How to Navigate a Hospital Birth on Maui

A Guide for Families and Birth Doulas

By: Kristina Statler CD

E-Published in connection with Pacific Birth Collective

4th Edition, 2023

Introduction.....3
Low Risk Pregnancy & Labor.....4
Tips for staying on track

Natural Labor.....5
Labor is hard work, it hurts, and you can do it.

Protocols to Expect.....6
At the clinic and the hospital

Your Preferences Document.....13
It's your Preferences, not a Plan

Click Here to Access My Birth Preferences Worksheet19
Other useful links you can also find at islanddoula.weebly.com:

Common Roadblocks.....20
and How the Hospital Environment Can Help

Some Notes for Doulas.....25
Important Tips for Creating a Supportive Environment

Author's note: I have attempted to use gender neutral terms when reasonable, but for clarity and brevity, occasional gendered terms are present in this edition.

Introduction

Why I created this e-book

A Birth Doula's Guide to Hospital Birth on Maui

I worked as a birth doula on Maui for over 20 years. My journey through birth began with the birth of my first son at Maui Memorial Medical Center (MMMC) in 1995. At that time, I was a champion of "Natural Birth", as were many of my peers. We believed that the medical establishment was the enemy of natural birth and we had to go into the hospital ready to fight for our rights. Over time, I realized that most of the OBs on the island, and certainly the majority of the nurses on the Labor and Delivery ward at MMMC, are wonderful supporters of the parents who want an unmedicated birth. However, I also understood that the doctors and nurses are trained to deal with many different types of complications, as well as many different levels of health in the birthing families they serve. Therefore, I came to appreciate that the basic protocols that are in place for all families who choose to birth at MMMC are fairly harmless and truly helpful when needed. I wrote this book to help families:

- Maintain health to remain a low-risk pregnancy and labor.
- Understand the basic clinic and hospital protocols and why they are there.
- Identify preferences of care during this time and communicate them to your care providers.
- Learn about some of the common issues that can stall or prolong a labor and how to use the medical resources at the hospital to have the best birth you can!

Low Risk Pregnancy & Labor

Tips for staying on track

Most of the families that seek doula services have already done some research and have been maintaining excellent health throughout their pregnancy. In the absence of any health conditions (high blood pressure, anemia, diabetes or issues with uterus, cervix, or pelvis), most families choosing a low-intervention labor and birth can increase their chances by focusing on some simple tips.

Your Body, Your Birth

If you are interested in having a birth where you can have the minimal amount of interruptions, you must be willing to put in some effort toward what I like to call a “straight forward labor and birth”.

> A straight forward labor and birth is one that starts spontaneously and progresses along an average timeline of about 12 -24 hours (for first time parents).

Suggestions for keeping your body on track include:

Maintain a reasonable diet. You are not, in fact, eating for two, though you do need extra calories to grow a healthy baby. You can gain 15 pounds or 50 pounds and still have a healthy diet. Avoid excessive dairy, sugar and calcium (that means you, Ice Cream!) including over do-ing it on calcium fortified milks, yogurts and kefir. These foods tend to grow large babies with big heads that are more challenging to birth, and bring extra challenges when you go past your “due date”.

Avoid “Tums” for heartburn and instead try apple cider vinegar, ginger, acupuncture, small amounts of baking soda or other natural remedies. Tums is high in calcium and you are likely already getting plenty of calcium through your diet and prenatal vitamins.

Get red raspberry leaf tea in bulk, mix in some oat straw, nettles or any other nice pregnancy herbs and drink 4 cups daily. If you steep 4 cups in the morning and chill, you will have a quart per day to sip on and enjoy. Herbalists believe, and I have seen this work in my practice, that RRL tea at the end of pregnancy tones the uterine muscles and contributes to shorter labors and less bleeding postpartum.

Just do it: eat lots of dark leafy greens and avoid salty processed foods.

Be sure to get adequate protein from your favorite protein sources. Vegetarian and Vegan families need to be diligent, but have major success getting plenty of protein from non animal sources.

If your body is needing extra iron, try out a few varieties to avoid constipation. Chlorophyll is a great source of supplemental iron, with many other added benefits.

Walk at least 15 minutes per day. People that walk at least a mile per day tend to have shorter labors.

Attend a prenatal yoga class regularly, or do yoga at home. spinningbabies.com has a list of great exercises to promote optimal fetal positioning and pelvic health. Stretching and flat footed squats are great ways to avoid pregnancy aches and pains and keep you limber as your belly grows.

Skilled chiropractors can diagnose and work on areas in your pelvis and abdomen that may be creating pain or un-optimal fetal positioning.

Avoid long periods of reclining and instead choose belly forward sitting positions to help baby stay in best position.

Stay ultra hydrated. This can eliminate many issues (including edema and low amniotic fluid). Eight, 8oz glasses of water per day is generally acceptable, but sometimes more is indicated. Count your ounces to be sure you are getting enough.

Take a high quality Pro-Biotic to keep your microbiome in balance. Best ones are found in the refrigerated section of your health food store.

Natural Labor

Labor is hard work, it hurts, and you can do it.

The Difference Between Athletic Pain and Suffering

If you have ever run a marathon, biked up Haleakala, hiked up out of Sliding Sands, or even just challenged yourself to start jogging or lifting weights, you know the meaning of athletic pain. It is pain with a purpose and when you are in the "zone" you are not suffering. This is the goal in labor.

The uterus is a "muscle bag" with long fibers that run from the cervix to the fundus, as well as circular and interlaced fibers. In labor, we want only the long fibers to contract up toward the fundus, shorten and thin out the cervix, and push the baby out. The sensation of this happening brings your attention to it and makes you crave a safe, dark place without too much observation. This allows your body to release endorphins and you can find comfort in small things like warm hands on your back, a cool cloth on your forehead, or a moment of privacy in the bathroom. On the other hand, fear and anxiety release hormones that can make the circular and interlaced fibers contract too. This can counteract what the long fibers are trying to do and thus create more pain and prolong labor.

BREATHE. Plenty of oxygen to baby, and equally important, plenty of oxygen to your uterine muscles to avoid cramping. Breathe in through your nose, using even in and out breaths. Follow your breath as you breathe out tension and fear and breathe in strength and confidence.

RELEASE your body in forward leaning positions, letting your jaw go loose, your shoulders, your muscles around your pelvis. You will feel pressure and stretching and when you maintain deep relaxation, the sensations will be Do-able.

CALM your mind with practiced mantras of positive thinking. "My Body Rocks!" Words of gratitude and love counteract thoughts of fear and worry about your capabilities. "Thank you for this body that can do this, thank you for the strength and the endorphins to birth this baby."

Protocols to Expect
At the clinic and the hospital

Starting towards the end of pregnancy, there are some regular diagnostic testing and assessing that help determine your options during birth.

