to partners and doulas: It’s your job to encourage the mom to drink throughout her labor. If she is willing to drink, asking for it, and consistently taking several gulps when offered, then just keep the supply coming and keep an eye on her to ensure she doesn’t stop drinking at some point. However, if the mom is disinterested in drinking and reluctant to do so, then frequent small sips will be necessary. Keep offering!)

- Finally, don’t hesitate to accept IV fluids if you can’t keep anything down over a long period of time and are getting dehydrated. While most healthy women will not need routine IV fluids, dehydration can cause your labor to be dysfunctional and non-productive. An IV can turn the picture around and is an appropriate use of medical intervention.

**Raspberry Leaf Tea Labor Cubes**
Before labor begins, make up a VERY strong tea (two quarts of boiling water with 2 cups of dried red raspberry leaves added). Simmer with the lid off for at least 20–30 minutes as the volume reduces considerably. Strain and add ¼ cup of honey (raw is best if possible). Pour into ice cube trays and freeze, adding water if necessary for at least one tray’s worth. Store in a zippy bag at home or take with you to the birth center/hospital (usually you can store them in the freezer of the small room refrigerator or in the common “nutrition room” refrigerator). The honey gives mom a boost of energy, while the concentrated raspberry leaves provide minerals and may assist in bringing back strong contractions. In between the contractions, mom can easily crunch the cubes into a satisfying slush.

**Electrolyte-Balanced Sports Drinks**
There are a large variety of sports drinks on the market these days. Avoid the overly-sweet, chemically-generated metallic blue and other colored products not found in nature. See what’s available at your local health food store and find something you like. Have 2–3 quarts on hand for labor (your support team will appreciate these as well).

**Miso Broth**
If you’re unfamiliar, miso is a paste made from fermented soybeans. It is high in protein and tastes salty. If you haven’t tried miso, there are a number of different flavors available in the refrigerated section of your local health food store. Give them a try and find one you like. The paste can be brought with you to the hospital and kept in the refrigerator. Mix one tablespoon of miso into one cup of hot water. Avoid boiling miso as it kills many of the nutrients. There are also packets of instant “miso soup” on the market. This is a good option for doulas and midwives to carry with their birth supplies.

**Concentrated Home-Made Chicken or Beef Broth**
Place one whole (preferably organic) chicken or a couple of beef bones in a large soup pot. Bring to a boil and spoon off the scum that will rise to the surface over a 10-minute period and discard. Roughly cut up one onion, 3 carrots (washed, with skins on), and 3 stalks of celery, including tops. Chop up 2–3 garlic cloves and throw those in too (you can even leave the skins on as a timesaver). Cover and reduce heat, simmering for 1½ hours. Allow cooling and strain out the solids (make chicken salad with the meat). Put in refrigerator overnight so
that the layer of fat on top solidifies. In the morning, remove and discard the fat layer, but don’t worry if a little is left behind. Return the broth to the stove uncovered and bring to a boil, allowing the liquid to reduce to a rich-colored (and tasty!) broth. Add in salt to taste at the very end. Freeze in small containers to have on hand for labor.

**Herb Tea and Honey**
Bring a variety of your favorite herbal teabags and some raw honey with you to the hospital. When energy flags, especially in the second stage of labor, a cup of tea with a generous spoonful of honey can give you the boost you need to get the job done. Ginger tea can settle the stomach if nausea is an issue.

**Hot Drinks**
Americans are big on iced drinks, but in many parts of the world, ingesting iced drinks is not recommended. A number of cultures, from China to South America, have prohibitions against iced drinks for women in labor or postpartum. The wise women grandmas-to-be will not allow it. Feed the fire. You are supposed to get hot in labor! You will sweat. You will be uncomfortable. It’s okay. It’s more efficient.

**Labor Food**
Women have been using tubes of concentrated carbohydrates found in the runners’ stores (aka “goo”). Lots of flavors, promoted as digesting rapidly and easily while vigorously exercising, and easy to just take a squirt. Be sure and follow up with water as it is very concentrated. Rave reviews from birthing moms.

