

Loudoun Community Midwives

Low Tech Birth

HOW LOW-TECH CAN WE GO?

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

It is our heartfelt wish to be trusted, that if we discuss or do these things, they are based on long experience with more than 2,000 normal births, and represent in our best judgment, the safest and best management of the situation, to end the day with a healthy mother holding a healthy baby.

When all appears normal, here's a discussion of what we can and can't do.

In Pregnancy:

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

Sonograms/Ultrasounds:

With a clear menstrual /conception history to determine due date, and no other clinical concerns, only one ultrasound is ordered, in the middle of the pregnancy. Our clients have had twins and even triplets (which require high-risk obstetrical care), discovered during this routine sonogram, therefore it is a required component of our care program. We will carefully assign a due date, based on accurate obstetrical standards, and once assigned, it does not change.

Doppler/fetoscope:

We have both hand-held Doppler and acoustic fetoscope for office checks of baby's

heartbeat. Most mothers like to hear the baby's heartbeat during the exams, by Doppler, which uses about 5-10 seconds of ultrasound beam. In the second half of pregnancy, we can use the fetoscope instead, at client's request.

In Labor:

Upon admission to the hospital, a blood sample is drawn, and a 20-30 minute electronic fetal monitoring strip is done. If all is normal at that time, we discontinue the continuous fetal monitoring, and encourage the mother to be out of bed, moving and choosing any positions that help her labor. We do listen electronically to the baby's heartbeat every 15 minutes thereafter, with a hand-held unit. We do not use a fetoscope for labor. If concerns arise that require continuous fetal monitoring, wireless telemetry monitors can be used, which are also waterproof, allowing full mobility and use of the bathtub.

In normal labor situations:

IV's are not required routinely. We don't routinely use Pitocin augmentation. We discuss pros and cons of all procedures, including rupturing membranes, prior to doing anything. We do vaginal exams when the information is useful for making management decisions or evaluating progress, and as infrequently as possible. We don't routinely cut episiotomies. We do support the perineum and Dads can help catch the baby and/or cut the cord. We do place the baby directly on a warm towel on Mom's tummy. We can leave the cord pulsating if you request it. Research has also shown that one intramuscular injection of Pitocin in the mother's leg, after the baby is out, can dramatically reduce the possibility of maternal hemorrhage. The midwife may recommend this.

When things are not going normally: When a mother's bag of waters breaks at term, labor usually begins within a few hours. If no labor ensues, there is concern that infection risk may increase, both in the baby or mother, especially after 24 hours. If the mother has tested negative for Beta Strep ("GBS"), and fluid is clear, we are comfortable waiting up

to 8 hours in first-time moms, and up to 12 hours, in mothers who have already had one or more babies, prior to inducing labor. If this 8-12 hour window is reached without active labor, admission to the hospital and Pitocin augmentation is necessary. We recognize that infection is also minimized by performing as few vaginal exams as possible, particularly before contractions have begun. For women who have tested positive for GBS, admission to the hospital and antibiotic treatment should begin as soon as possible after rupture of the membranes.

Other indications that intervention may be needed include: meconium noted in amniotic fluid, lack of progress in labor over many hours, dehydration, fever, vomiting, or rising blood pressure in the mother, or abnormal fetal heart rate changes. Sometimes we do recommend IV hydration, Pitocin augmentation, internal monitors, epidural anesthesia, or even, as a last resort, cesarean section. We can cut episiotomies, stitch up lacerations, give emergency drugs for bleeding, and participate in surgery if needed. None of this is routine, and your birth wishes are very important to us! We also believe that careful and judicious use of technology and interventions at times can help achieve a vaginal birth vs. a c-section, or in other ways preserve safety.