A word about your due date first. Accuracy. Be sure you give your care provider all information necessary to create an accurate Estimated Due Date (EDD); your last menstrual period, how long your cycle is, if you had odd cycles before conceiving, and if you know conception date for certain (which may be the most accurate puzzle piece). Ultrasound diagnostic of due date is usually what is recorded in your file, and discuss the date with your care provider if you believe it to be inaccurate.

- At around 24 - 28 weeks, your care provider will want you to be screened for gestational diabetes. This commonly calls for a brief fasting period, then a sugary drink and a blood test. More clinics are making a finger prick method available in response to families wanting to decline ingesting the glucola drink. A positive result would require retesting and possibly placing you in a higher risk category. All the more reason to focus on healthy eating habits.
- At around 37 weeks, your care provider will want you to be screened for group beta strep in the vagina and anus. Most of us carry GBS in our bodies and an overgrowth at birth can contribute to possible infection in the newborn. A positive result would require regular

doses of IV antibiotics during labor. All the more reason to focus on a healthy microbiome during pregnancy.

- Also, starting around 37 weeks, your care provider will suggest weekly cervical exams. A cervical exam is performed by your care provider by placing two fingers in your vagina and assessing the position, length and dilation of your cervix and the level in your pelvis that the baby's head is resting. The exam at 37 weeks is commonly uncomfortable since the cervix is generally still tilted toward your back, thus reaching in quite far is needed to assess it. The exam can result in spotting of bright red blood or older brown blood and possibly cramping for a day or so. From my experience, there is often not too much information to be gained by this exam at this week's gestation; most women's cervixes are still long, and not dilated, at this point. If your care provider has not done a general pelvic exam yet, it is usually good to rule out any anomalies in your pelvis or cervix, but if you have had a full pelvic exam at the beginning of your visits to your clinic, you can safely decline this exam and wait until closer to term to see what your cervix is doing. Of course, if you are curious or your care provider has an important reason to do the exam, go for it. Just know it is your choice. Your cervix will soften, shorten and open according to its own time table. Sometimes, a cervix can be diagnosed as "unfavorable", meaning it is not showing any signs of softening, shortening and opening at the end of pregnancy, and this could be an important piece of information to have, though it still does not mean the cervix absolutely will not do what it is supposed to do. Again, ask questions, gain information, make your best choices based on all of the elements.

- Sometime around 39 - 40 weeks, your care provider will suggest scheduling an induction. I like to let clients know that this is more of a scheduling thing than any indication that something is wrong. OB's would prefer labor to spontaneously begin before 41 weeks gestation to eliminate a baby from growing particularly big and eliminating any concern over placental function. I encourage my clients to read Evidence Based Birth (evidencebasedbirth.com) article on inducing labor for going past your due date to gain some insight into the risks and benefits of allowing labor to begin spontaneously. If you would like to wait, most providers are fine with a pregnancy going to 42 weeks as long as there are no indicators that something is wrong. Be aware that half of first time labors do not start spontaneously until 5-7 days past the due date, and some after that.

- During this time past the due date, your care provider will want you to come in more often to do what are called Non Stress Tests. Straps and monitors will be placed around your belly to listen to fetal heart tones and record any contractions. They are looking for active, variable heart tones that are re-active to the presence of contractions. An active baby with heart beats that go up and down in response to its environment is a healthy baby. They will also use an ultrasound machine to assess your levels of amniotic fluid around the baby.

Plenty of fluid means you are staying well hydrated and your baby's kidneys are handling the end of pregnancy well. In preparation for your NST's, be sure to drink plenty of water before your appointment and if it is generally baby's in-belly nap time, consider eating a sweet snack or drinking a cold beverage to wake the baby up. Alternately, care providers have a horn or a vibrating tool that they can use on your belly to stimulate the baby.

Moving on to your spontaneous beginning to your labor, what protocols to expect when you arrive at the hospital:

- Call ahead to L&D at 808-242-2436 and let them know you are coming in. The nurse will usually ask for laboring person's name, care provider, indicators of labor progression, and where you are driving from. If you are unsure, you can ask which hospital entrance you should take.
- Between the hours of about 6am and 7:45pm, you will enter the hospital at the front lobby. Go ahead and use their free valet service. Hopefully, your doula can meet you there and help you carry your things. If you need to, you can leave your postpartum supplies in the car and get them after the birth. There is usually someone at the front desk to guide you to registration (offices behind front desk).
- Between the hours of 7:45pm and about 6am you will enter the hospital through the rear Emergency Entrance. You can drop off at the ER door and then park the car, or just park to the left in the "ER only parking" that is hopefully available for you. Doulas and other support people should find public parking in the lot. You do not have to wait as the other people in the ER do, you can go straight to registration (opposite the bathrooms, almost straight across from the automatic doors). Partner, doula and anyone helping you carry supplies during the After-Visiting Hours times of 10pm to 8am and must present an ID and get a visitor's pass at the security desk located at the non-emergency door to the left of the ER. As a doula, I usually grab the partner's ID and get the passes as they fill out paperwork.
- Even if you pre-register (definitely recommended) you will still be asked questions and need to sign papers. If you arrive just about pushing the baby out, you can be ushered upstairs quickly and sign papers after. I have had clients who were able to get these papers before labor and have them signed, thus saving a little time. Ask at registration when you go for your tour (definitely recommended).
- Upon arrival at the L&D, you will be asked to change into a hospital gown and lay down on the hospital bed to put the monitoring straps on. You may ask if you can use your own gown if you have one, and if you may be monitored while standing, sitting up on the edge of the bed, or on a chair, birth ball or stool. I find most of the nurses are fine with this, especially when a doula is present. It is important that they get a clear monitoring for about a half hour to rule out any problems with the baby. By choosing your most

comfortable position (and it may be on your side in bed, just take a moment to figure it out), you can then try to remain in that basic position, so as not to dislodge the sensors.