**Other Labor Foods**
- bananas (worth mentioning twice due to portability and high potassium content)
- yogurt or keifer or fruit smoothies
- light foods that appeal

*This article was written by Patty Brennan and is excerpted from our cookbook, Whole Family Recipes: For the Childbearing Year & Beyond, edited by Patty Brennan (2007).*
Bishop’s Score for Induction of Labor

This is the table used to determine how successful an induction of labor might be. It is recommended that the Bishop’s Score be greater than 7 (9 is optimal if using the midwifery model of the Bishop’s Score which is included below) for induction to be successful. To ensure your own induction's success rate, inquire about your Bishop’s Score. The unfortunate reality is that there are inductions being performed with scores as low as 2 that make induction very difficult and success rates low. Induction with a low Bishop’s Score decreases a woman's coping ability with the increased pain of induction and the increased length of labor. When combined with artificial rupture of membranes (in an effort to increase the success rate), the risk of infection for mom and baby, as well as the incidence of cesarean delivery, go up. We encourage you to make informed decisions for both you and your baby!

Bishop’s Score
0, 1, 2, or 3 points are assigned for each parameter listed.

**Position of Cervix**
0 Posterior (towards the back)  
1 Midposition  
2 Anterior (towards the front)  

**Consistency of Cervix**
0 Firm  
1 Medium  
2 Soft (ripe)  

**Effacement of Cervix**
0 0-30%  
1 40-50%  
2 60-70%  
3 >80%  

**Dilation of Cervix**
0 Closed/0 cm  
1 1-2 cm  
2 3-4 cm  
3 >5 cm  

**Baby’s Station (degree of engagement in mom’s pelvis)**
0 -3  
1 -2  
2 -1 to 0  
3 +1, +2
Navigating the Medical Setting

+ Cervical Sensations
0 None
1 Slight
2 Strong and frequent
3 Coordinated with some or all toning contractions

+ Vaginal Secretions
0 No increase
1 Increased mucus
2 Increase with bloody mucus

+ Toning Contractions
0 None to slight
1 Mild
2 Strong, sporadic, frequent
3 Almost regular, visible on abdominal observation

Modifiers
Add 1 point to score for each of the following
• Preeclampsia
• Each prior vaginal delivery

Subtract 1 point from score for each of the following:
• Postdates pregnancy
• Nulliparity (never having borne children)
• Premature or prolonged rupture of membranes

Total Score=sum of all points for each parameter.

Interpreting Your Score
7 or less: Do not attempt induction without ripening the cervix first
9 or more: Favorable to attempt induction
12 or more: You are quite ready for labor or in early labor; consider if there is anything you need to feel ready

Note
+ All items with a “plus sign” are added by Anne Frye, Holistic Midwifery Volume II, and have been proven helpful from a midwifery-model perspective. All others are original components of the Bishop’s Score.
Fetal Movement Counting

One way to check your baby’s health before birth is to count the number of times he or she moves in a certain period each day. This number is the fetal movement count. Babies do not move constantly. They may sleep and then wake up and move. Your midwife or doctor may recommend that you count fetal movements at some point in late pregnancy, due to the presence of a specific risk factor, or you may notice a change in movement on your own that you find concerning. Here is a way to check in with your baby.

How to Record Fetal Movements

- Choose the time of day when your baby is most active.
- Rest on your left or right side. Get in a comfortable position.
- You may want to eat or drink something before counting fetal movements; food can make your baby more active.
- Your baby may be more active if you move around shortly before doing counts.
- Do not smoke; smoking is harmful to you and your baby and may make your baby less active for up to 90 minutes.
- Count all of your baby’s movements—kicks, rolls, and big and little movements; sometimes you can see a ripple or little bump on your abdomen when the baby changes position; some women describe the movements as rolling, stretching or pushing; each feeling of movement counts as one movement.
- If you cannot feel your baby moving on the inside, place your hands lightly on your belly and watch for movement.
- Look at a clock and write down the time you start counting.
- Each time the baby moves make a mark on the paper.
- **When you have counted 10 movements in an hour, stop counting; this is reassuring.**
- If the baby moved less than 8–10 times in an hour, count the movements for another hour.

If you would like to use a chart to keep track of your Fetal Movement Count, you can print one online here: http://medicalcenter.osu.edu/PatientEd/Materials/PDFDocs/women-in/pregnancy/fetal.pdf.

Call your midwife or doctor if there are still less than 8–10 movements in the second hour of timing.