- Your nurse will introduce themselves and ask the names of all who will be joining you for the birth. There are two support people allowed in your room and there can be no switching out with people in the waiting room. Your nurse will also let you know what doctor is on call in your clinic's rotation. Take a moment to hand her your birth preferences document and thank them for being there.
- At some point, they will need to make a cervical check for dilation. This will require you laying on your back, mostly flat, for them to get an accurate assessment. This can be extraordinarily uncomfortable, so try breathing through, they will try to be as quick as possible. Of course, if your water is leaking, they will avoid doing an assessment and may wait for your doctor to do it. And, also of course, you can politely ask for a delay (I need to pee, poo, have this contraction first) or decline if you feel it is necessary for your coping. If you are obviously in strong active labor, this is more likely to be okay for a bit. If you are early in labor, your nurse will tell you how important it is to report to your doctor exactly where in the process you are.
- A phlebotomist will come in at some point to take a few vials of blood, and if you have agreed to a heparin lock, that will be managed within the hour or so. Sometimes, if getting a vein is challenging, you can request that the hep lock and blood sample collection happen at the same time (please, thank you, if possible).
- If you are having IV antibiotics or if you present at the hospital dehydrated and ill, you will then be hooked up to an IV. The antibiotics usually take about 20 minutes per dose (every four hours) and if you can (please, thank you, if possible) to have the IV and the fetal monitoring happen concurrently, that can be a bonus.
- Once all the intake information is complete, and everything seems normal and progressing, the nurse will politely leave you alone to do your thing for about 45mins - 1 hour before wanting another "strip", or fetal monitoring. As a doula, this is when we set the "zone". I have likely already had time to set up my essential oil diffuser, plugged in my electric tea pot, and helped the partner set up music and other comfort supplies. Now we can turn down lights (I like the light over the sink on and everything else off or everything off and an electric candle or two). Though the staff may flip them on when entering, you can just turn them off when they leave the room. Expect your nurse (usually just one nurse) to attend to you once an hour or so, and you can push the call button on the bed or go out to the nursing station if you have questions. Shift changes happen at about 7 - 8 am and 7 -8 pm so you may have two nurses and two doctors.

- There are blankets, towels, washcloths, cups, straws, water and ice available in the hallway. Just ask your nurse where and then serve yourself quickly and quietly when you need. Towels and washcloths, the nurse will likely want to get for you, so just ask nicely.
- The shower is large and has a nice strong stream, both from the wall and a hand held. My experience is the water is therapeutically warm, but not as steaming hot as some of my clients would like. If the water is not hot enough for you, consider using some of the small white buckets that are supplied in your room and a half dozen wash cloths and your hot water from the tea pot, cooled a bit with tap, and placing and replacing hot towels on your back or belly. A hot water bottle can be used also, though the streaming water from the compresses may be more satisfying along with the privacy of the bathroom.
- These white buckets are also perfect for vomiting if you need to. Most women feel nauseous at some point in labor. It is common to vomit when you are in or nearing "transition" (those last few challenging centimeters) and is encouraged due to its ability to open you all up. Rinse your mouth or brush your teeth and keep on hydrating!
- Your nurse does not monitor your fluid intake and urine output, so it is important to keep track of how much water (or coco water or electrolyte drink) you are getting (8oz per hour is generally good), and how often you empty your bladder (at least once per hour). By the time your nurse notices you are dehydrated or your bladder is distended, the solution will need to be IV fluids and a urine catheter, so best to stay on top of this. Besides, getting to the toilet is a great way to change up your position now and then. This is important to help the baby wiggle down into your pelvis.
- Positions are key and your ability to find your comfort zone; physically, mentally, musically, aromatically are going to be your best bet for getting through your labor at the hospital. There will be interruptions, and try to handle them with grace and gratitude since the nurse and doctor are only making sure everything is still ok. You can delay or decline any interruptions in your flow (please, thank you, if possible) and still allow your safety to be top priority.
- At some point in your labor, you may feel big pressure in your rectum, possibly accompanied by an unmistakable urge to empty your bowels. You may actually need to empty your bowels, and I do recommend sitting on the toilet as often as possible to keep your bladder and bowels empty and unobtrusive (a full bladder makes contractions hurt more). However, this feeling may mean you are almost, or in fact are, fully dilated and the baby is starting to enter the birth canal. You can continue laboring with this sensation for hours still, in which case it is best not to put any aggressive pushing in action, just allow your body to move the baby down. Your nurse will want to check to see if you are fully dilated. If you are not quite, she may say the words "don't push", but like I said, you are already not

actively pushing; you are maintaining slow even breathing, your body is just moving the baby down to help you finish fully dilating. So let your nurse know you will not be pushing and just keep on coping with these intense contractions in the same manner you've been coping all along. Hands and knees position can feel good here.

- When birth seems imminent, your nurse will start setting up the room. She will consolidate your belongings, move out any extra chairs and bring in a long table with many instruments on it (don't be alarmed, doctors rarely use anything but the instruments to clamp and cut the cord, and sutures for repairs, if needed). Your nurse is trained to help you through to almost crowning at which point she will call in your doctor. You may move about any way you wish, and/or you can ask her for suggestions if you can't seem to get in the groove. Most upright positions bring the baby down more smoothly than being on your back or semi-sitting. The nurses have a style of coaching that they feel works best (the classic semi-reclined, with knees up near your ears), so feel free to ask for this help if you want it. Pushing a baby out of your body can be intense for you and your partner. Having a doula there can help reassure you that it is all normal.
- Just so you know what to expect, some OB's routinely have the nurse wash the vaginal area with iodine or a povidone-iodine solution, some don't. I recommend asking your OB what their protocol is if you are concerned about using antibacterials at your birth.
- At birth, your baby will be placed on your chest while the doctor cuts the cord, stopping to ask your partner if that job has been designated to them, and delivery of the placenta (generally a very "managed" event). As long as there is no concern about how the baby is transitioning, baby will remain on your chest as long as you like (up to an hour or two depending on how busy the floor is). If you need stitches, the doctor will numb and stitch and then everyone will clean up, clean you up a bit, put the room and the bed in order and leave you alone for a moment.
- This is the delightful time when you finally get to quietly encounter this being that has been swimming around inside you for so long. Drink them in, stay skin to skin, experience the "breast crawl" and/or help the baby get to nipple. The nurse and/or your doula can help with the first latching, and don't worry if it takes a while, remember you are both new at this.
- At some point, the nurse will want to do a brief newborn exam on the warming table that is just a few feet from your bed. They will also weigh and measure, take temperature and put a diaper on baby and swaddle and hand your baby back to you. Your partner can go watch these proceedings, holding baby's hand and speaking softly to them.
- From here, either you can choose to go to your postpartum room all together, or you can send your partner with the nurse and the baby to the nursery where baby will get a short

bath, a longer exam and the administration of eye ointment, Vitamin K injection, HepB vaccine if you have chosen these. Otherwise, when the nursery nurse and pediatrician aren't busy, they can come to your room to do most of these things, minus the bath... It is possible that they will be very busy and then the nurse would strongly suggest they be allowed to bring the baby to nursery. Consider your options and make your best decision.

- Once all is settled and everyone is stable and well, you can focus again on establishing your nursing relationship. All of MMMC L&D nurses are really helpful with getting you going. Just remember to be patient and understand this is all a learning curve and not actually sustenance just yet. You will need to practice, practice, practice while you are in the hospital for about 24 hours after birth. And, get some rest. And, take pictures for the family. Welcome to parenthood!

Your Preferences Document

It's your Preferences, not a Plan

This is where you and your partner, your doula and your care provider will come to agree on the protocols and procedures that you'd like to follow or avoid, as long as you are experiencing a straight forward birth. Also implied is the agreement that in case you hit any roadblocks, you are willing to compromise so that you receive the benefits of birthing in the hospital while still maintaining your sense of autonomy.