Call your midwife or doctor if you notice a big change in movement. Tell him or her when you last felt your baby move and if the movement changed slowly or suddenly. Your midwife or doctor may use other ways to check the baby such as listening to the baby’s heart rate or monitoring the heart rate pattern over time.
Active Management of Third Stage of Labor

Summary and Critique by Patty Brennan
With thanks to Alicia Montgomery for her contributions

Definitions and Related Facts

Postpartum hemorrhage and complications of third stage of labor
- Blood loss in excess of 500 ml, with severe postpartum hemorrhage being loss of 1,000 ml or more, and very severe being a loss of 2,500 ml or more.
- Anemia in the mother can pre-exist or be the result of hemorrhage; severe cases may necessitate a blood transfusion.
- Postpartum hemorrhage is the main cause of maternal death in a number of countries, the vast majority of which occur in the developing world.

Active management of third stage
- 10 units IM pitocin administered to all mothers within one minute of delivery
- Early clamping and cutting of the umbilical cord, often before the cord ceases to pulse
- Wait one minute, after clamping the cord, and initiate controlled cord traction for delivery of the placenta

Expectant management of third stage
- Signs of placental separation are awaited and the placenta is delivered spontaneously
- May involve nipple stimulation by putting the baby to breast immediately after delivery
- Interventions that interfere with the body’s natural oxytocin release may reduce the effectiveness of the physiological process (e.g., oxytocin release can be inhibited by anxiety and excess adrenaline, oxytocin augmentation in labor, and administration of epidural or narcotic analgesia)
- Does not involve early clamping and cutting of the umbilical cord
- Uterotonic drugs are used only in case of excess bleeding

What does the evidence say?

Current medical recommendations in favor of active management are based on five studies (involving 6,477 women) that found active management of third stage reduces severe postpartum blood loss, blood transfusions, and postnatal anemia for all women, irrespective of risk. In a general low-risk population, for every eight women treated with active management, one postpartum hemorrhage can be prevented.
The following negative effects of active management were noted:

- Increase in mother’s blood pressure, afterpains, nausea, vomiting, and use of drugs for pain relief; these effects are apparently due to administration of a specific uterotonic (choice of drug used, specifically ergometrine).
- Increase in the number of women returning to the hospital ER after discharge for excessive bleeding due to controlled cord traction leading to retained shreds of membrane or placenta.
- Decrease in newborn birth weight due to early cord clamping leading to a 20% reduction in the baby’s overall blood volume. (The World Health Organization now recommends active management with delayed cord clamping—allowing baby’s blood that is in the placenta to return to the baby’s circulation—to reduce the likelihood of anemia in the newborn. However, in many healthcare settings, this recommendation is not followed.)

In summary, while active management of the third stage of labor reduces blood loss at the time of birth (and concomitant treatments required), it puts mothers and babies at risk of a number of other negative outcomes.


Consumer Recommendations

From the review: “Women should be given information prenatally to help them make informed choices.”

Question for Parents to Consider:

For low-risk women, especially those experiencing drug-free labors, do the benefits of active management of third stage of labor outweigh the risks?

Comments/Other Considerations

In my experience, in healthcare settings where active management (including the non-evidence-based practice of early cord clamping and cutting) is routine, informed consent for this practice is rare. Two specific pieces of active management, the early cord clamping and administration of an uterotonic drug, are usually completed within 30 seconds after the birth of the baby, therefore many parents don't even notice until after the fact. Parents who prefer an expectant management approach will need to discuss their preferences with their care provider, express their wishes in a birth plan, and then be prepared to advocate for their birth plan at the birth.

Further study is needed on the possibility of a “mixed management option” but should be considered based on the mother’s risk factors. A mixed management system might be most beneficial for someone with a high risk birth. For example, for someone with low iron, one
option might look like this: “IM Pitocin immediately following the birth to decrease the chance of hemorrhage (active management), delayed cord clamping to allow the baby to receive his/her full blood volume from the placenta (expectant management), and careful cord traction once the cord is done pulsing to ensure there isn’t excessive bleeding behind the placenta (mild active management).”

If active management of third stage is being promoted as a benefit to anemic mothers (those with low blood levels of iron who might suffer more from even a normal blood loss at their birth), then let’s become as proactive as possible about preventing and treating the anemia prior to the birth through proper nutrition and supplementation!

Finally, active management of third stage of labor is inconsistent with the Midwifery Model of Care. Specifically, it violates the basic tenet of respect for the birth process as it unfolds uniquely, as well as the belief that birth is a normal life process for which women’s bodies are well designed. This is to be distinguished from the medical model approach wherein birth is viewed as an emergency waiting to happen and interference with the birth process is the norm. Parents are encouraged to discuss the benefits and the risks of active management with their midwife or doctor as it applies uniquely to their situation.

**Related Story**

In a recent post on Lamaze International's Science and Sensibility blog, pediatrician Dr. Mark Sloan examines common objections to delayed cord clamping and what the evidence says about its benefits. Dr. Sloan writes, "The evidence of benefit from delayed cord clamping is so compelling that the burden of proof must now lie with those who wish to continue the practice of immediate clamping, rather than with those who prefer--as nature intended--to wait." [Read the blog post](#).
Steps for Reducing the Need for a Cesarean

- Eat properly; get plenty of rest and exercise, and avoid undue stress.
- Develop trust in the birth process; take personal responsibility for the birth rather than expecting the doctor/midwife to take care of everything.
- Avoid all routine or “just-in-case” interventions; if a clear problem exists, use the least invasive interventions first.
- Choose supportive providers and birth environments, even if it means changing late in pregnancy.
- Use alternative treatments for the four major indications for cesarean, together responsible for about 80% of all cesareans. These are previous cesarean, prolonged labor, fetal distress, and breech presentation.

Alternative Treatments for Prolonged Labor

- Patience and emotional support; simply slow progress is not dangerous; arbitrary time limits are inappropriate; the diagnosis should not be made before active labor (cervix at least 3–4 cm and effaced, contractions regular, painful, and progressive)
- Ambulation and position changes
- Help with relaxation, including massage, warm water, mental imagery, slow deep breathing, and other means
- Nipple stimulation to increase natural oxytocin
- Avoid epidural anesthesia or medication, or let it wear off when second stage is reached or if progress stops.
- Meet fluid and calorie needs; total fasting in labor stresses both mother and baby without avoiding the risk of aspiration.
- Physiological pushing, in an upright position, only with the mother’s reflexive urges, with an open mouth and throat.

To Minimize Fetal Distress, AVOID:

- Supine or back reclining positions (less than 45 degrees from the horizontal)
Navigating the Medical Setting

- Artificial rupture of membranes, except for specific medical need
- Sedation and anesthesia
- Pushing with prolonged breath holding
- Continuous electronic fetal monitoring in low-risk labor; fetal scalp sampling is advised to confirm distress

Alternatives for Breech Presentation

- Attempt to turn the baby before labor through postural exercises, external cephalic version, or acupuncture.
- Vaginal breech birth by skilled attendant for full-term, normal-sized frank and complete breech babies, without hyper-extended head.

Other Steps to Reduce Risk of Cesarean

- Be a good consumer; show around for your midwife or doctor. Ask what the cesarean rate is for your caregiver and for your place of birth.
- Take personal responsibility for yourself and your pregnancy through excellent nutrition, prenatal care, self-education, and decision making.
- Avoid induction of labor.
- Write a Birth Plan; make sure it is in your chart at the hospital.
- Stay home until active labor is established.
- Don’t go alone! Take your well-prepared partner and a professional doula; it’s your best investment in cesarean prevention.
- Get up to urinate at least once per hour.
- Change positions frequently—active birth!
- Walk, walk, and walk some more.
- Eat and drink to appetite and thirst.
- Avoid all drugs—anesthesia and/or analgesia.
- Avoid IVs and minimize use of electronic fetal monitor.

- If you want a VBAC (vaginal birth after cesarean), find a practitioner who has a high success rate.

- If you are told you need an emergency cesarean, ask why and ask for a second opinion, if time allows.
Birth Plans

What is a Birth Plan?
The short answer is that the birth plan is a tool to facilitate communication. It is a written description of how you would like to be supported during labor, delivery, and immediately postpartum. It also includes your preferences for the baby during these times.

Ideally, a birth plan facilitates communication on a number of levels:
- Between the mother and her partner
- Between the couple and their doula and/or other support members of support team
- Between the couple and their medical care providers

A birth plan is only useful or helpful to the extent that it actually facilitates good communication, helping everyone to be on the same page.

Planning for labor may seem overwhelming when you consider all the options that are available to you. You may wonder about the value of it, since you can't really plan how your labor will unfold and it's not realistic to plan for every possible contingency (your birth plan would be ten pages along and no one would actually read it!). Your birth plan is an introduction to you and how your support team (medical and otherwise) can best support you and your baby through this experience. It might explain what pain relief techniques you would like to try, what interventions you would like to avoid or what atmosphere you would like in the labor room. It can help to set a tone for your birth.