Here I list each item and explain the procedure and protocol. At the end of this chapter there will be the worksheet I use with clients. You may use that to work off of when you sit down with your team (or your clients, doulas).

In the absence of complications we ask that the following requests be honored:

We would like to request a private postpartum room if one is available. At MMMC, if the unit is slow, you may be able to request a private postpartum room for a fee, out of pocket. With a private room, your partner can stay with you 24 hours day and night. With a shared room, you are subject to regular partner visiting hours of 8am to 10pm. If you birth during non-visiting hours, the postpartum nurses will allow your partner to stay for a fairly generous amount of time, but then they will have to go and come back at 8am.

We wish to be fully apprised and consulted of all risks and benefits before the introduction of any medical procedures or intervention. Just makes sense.

We ask that all members of our birthing team remain with us at all times. This includes our doula, (or my mother, my sister) whose primary task will be to assist us. This helps with introductions.

If labor induction or enhancement is required at any time, we would like the opportunity to try all the natural inducers first as long as the baby and mom are healthy. If you get to the hospital and find that you are only 0-3 dilated with membranes intact, they will likely suggest that you go back home. If your water is broke, they will admit you and suggest an IV of Pitocin to get things moving. You may decline the Pitocin and try

walking, squatting, nipple stimulation and anything else your team can think of to get things moving. It is possible your baby is in a less than optimal position, so some spinningbabies.com tricks might come in handy. Or Miles Circuit, or some rebozo sifting (see my website for links and/or ask your doula!)

If TermPROM occurs and mother is GBS negative, we would like to observe the "expectant management" protocols of absolute minimal vaginal exams and watching for indicators of infection (fever, meconium staining, fast heart rate in the mother or baby). Term PROM refers to Premature Rupture of Membranes at term (or full gestation). Premature, in this case, meaning before contractions have started. This can be a common roadblock to the birth you've imagined, because now instead of laboring at home for as long as you and your team are comfortable, you are required by your care provider to come into the hospital to be monitored for possible infection. If you are Group B Strep negative, you have one less indicator that you would be likely to develop an infection, and are asking that instead of being given Pitocin to speed up labor, you would like your care providers to avoid introducing bacteria into your vagina as much as possible and just watch you closely for signs of infection. And, if there are signs of infection, then you can agree to the Pitocin. Now, if you are GBS positive, you will already be receiving IV antibiotics to prevent infection, so the same expectant management protocols *should* be allowed, but you will face a steeper hill.

We plan to stay hydrated by drinking clear fluids but we are aware that an IV may be required during labor for dehydration, medication instillation or other medical needs. We are/are not (choose one) willing to compromise on the need for an IV by utilizing a heparin-lock for access if medically indicated.

If you are insistent that

none of your veins are opened unnecessarily, you can decline the heparin lock. The hep-lock is like just starting an IV, but not hooking you up to anything. It is a poke, and a flexible narrow catheter that is taped securely to your arm, hopefully in a location that does not inhibit freedom of movement. To get in the shower, you will need to place a plastic bag or wrap over it, your nurse can help with that. Most care providers would really like to you have the hep-lock as an insurance policy that they can get medications into you quickly if needed, and the nurses don't need to be hunting around for a vein when there is a complication present. This becomes important commonly right after birth and your doctor believes you are losing too much blood and would like to give you a little pitocin to clamp your uterus down and stop the bleeding. If you are determined, you can request that they have available to you an inter-muscular injection of pitocin in case you need it. In my experience, this is one of the more complicated struggles, but remember, you are the consumer and you get to make

these decisions. If there is a true emergency, that is when your doctor will make the decisions, and you may end up with additional medications for bleeding. If this is important to you, discuss it with your care provider.

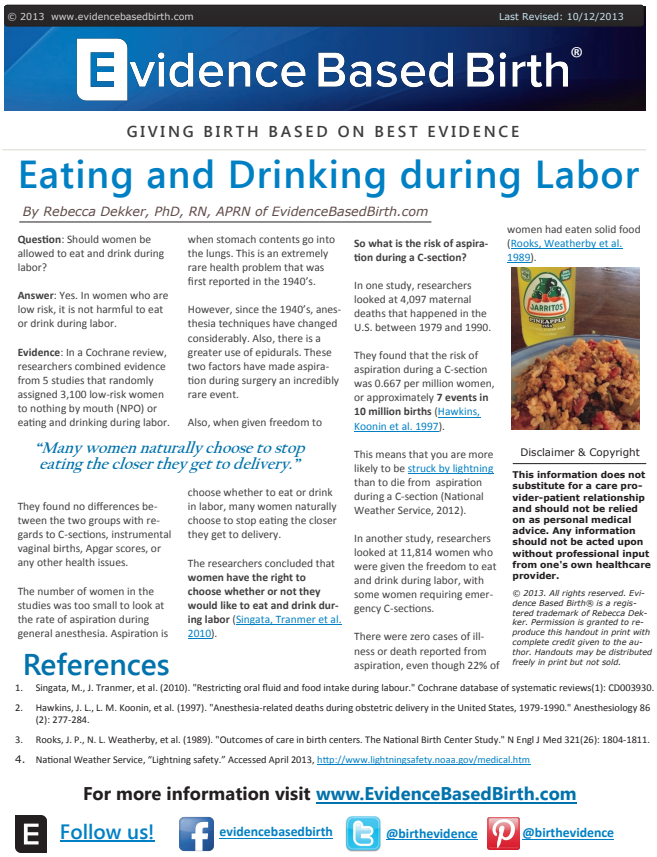
We wish to have no offer or suggestion of medication or self evaluation of pain level (scaled 1-10) unless requested by us. We will freely communicate with you if we need to describe a pain level. It's best not to ask a laboring woman what her pain level is. Practitioners can use this self evaluation as a way of determining how far along in the labor you are, but they will ultimately be checking your cervix anyways. Otherwise, this could be the first innocent step down the road to medication.

We ask that the baby be monitored as per ACOG guidelines for intermittent monitoring (about 20 minutes per hour) rather than continual monitoring, as long as no abnormality or complication is detected to allow for freedom of movement and maternal comfort during labor. (I prefer to not lay down to be monitored, and I reserve the right to decline or delay monitoring if I continue to remain low risk during my labor). The American College of Obstetricians and Gynecologists determined that being hooked up constantly to the monitor does not improve outcomes any more than intermittent monitoring. There have also been more studies that show that intermittent monitoring doesn't improve outcomes any more than asculting intermittently (listening with a hand held doppler) does, but MMMC does not have that option available, yet. Most nurses are cooperative about putting the monitor on in most any position, but you may have to compromise just to get a good "strip" and then they can remove the straps for a while. You can always say "not now, thank you" and if they need to, they can put in your chart "patient declines". Use your best judgment on this.