Many women today are attended by doctors and midwives who work in large group practices. You may have an excellent relationship with one particular doctor or midwife, but there is no guarantee that that will be the same person who attends you in labor. And no matter how good your prenatal communication and relationship is with your doctor or midwife, you do not know the nurses at the hospital and they do not know you. A birth plan helps people get to know you at a time when you may not be in a frame of mind to introduce yourself and explain all of your needs and preferences.

During labor, if situations arise in which a decision must be made, it is easy for a nurse, doula, or coach to check your birth plan for guidance. It lets them know what options you would like to try and what options you would like to avoid if possible. The value of the birth plan is not in its ability to help others determine how to respond to both the expected and the unexpected situations of labor.
How to Write a Birth Plan

Understand your options.
The first step in writing a birth plan is to find out what your options are. Different doctors will give you different choices for handling the same situation. Different hospitals or birth centers will vary in environment, protocols, and available options. And, finally, differences in your health status between pregnancies can impact the options that are available.

Your first job is to find out what options are available to you. Review the Birth Plan Checklist included here. Read through the list and determine what options appeal to you and what options you don't think you want. You can use this list to find out what your caregiver feels comfortable with. You should also take the Birth Plan Checklist on a hospital/birth center tour to find out how the policies may affect your options. Ask lots of questions on your tour, even if you are the only one asking questions! Some hospital tour guides may adopt an approach that is best summarized as “how to be a good patient in our hospital.” When they understand that you are interested in all of your options, they should be able to switch gears and accommodate you. If you are not satisfied with the options available with your current caregiver/place of birth, then you may want to explore other options in your area.

Examine your feelings and consider your priorities.
Once you know what choices are available to you, it is important to determine how you feel about the options. Some things will be very important and others will seem small or unimportant. There is no right or wrong; it is simply a matter of understanding who you are and how you want things handled. You may find that there are several options that you feel very strongly about. In this case, it might be helpful to use the Ideal Birth Worksheet (below) to work through your feelings and rank your choices according to level of importance to you. Both the mother and her partner (if any) need to decide what things are important to them and then discuss their feelings and make any necessary compromises. In the written birth plan, list your choices in order of priority, most important first. This is how most medical people think.

Determine whether you can get what you want.
As you create your birth plan, be sure and bring it with you to prenatal visits with your doctor or midwife. It is important to begin this process of claiming ownership of your birth during the prenatal period and to begin a discussion with your chosen care provider. The provider can let you know if your requests are realistic, likely to be honored, or even possible within the context of your chosen birth place and given your personal circumstances and medical history. In some cases, you may learn that your care provider does not particularly want to enter into a discussion about your preferences, seems impatient with the entire subject, or flatly states that they cannot support your choices. This will help you determine if your chosen caregiver is the best match for you. If you are not getting a receptive response, consider whether there is room for negotiation and compromise. If not, you may want to consider changing providers, even at a late stage of pregnancy, though this may prove difficult. In that case, keep trying. You are the customer and you are paying the bill. You have some power here, but you will only be as powerful as you believe yourself to be.
Prepare for a positive experience.
Be sure to phrase your final birth plan in a pleasant and polite tone. Do not present your preferences as a list of demands. This can help everyone feel more confident and increase your chances of having the birth experience you want.

Birth Plan Tips
✓ Make it short and easy to read.
✓ Divide it in two sections—one for labor and birth and one for postpartum mother-baby care.
✓ Put the most important items first.
✓ Use positive, flexible language (e.g., how you would like to be supported rather than what you don’t want people to do).
✓ If you use a template, inject some personality into it.

Sources
Written by Patty Brennan; partially adapted from:

- Jennifer Vanderlaan, http://www.birthingnaturally.net/birthplan/what.html. Check out this helpful site for a variety of birth plan templates, sample birth plans, and related resources.
Birth Plan Checklist

Use this checklist to make sure you have covered everything you feel is important in your birth plan. You do not need to have something written for all these areas, this is only a list of areas you may have strong preferences about.