I reserve the right to refuse any vaginal exams/cervical checks to determine dilation. As I mentioned before, these exams can be quite uncomfortable, so it is prudent to minimize their number. The nurses are very careful about the number of cervical checks when amnionic fluid is leaking, and also try to keep these checks to a minimum in the absence of ruptured membranes, but do know that you can delay or decline if you need to (thank you, please, if possible).

If I remain low risk during labor, I would like to eat simple foods I've brought from home to maintain energy and stamina. Sometimes, nurses stop us when we

attempt to give the laboring mama some fruit or a bite of yogurt when she is hungry. In the past this wasn't an issue, so I am not sure why this changed. Current evidence (see evidencebasedbirth.com) points to the fact that "you are more likely to be struck by lightning than to die from aspiration during a C-section" (the logic behind NPO or Nil Per Os - nothing by mouth) and I encourage families to bring up this topic with their care provider. Best foods for labor include anything that is easy to spoon into your mouth, doesn't require a lot of chewing and won't be too painful to vomit back up if necessary. This could include soup broth, which is what the staff prefers, or your favorite yogurt (great for energy), grapes or cut up melon, honey sticks or electrolyte chews.



© 2013 www.evidencebasedbirth.com Last Revised: 10/12/2013

Evidence Based Birth®

GIVING BIRTH BASED ON BEST EVIDENCE

Eating and Drinking during Labor

By Rebecca Dekker, PhD, RN, APRN of EvidenceBasedBirth.com

Question: Should women be allowed to eat and drink during labor?

Answer: Yes. In women who are low risk, it is not harmful to eat or drink during labor.

Evidence: In a Cochrane review, researchers combined evidence from 5 studies that randomly assigned 3,100 low-risk women to nothing by mouth (NPO) or eating and drinking during labor.

"Many women naturally choose to stop eating the closer they get to delivery."

They found no differences between the two groups with regards to C-sections, instrumental vaginal births, Apgar scores, or any other health issues.

The number of women in the studies was too small to look at the rate of aspiration during general anesthesia. Aspiration is when stomach contents go into the lungs. This is an extremely rare health problem that was first reported in the 1940's.

However, since the 1940's, anesthesia techniques have changed considerably. Also, there is a greater use of epidurals. These two factors have made aspiration during surgery an incredibly rare event.

Also, when given freedom to choose whether to eat or drink in labor, many women naturally choose to stop eating the closer they get to delivery.

The researchers concluded that **women have the right to choose whether or not they would like to eat and drink during labor** (Singata, Tranmer et al. 2010).

So what is the risk of aspiration during a C-section?

In one study, researchers looked at 4,097 maternal deaths that happened in the U.S. between 1979 and 1990.

They found that the risk of aspiration during a C-section was 0.667 per million women, or approximately **7 events in 10 million births** (Hawkins, Koonin et al. 1997).

This means that you are more likely to be struck by lightning than to die from aspiration during a C-section (National Weather Service, 2012).

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 illness or death reported from aspiration, even though 22% of women had eaten solid food (Rooks, Weatherby et al. 1989).

Disclaimer & Copyright

This information does not substitute for a care provider-patient relationship and should not be relied on as personal medical advice. Any information should not be acted upon without professional input from one's own healthcare provider.

References

1. Singata, M., J. Tranmer, et al. (2010). "Restricting oral fluid and food intake during labour." Cochrane database of systematic reviews(1): CD003930.
2. Hawkins, J. L., L. M. Koonin, et al. (1997). "Anesthesia-related deaths during obstetric delivery in the United States, 1979-1990." Anesthesiology 86 (2): 277-284.
3. Rooks, J. P., N. L. Weatherby, et al. (1989). "Outcomes of care in birth centers. The National Birth Center Study." N Engl J Med 321(26): 1804-1811.
4. National Weather Service, "Lightning safety." Accessed April 2013, http://www.lightningsafety.noaa.gov/medical.htm

For more information visit www.EvidenceBasedBirth.com

Follow us! evidencebasedbirth @birthevidence @birthevidence

I would prefer to push to crowning on my own without massage or stretching unless it is needed for the baby's safety or I request it. My preference would be to have a warm compresses applied to my perineum if I desire. Nurses and OB's are trained with a perineal massage technique that involves some pulling and stretching of the perineal tissue. Some women find this helpful during coached pushing, but you might find that just a warm washcloth on your perineum or no touching at all is preferable for you. As a doula, I would ask my client, "Do you like the massage and stretching or would you prefer not?" Again, you have a valid voice, because it is your body. If it is helping you bring the baby down, go for it. If you find it distracting, ask them nicely to stop.

I would like to leave my options open in terms of position for delivery, and ask that suggestions be made if I am having difficulty bringing the baby down. Most people find that moving around a bit during this stage of labor can help bring baby down. It is a wild experience feeling your baby move through your pelvis and it can help to stand, squat, go on hands or knees or just sit on the bed. Some OB's are willing to have you deliver in a side lying or hands and knees position, and some are willing to have you get close to crowning and then get you in a semi-reclined position for delivery. Discuss what your options are with your provider. This stage can be anywhere from a few pushes to many hours, and if you decide that you need help focusing, your nurse will suggest you get in the semi-reclined position (while you grab you legs and push to the count of ten, three times during each contraction) through to delivery.

Please delay cord-clamping and cutting and I prefer to not be rushed through delivery of placenta. Delayed cord clamping and cutting has been in the news recently, new studies are finding the many benefits to allowing placental blood to continue transfusing into the baby for at least 90 seconds and onwards of many minutes as the cord stops pulsating. Protocol is about 90 seconds, unless they believe the baby is having a hard time transitioning in which case they will clamp and cut immediately so baby can be brought to the warming table. If you would prefer this moment to not be rushed, include a statement about it on your birth preferences document.

The father/partner/I would like to cut the cord. This is up to you, just let them know, as long as there are no complications present.

We agree to routine pitocin after delivery. OR Unless there is excessive bleeding we would prefer not to have routine pitocin after delivery. This (and IV fluids) is mainly what the hep-lock is in place for and most OB's would like to give you a little pitocin prophylactically after the delivery of the baby. There are indicators when this is an important thing to do and if it is a priority to you to not be medicated unnecessarily, discuss your options with your care provider.

Unless our baby is in crisis, we wish for them to be delivered directly onto the mother's abdomen and remain there for bonding and immediate breastfeeding. We wish to delay any routine newborn procedures (eye drops, newborn exam, Vit K, etc) for at least 1-hour post-delivery, and preferably for 2 hours, (and ask they be performed bedside in our postpartum room.) If there is an indication at the end of labor that your baby is experiencing some sort of crisis, they will have an extra nurse in the room who will focus solely on your baby on the warming table. This will mean an immediate clamping and cutting of the umbilical cord. As long as baby is transitioning well, baby can remain skin to skin for a period of time.

We prefer our baby not be routinely bathed. OR We prefer baby goes to nursery for routine bath and exam. If you prefer baby to go with you straight to your postpartum room, you can indicate that here. Otherwise, regular protocol is for baby to go to nursery for bath and routing newborn procedures. Partner can join them, and if the nursery is not busy, partner can be in the room for this. There is no evidence to support any benefit to a newborn being bathed, by the way. Look up "reasons not to bathe a newborn".

With a normal labor and birth, mothers and babies remain in the hospital for 24 hours after birth. If there are any issues, the pediatrician (or your OB, if the issue is with your recovery) will not release you until all is stable. Some common issues are baby not transitioning smoothly to breathing, physiological jaundice with a concern it may turn into pathological jaundice and poor weight gain. At midnight and at 24 hours, baby is weighed. Most newborns lose 5-10% of their birth weight and if this is combined with breastfeeding challenges, you may be required to stay. Sometimes, the mother is "released", but the baby is not. This can pose many challenges, both physically and emotionally, so be sure to reach out for support from your family and your doula. The time spent in the hospital can be very helpful with healing and with getting a good start to breastfeeding. Be sure to ask questions when you have them, or ask your doula (or postpartum doula) to check in regularly. Be

aware, though, that your time there is not particularly restful. There is someone coming in regularly to check vitals, take blood, bring baby to nursery for weighing or other procedures, even the security guard checks in to see how many visitors you have. Try to sleep when you can, and be sure to practice your nursing every couple of hours so as not to risk too much weight loss in your baby. It is nice to get your discharge papers and go home together as a family, into the comfort of your own home.

These are the most basic decisions most families birthing at MMMC are faced with. If you have pre-existing health conditions with you or the baby, your journey can be less open to interpretation. And, again, we are so grateful to have our medical team in place to help us avoid serious complications.

We would like to bring our placenta home and will do all necessary testing and paperwork while we are here. If this is important for you, request this when you arrive. It is critical that you name a person to pick it up (it can be you, or a friend, or your doula) and you cannot change the name once you've registered it, so be sure the person is available that week.

Useful links you can find at birthonmaui.com:

Evidence Based Birth (all kinds of important current research)

Spinning Babies/optimal fetal positioning (key to labor)

Article and video about Nuchal Cords (it's not that scary around the neck!)

Eating in Labor Handout (from most current research)

Link to a Video about Getting a Good Latch for Breastfeeding (you can do it!)

AND MORE!

Common Roadblocks

and How the Hospital Environment Can Help

In the absence of any dangerous complications, normal variations on the length and intensity of an individual's labor can extend to the ends of a long continuum. Ideally, a family can and will sustain their momentum with their determination to have an unmedicated labor and birth. However, in the hospital environment, families are aware that there is a way "out" to a certain extent. It is important for a person who is anticipating labor to know that no one can do this "for you" or "save you" from your experience, however, many families choose a hospital environment specifically so that they know that if it gets over their head, they have an alternative... A body can get hung up in labor for a variety of reasons; everything from anatomy to psychology. Read through these common roadblocks and make a flexible plan about how to proceed if you find yourself here:

- Slow progression: This is your first labor and you start laboring at home. You want to stay at home as long as you are comfortable. At some point, you may think, "It's time to go to the hospital". In my practice, if the mother says go, we go, even if I think she may still be in early labor. However, she may seem to be progressing well; contractions are close together, lasting a minute or more, she is breathing strongly and focusing on coping. She may have taken off some clothes and spent a lot of time in the bathroom. These are all good visual signs that labor is gradually increasing in intensity. But without a cervical exam, it is hard to know for sure. So if it is during normal clinic hours, one option could be to go there and see how dilated she is. It is easier to go back home from the clinic. Some women learn how to check their own cervixes, and that can be very helpful. Another option is to work with a "monitrice" who is a doula trained in some physical assessments. Otherwise, the family goes to the L&D, with all of their gear and hopes and expectations, only to be told she is barely 1-2 cm dilated? Auwe. So, what to do? If the amniotic sac (water bag) is still intact, one choice is to go back home. This is a difficult choice and if there is a possibility to stay at the hospital (they are not too busy on the floor), it might be better to try to encourage progress there. Hopefully, you have your birth ball or stool or something that allows for a supported squat so she can stay upright without getting too tired. You can also try squats, walking, doing the stairs between floors, going into the labyrinth garden if it is during visiting hours... OBs do not usually address the baby's position, so if you think the slow progress might be due to either a posterior presentation (baby's back is to mother's back)

or asynclitic head presentation (baby's ear is toward his/her shoulder instead of aligned with spine), you can easily try some cat/cow, simple inversions, Miles Circuit, Side Lying Release and Rebozo Sifting to help baby get in a more productive position. Hopefully, these things will help to start moving things along and hearing that you made some progress after a few hours will be music to your ears.

    - Slow progress is very challenging, so any opportunities that the laboring person can sleep are very important. This includes the hours before the trip to the hospital. When you become aware that labor may be starting, figure out if you are well fed, well hydrated and well rested, and if not, tend to those to the best of your ability. If it is 10pm and you were just going to bed, try taking a warm bath to calm the sensations down enough to get some rest. You can't stop the fact that labor will kick in soon, but you can delay the start for the purpose of getting some necessary rest. A glass of wine or some chamomile tea can assist at this point. If you do get to the hospital at 0-3cm and have the option of not being admitted, it may be best to go home and sleep, as you are more likely to get rest in your own environment. Have your doula come with you, so you don't feel vulnerable now that you are returning home.

- Stalled or continuously slow progression: If mother is losing focus; they are tired, worried, and in pain, it is not particularly helpful to insist they keep on keeping on. You are in an environment that can manage the birth safely and successfully if they choose to allow it. If going home is not an option, either because membranes are ruptured, labor pain is too much, or mother truly does not want to leave, consider getting epidural anesthesia. Of course, if the mother still wants to keep trying, I'd suggest getting a chair or stool in the shower, placing their drinking water and an electric candle on the shelf in the shower and giving them some time to find their way through. The privacy and the warm water can revive a laboring person's spirit. Maybe the partner or doula can apply and re-apply hot compresses while they gather their strength, tune into their baby and speaks to the warrior within. If they are unhappy with that option, do not make them feel bad, and remember you (the partner or the doula or the sister or the auntie) are not the one doing this and the laboring person deserves to make the important decisions.