1. Important Issues
   o Concerns (Why? Tell your story, briefly.)
   o Health Issues
   o Fears

2. Pain Management Preferences
   o 1st stage medications
   o Epidural
   o Water immersion
   o Non-drug comfort measures
   o Consider requesting that staff refrain from offering pain meds or asking you to rate your pain if you are attempting a natural birth

3. Medical Interventions you wish to use or avoid
   o For inducing or speeding up labor
   o For pain management
   o For monitoring
   o After baby is born

4. 2nd Stage
   o Positions you are willing/wishing to try
   o Style of pushing
   o Preferences for perineal support

5. Preferences in case of cesarean
   o Type of cut on uterus (low transverse vs. vertical)
   o Who should remain with mother/baby
   o How soon to hold/feed baby

6. Postpartum care of baby
   o Cord cutting delay?
   o Timing of routine assessments
   o Breast or bottle feeding?
   o Rooming in or nursery?
   o First bath
   o Circumcision or intact?
   o Consent to Hepatitis B vaccine or no?

7. Other Important Items
   o Identification of support team
   o Photos/videos
   o Privacy needs
   o Environmental issues (lighting, music)
   o When to discharge
   o Educational needs (anything you want to be sure to learn about baby care before you leave)
Ideal Birth Worksheet

This exercise will help you sort out your thoughts and wishes about your upcoming birth. For this exercise, imagine you are having your perfect labor—everything works out exactly how you would want it. Remember, the answers should be about your ideal birth, not what you think others want for your birth.

The Uncontrollable Issues
In real life, you cannot control these things, but if you could how would your labor happen?
- When and where does labor begin?
- Who is with you when labor begins?
- How strong are your contractions?
- How quickly to your contractions progress?
- How long do you push?

The Almost-Controllable Issues
There are some circumstances in labor which you might have control over or might not. It all depends on how your labor unfolds. If you have a choice about these issues, how do they happen?
- How does your midwife assist you?
- Where do you labor?
- Where do you give birth?
- What tools do you use to cope with labor?
- Who labors with you?
- What techniques are used to help you?
- What techniques are not a part of your labor?
- What happens after the baby is born?

The Most Important Issues
After working through the previous two lists of questions, you should begin to have an idea about what issues are most important to you. Complete these sentences.
- My top three priorities for this birth are…
- For me, the ideal place to give birth is …
- I want to be sure that the following labor tools are available at my birth …
- For my birth, the ideal clinical personnel are …
- I want to have the following people there for my emotional support and well-being …
- For me, the best approach to pain relief is …
- The following are also very important to me …
Birth Plans and Care of the Newborn

Summary of Choices Regarding Immediate Postpartum Care of the Newborn Checklist

Expectant parents are encouraged to consider their preferences regarding the following medical procedures and protocols commonly used with the newborn and to begin a dialogue with their care provider prior to the birth. As you sort out your priorities, you can begin to incorporate your preferences into a Birth Plan. For a hospital birth, typically it is the labor and delivery nurse’s job to see that routine procedures are accomplished. If it is important to you to do some things differently than her protocols may require, then it is essential that you get her on board with your plan.

In our Caring for Your Newborn PowerPoint presentation, we presented information on these items. Please see that program and the Additional Resources for links to some excellent (short) videos and other recommended resources, especially if you want to go into a little more depth on any of these topics.

Do you have preferences about any of the following?

- Delay cord clamping until the cord has stopped pulsating.
- Refrain from routine suctioning of the baby and provide only if/when necessary.
- Allow for immediate, undisturbed, skin-to-skin contact between mom and baby.
- Stabilize baby’s temperature with skin-to-skin on mom or dad rather than using warming table.
- Delay all routines until one hour postpartum (e.g., weighing, measuring, eye drops, etc.).
- Perform routine procedures bedside or even while mom is holding baby, if possible.
- Allow mom and baby some time to figure out breastfeeding on their own. Provide support only if asked to do so. Care providers should ask for permission before doing any hands-on breastfeeding support techniques.
- Allow parents to be involved with giving baby his/her first bath; or have it done bedside; or delay until parents are ready.
- Rub vernix “in” rather than “off.”
Navigating the Medical Setting

These procedures are routines, but may be negotiable:

- Administration of Vitamin K within first hour after birth; may need to request a waiver form
- Blood sugar checks (heel poke), especially indicated for 9+ pound babies; may request to keep baby at breast as an alternative (if baby is not breastfeeding, supplementation may be required to prevent dangerous drop in baby’s blood sugar)

These procedures are required by state law:

- Antibiotic drops in eyes within first hour after birth (prevention against possible gonorrhea infection); parents may be able to sign a waiver in some care settings.
- Newborn Screening (heel poke for blood samples); very difficult to opt out of this one; see Limitations to Parental Rights below.