- Rupture of membranes before labor begins: This is an important roadblock to an intervention-free birth at the hospital. Protocol is to immediately admit yourself to the hospital and be closely monitored for signs of infection. This is challenging because you had made plans to labor at home as long as possible before getting to the hospital. Auwe. My best advice is to read the Evidence Based Birth article about this topic before labor begins and have a plan for managing this common roadblock. Refer back to the previous

chapter about requesting the opportunity to get labor going spontaneously while being closely monitored for signs of infection. Before you get to the hospital, they will want to be diligent about following the protocol for not introducing bacteria into the birth canal because now the protective barrier is gone to the uterus and the baby. Stay extraordinarily hydrated, the body will continue to replenish amniotic fluid. Wipe carefully, front to back, after using the toilet or even just shower off with a mild soap, being careful not to enter the vagina. Don't have sex, or go in the ocean, of course, but also do not get in a bath or leave a panty liner on for more than an hour. Just because the membranes are ruptured, it does not mean there will immediately be an infection. Be cautious and use common sense. Upon arriving at the hospital, if the laboring person is GBS negative and not showing signs of infection, they should be allowed to try to get things moving naturally before artificial methods are required.

- Medication for Pain is now Required: With my clients, I call this "hitting the I Quit Switch". And, believe me, I have been in labor for many hours myself and know that even in the most standard of labors, everyone hits a wall. If the laboring person is progressing smoothly and in a straight forward manner, they may be able to be talked over this wall. Some gentle and kind encouragement, the reminder that you are doing so perfectly, a change of scenery (get in the shower or out of the shower), possibly a cervical check to prove the progress is going well, and the reassurance that this won't last forever can often get them back from the edge. If they are tired, scared, hurting and feel like the finish line is still absurdly far away, pain medication is often the best choice. I recommend just going for the epidural because it normally eliminates the painful sensations without making them feel drugged (the body below the breasts feels drugged, the mind does not) and babies tend to handle it better than opiates (getting morphine or stadol through an IV is less involved than getting an epidural, but be aware that it will wear off rather quickly and does make the baby sleepy, which can lead to other interventions). If things have been moving slowly, the introduction of Pitocin at this point (after the epidural) can be helpful. Since they will not feel the increasingly longer, stronger and closer together contractions, it is a great tool for getting to the finish line quicker. That said, all of this does have its risks. The epidural can cause an unsafe drop in the laboring person's blood pressure, it can make it difficult for baby if the required fully reclined positions place compression on baby's cord. It can also give the laboring person a terrible headache and the shakes. There are ways for the staff to help with all of these, but now we have "a cascade" of interventions. Most clients that I have worked with that have chosen an epidural handle it fine and once the birth is complete, they can recognize how that was the best possible birth for them at this time.
    - An Epidural is best as a last resort. After trying all natural options first and giving the body enough time to create the chemistry that makes labor "do-able", you may find that the progress is still too slow or you

are too exhausted to keep going. The epidural usually requires about an hour to arrange, so there is a bit of lag time between deciding to get it and actually getting it. If you are not hooked up to an IV yet, you will need to receive about an hour's worth of fluids as prep for the epidural. Once the anesthesiologist is available he or she will come talk to you about the procedure. It is fairly simple and quick, requiring some added discomfort for about 10 -15 minutes as the spinal catheter is installed and you are sitting still on the edge of the bed (some anesthesiologists are comfortable with the mother laying down for the procedure). Once it is done, the laboring person will feel instant relief. The nurse and partner and doula can help get you laying down flat for the medicine to take effect equally in both sides of your body and you will be hooked up with a blood pressure cuff, the two monitoring straps and sensors, the IV fluids and usually Pitocin, and you will be given a urine catheter in your urethra to keep your bladder empty (since you can not get out of bed). After a bit, everyone can help you get in a comfortable side lying position so you can rest. If baby's heart rate shows repeated decelerations during contractions, the nurse will keep switching your position to find the sweet spot, or possibly it will require an amnio-infusion, which is another catheter into the uterus to provide extra fluid and "cushion" the baby and cord.

- Medicated second stage: During your labor with the epidural, you will have the opportunity to push a button to receive a "bolus" dose of medication if you are beginning to feel the contractions. Go ahead and use it to your satisfaction, there is a lock out system so you cannot overdose. However, you may want to hold off once you get to completely dilated so that you can have some sensation while participating in the pushing stage. A medicated labor can be liberating, but a heavily medicated pushing can be very challenging. It is hard to understand the directions your nurse is giving you and it can take quite a while to get in the groove. You will likely feel big pressure, but it is different from the urge to push you get when you are unmedicated. So, do your best, listen to your nurse because she does this many times per day and has come up with an effective system. Try to ignore everyone staring at you and the bright light on your vagina. Some women find some loud music to be helpful, or ear buds in as long as you can hear instructions, or a cool washcloth over the eyes. Just know that your concentrated participation is the difference between a normal vaginal delivery and one that needs more help. Follow directions clearly and keep going. Partner and doula can help by holding legs or fetching water or ice cubes and replacing the cool washcloth.

- Medicated Third Stage: Once baby is birthed, and having a smooth transition, all should go as if you are unmedicated. There will be extra tubing and various wires to contend with and your blood pressure cuff will go off every few minutes for a bit, but otherwise there you are with your baby and your partner (and your doula). Cord clamping can be delayed as you wish, placenta delivery should be quick, a little Pitocin to constrict your bleeding, numbing and stitching if needed, and on to getting a good latch for breastfeeding. Slowly, various catheters will be removed, but the hep-lock will stay just in case there are complications postpartum. Baby can still go with you to your postpartum room or to the nursery, whatever you've decided.
- Artificial induction for going past your due date: OB's do not want you going past 42 weeks gestation. Earlier even, if the baby seems big to them, is not handling its environment well, or if you are having any health issues. If you are faced with an induction and you have already been through all of the tricks to help baby get in great position; you've done spinningbabies.com, you've been to the chiropractor to find out if your round ligaments are tight and holding baby up, you've been to the acupuncturist to see if she can get your chi moving in the right direction, you've tried Evening Primrose Oil, dates, and all of the anecdotal "trigger" foods, and even tried a swig of castor oil, you may have to have your labor started medically. If this is the case, talk to your doula about the best ways she can support you. If you are being admitted overnight for Cervidil (a vaginal insert to help ripen the cervix), you may or may not need your doula there for that. It would entail basic hospital protocol for admittance, fetal monitoring, baseline health assessments and the Cervidil application. The biggest challenge will be getting sleep, so bring some music or eye coverings to help. It is possible that the Cervidil alone can send you into labor, so be aware of this. If your cervix is already heading in the right direction, just contractions have not begun, you might just go in for Pitocin induction. This is a good time for your doula to come and help from the start. If it is a slow start, she can leave you alone and rest in the waiting room (or whatever you decide - I think it is important to always stay from start to finish. Clients can be polite, but I only let them send me away, if I am certain they want and need alone time. Rarely, do they truly *want* me to leave). A Pitocin induction is very challenging. I have heard from mothers who have had natural contractions as well as Pitocin contractions, that they are vastly different. They are described as "synthetic" which sounds like an accurate word. One of the reassuring things I say to the average laboring woman, is "your contractions are a part of you so they cannot be more than you can ultimately handle". However, Pitocin contractions can easily get out of reach of what a woman feels she can handle and it takes a very determined family to make it through an induction unmedicated. It is possible that a little bit of Pitocin will kick start labor and then the Pitocin drip can be stopped to see if the body will take over. It never hurts to ask!