These procedures require explicit parental consent (meaning you have the right to decline and they will not be done without your expressed consent):

- Circumcision
- Hepatitis B vaccine

Limitations to Parental Rights
In the U.S., parents do not retain the legal right to decline recommended medical treatments for their minor children. So, once a family interfaces with the medical care system, they are at risk of losing ultimate decision-making power over their child’s medical care. Of course, many doctors will include parents in treatment choices and decisions. However, if parents are refusing what doctors believe to be lifesaving treatment (e.g., antibiotics or blood transfusions), doctors are able to get a court order granting authorities legal custody of the child on the basis of “medical neglect” on the part of the parents. These situations can become quite contentious, but the courts typically come down on the side of the medical professionals rather than the parents.

Consider Early Discharge
If your birth went well, meaning mom feels pretty good and the baby is healthy, then you may want to consider leaving the hospital environment sooner rather than later. This will work especially well if you have a knowledgeable helper at home—perhaps your mom, a doula, or an experienced friend. It is a myth that anyone “gets more rest” in the hospital and no one would ever argue that the food is good. In addition, hospitals are notorious for being a good place to acquire an infection. While you may feel a bit overwhelmed at the prospect of going it on your own, you really don’t need to be hospitalized if there are no specific health concerns.
Get a Second Opinion
If treatments are being recommended for your newborn, especially treatments that require re-hospitalization of the baby or a disruption in breastfeeding (e.g., for jaundice), consider bringing in your private pediatrician for a second opinion. After all, this is the person who is going to be following your baby’s care and it makes sense to involve them sooner, rather than later, if an issue is being raised by the hospital’s neonatal staff.
Kangaroo Mother Care

A few years ago, I attended a Networking Conference for Community-Based Doula Programs in Chicago. The conference began with a dynamic presentation on “Kangaroo Mother Care” by Susan Ludington. Dr. Ludington is the author of two books, How to Have a Smarter Baby and Kangaroo Care: The Best You Can Do For Your Preterm Baby. Dr. Ludington’s research on KMC, which has taken her to a number of countries worldwide, has produced a solid evidence base for this practice. The basics of KMC involve removing premature babies from incubators and placing them skin-to-skin, nestled between mother’s breasts. A blanket is used on the baby’s backside to keep her warm or the baby can be tucked inside the mother’s shirt. Even babies with feeding tubes or other medical equipment can receive KMC.

The benefits of KMC include: superior regulation of the baby’s temperature, heart rate, and respirations, a lowering of infection rates, and improved brain maturation. Her research has demonstrated that brain maturation is promoted when the baby is in a deep sleep, a state rarely achieved in the incubator, but consistently experienced with KMC (not a bad idea for full-term babies either!). When KMC was first introduced in Bogotá, Columbia, the infant mortality rate dropped 70% in the first year. Researchers attributed lower infection rates to the fact that maternal antibodies were passed to the baby via the skin. If the baby is cold when placed in KMC, the mother’s body temperature will shoot up rapidly to warm the baby. Once the baby’s temperature normalizes, the mother’s body temperature will return to normal in order to stabilize the baby’s temperature. Furthermore, researchers discovered that each breast is capable of independently regulating body temperature so that, for example, a mother of twins might have different temperatures on different sides of her body, depending upon each baby’s needs. Dual climate control!

Interestingly, dads who participated in KMC were also found to have an internal regulating system – they got restless (humorously referred to as “butt fatigue”) coincident with the baby’s temperature normalizing (often after about 1½ hours of KMC). If KMC was continued at this point, the babies overheated since dads apparently do not have the same capacity to stabilize the baby’s temperature over time.

Additional benefits noted were that babies in KMC do not cry and that there is a zero incidence of SIDS. All in all, fascinating work.
Additional Resources

Medical Interventions in Labor & Birth

Books

- *The Official Lamaze Guide: Giving Birth with Confidence*, by Judith Lothian and Charlotte DeVries
- *Creating Your Birth Plan: The Definitive Guide to a Safe and Empowering Birth*, by Marsden Wagner
- *Wise Woman Herbal for the Childbearing Year*, by Susun Weed

Lamaze Healthy Birth Practices

- Let Labor Begin on Its Own
- Walk, Move Around, and Changes Positions Throughout Labor
- Bring a Loved One, Friend, or Doula for Continuous Support
- Avoid Interventions That Are Not Medically Necessary
- Avoid Giving Birth on Your Back, and Follow Your Body’s Urges to Push
- Keep mother and Baby Together—It’s Best for Mother, Baby, and Breastfeeding


Best of the Web

The Birth Facts
[http://www.thebirthfacts.com/site/default.asp](http://www.thebirthfacts.com/site/default.asp)
Links to evidence-based maternity care; numerous helpful articles

The Birth Survey
[www.thebirthsurvey.com](http://www.thebirthsurvey.com)
*The Birth Survey* is an on-going, online consumer survey that asks women to provide feedback about their birth experience with a particular doctor or midwife and within a specific birth environment. Responses are made available online to other women in their community who are deciding where and with whom to birth. Paired with this experiential
data are official statistics from state departments of health listing obstetrical intervention rates at the facility level.

BirthNetwork
www.birthnetwork.org
Consumer advocacy group

Childbirth Connection
www.ChildbirthConnection.com
Links to articles on evidence-based maternity care; excellent resource

Coalition for Improving Maternity Services (CIMS Mother-Friendly Initiative)
www.motherfriendly.org

Gentle Birth, Gentle Mothering (Website of Sarah Buckley, M.D.)
http://sarahbuckley.com/
Check out especially Pain in Labor: Your Hormones are Your Helpers
http://www.sarahbuckley.com/pain-in-labour-your-hormones-are-your-helpers/

Giving Birth with Confidence (a blog from Lamaze International)
http://givingbirthwithconfidence.org/

International Cesarean Awareness Network
www.ican-online.org

Science & Sensibility
http://www.scienceandsensibility.org/
A research blog from Lamaze International about healthy pregnancy, birth, and beyond.

U.S. Maternity Care Facts and Figures (2011, PDF)

VBAC (Vaginal Birth After Cesarean)
www.vbac.com

Waterbirth International
www.waterbirth.org

Medical Procedures with the Newborn

Breast Crawl
http://www.youtube.com/watch?v=zrwflcPB1u4
Circumcision

- http://www.icgi.org/birth_care_providers.htm
- http://blog.practicaledics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/

Circumcision: Make the Informed Decision DVD (20-minute video)
http://video.google.com/googleplayer.swf?docId=-5395565256830319025

Circumcision Decision Maker (online consumer tool)
http://circumcisiondecisionmaker.com/

National Organization of Circumcision Information Resources Centers
www.nocirc.org

YouTube video featuring Dr. Dean Edell discussing circumcision and HIV studies from Africa and how they relate to the U.S. experience.
http://www.youtube.com/watch?v=Ol5Ug0sdAtE

Delayed Cord Cutting

Watch a demonstration by Penny Simkin:
http://www.youtube.com/watch?v=W3RywNup2CM
http://www.youtube.com/watch?v=cXzD8jKne0&feature=results_main&playnext=1&list=PL24D5C87F0C644569

Vitamin K Injection


Vaccines

By Patty Brennan
Available from www.center4cby.com or Amazon
Summarizes vaccine controversies (why do some parents choose to NOT vaccinate?) and how to prevent adverse vaccine reactions. Also discusses how to enhance natural immunity and the role homeopathy can play in: (1) preventing adverse vaccine reactions, (2) treating reactions, (3) preventing the diseases after exposure in non-vaccinated individuals, and (4)
treat the diseases if contracted. And, finally, we discuss parental rights and vaccine waivers.

American Academy of Pediatrics
www.aap.org
To locate recommended vaccine schedules and alternative vaccine schedules.

Center for Disease Control
www.cdc.gov
To locate recommended vaccine schedules and alternative vaccine schedules.

Michigan Opposing Mandatory Vaccines (MOM)
www.momvaccines.org
Michigan vaccine consumer advocacy group; legislative action alerts for Michigan residents; publishes a Doctor’s/Clinic Referral List of medical practitioners who support parents’ right to make vaccine decisions; provides vaccine waiver forms and resources for Michigan residents. Many states have their own consumer advocacy groups.

National Vaccine Information Center
www.nvic.org
National consumer group advocating for vaccine safety. Find your state group here.

Think Twice Global Vaccine Institute
www.thinktwice.com
Website belonging to Neil Miller, a public health statistician who has published extensively on the safety and effectiveness of vaccines.

*The Vaccine Book: Making the Right Decision for Your Child*
By Robert W. Sears
www.AskDrSears.com
Essentially pro-vaccine doctor discusses safety concerns regarding each vaccine and how to minimize risks.