Some Notes for Doulas

Important Tips for Creating a Supportive Environment

A common question I get when I interview with a family is “How well do you work with my care provider?” I have heard OB’s question the value of a doula by way of warning families that they may get between the family and their trusted care provider, thus creating problems instead of solving them. I completely understand this point of view, because as I said earlier, we were once of a mind that the medical model was the enemy to a Natural Birth. And, though I do experience regularly, that the less someone interrupts a laboring woman, the less likely she will lose focus, it is important to remember that families consciously choose our hospital as their birth place. So, doulas, if we truly want to support families in their choices during birth, we must approach this with the utmost respect. Who would it serve if I were to make a family question the very foundation of their birth choices by trying to subvert the intentions of their OB? I give them the benefit of my experience and let them know the variations within their OB’s care that I have witnessed and feel confident to share with them. Each experience in MMMC’s L&D has been a little bit different and depending on the workload of the nursing staff and the character of a family’s labor and birth, there are many little tweaks that can occur that do not off-put the staff or get between a family and their trusted care provider. This is the basis of my Birth Preferences outlined above.

When you interview with a family, be sure to let them know you will always work with their OB and the hospital nursing staff to help get you the best possible care. This includes being very friendly and gracious to the staff. I generally avoid talking to the nurses or doctors, there is no reason for me to either make commentary or explain that I know what I am doing. Trust me, they have so much on their mind, the less people that talk to them the better. Plus, it is REQUIRED that anything the birthing family wants the staff or their doctor to know, they must be the ones to tell them. This is very important. If a protocol or new procedure is being suggested and the family is not asking all the questions you are thinking of, use your agreed upon signal to let them know "Let's discuss this for a minute". The family can then let the staff know they'd like to discuss it for a minute, and everyone will indeed leave you alone. Then, when you are discussing it, be sure to outline all valid possibilities, including the best scenario accomplished by following the staff's suggested protocol.

> For example: A family has arrived at the hospital after some hours of laboring at home to find they are only 2-3 cm, membranes intact. They make the empowering decision to head back home with the hopes that being in a comforting environment, she can rest and labor can progress smoothly. After another 24 hours, they return to find she is now only 3-4 cm. She is tired, disappointed, frightened and her OB on rotation (not her chosen OB) is suggesting many things. We get a moment to speak alone and go over the options and pinpoint what her biggest priority is. Does she need rest? Does she need this over with and on to the next phase of parenting? Does she need to continue to remain unmedicated? Or minimally medicated? She chooses rest first. Ok, so epidural anesthesia and let's see if an hour of relaxation brings progress. A couple hours later after some sleep, still no progress. Next priority? She chooses quick progress to birth, please. So, pitocin augmentation to bring contractions longer, stronger and closer together. OB has suggested artificially rupturing membranes and we discuss the pros and cons of breaking the water bag. She chooses to keep it intact unless the pitocin doesn't move things along quick enough. At the next exam, by the OB, she had made great progress and her bag had broken spontaneously. So after some more rest, she is complete and with guided coaching by the nurse, the OB and I, she successfully births her daughter. No where in there did I talk to the laboring family in front of the doctor or staff, nor would I ever imply to the staff that I know this family's wishes better then they. Again, who would that serve? And, this family feels empowered by having made each decision thoughtfully.

It is critically important to not be in between the nurse or OB and their patient. Not physically or psychically. As I said, do not answer questions for your client. Do not interject even if you think you are hearing something completely different than what they have said to you. The laboring person may have changed their mind, or maybe you didn't hear them clearly the first time. Never assume you know what they are experiencing. I know that we are called upon in the media to be "advocates" or "a voice" for the laboring woman, but this is not a helpful stance for a doula who wants to be welcomed again and again by the staff at MMMC. Be sure to spend a lot of time prior to the onset of labor discussing how you will not speak *for them* or directly to the staff, but they can always ask for time alone with you and the partner to clarify what the best decisions are. Sometimes it is as easy as eye contact between you and the family to assure them that they are being treated respectfully. If you are hearing discussion in the room that is far off the track they had been hoping to be on, use your pre-arranged signal for "let's talk" and they can ask everyone for a moment before making a decision. Some families make agreements that the partner will speak for the laboring person as much as possible, this can help with keeping them focused on moving through labor.

The frequent interruptions and monitoring at the hospital can be daunting to helping a family achieve an unmedicated labor. Our goal is to help them get in the "zone" with the comfort measures we learned in our trainings and our experience, but having a kind of "game off", "game on" rhythm can be challenging to finding a groove. Just prepare them for this, let them know what to expect and how you will be right there to help them back into "labor land" when the assessment or discussion is finished.

Besides helping a family understand what to expect and what some typical roadblocks are, I find that one of the most helpful roles I have as a doula at MMMC is to help the partner feel supported. The one who is experiencing labor and birth has done a ton of research, usually, read all the things, talked with numerous friends and family members and has a general idea of how they'd like to be supported during labor. Many times, the partner has not done as much reading and asking questions, and may either feel unprepared or feel confidently (un)prepared, much to the worry of the pregnant one! In my experience, the partners really do rally to the occasion and become the laboring woman's biggest support. As a doula I help the partner find the best hands on techniques, reminding them that laboring bodies usually like a steady pressure in one (or two) places and not random touching during a contraction. I help them remember to not ask a lot of questions or make small talk during contractions. I remind them to offer a sip of water frequently and to keep track that they're urinating often. I am right there with a confident nod when they start to sound quite primal; the partner has likely never heard them in the midst of the most challenging effort a woman makes in her lifetime and may get worried that they do not seem as calm and put together as they usually are. The partner is grateful to have someone that has an understanding of their preferences and their personalities and who is able to offer suggestions and answer questions as they come

up. All of this, and the partner did not have to arrive with a cheat sheet of labor ideas, or be calling someone for ideas when the going is seeming to get tough. “Yes, this is normal” is a sentence I speak a lot, “This is what birth looks like”.

If the family’s labor hit any of the common roadblocks and they have decided to change course and use medicine in some form, a doula can be of assistance by adding bits of assurance along with the nurse’s description of what she is going to do to help. By giving the family a brief but thorough description of what a medicated labor looks like, prior to going into labor, they can be better prepared for all the procedures and tubes and wires, and know “This is what birth looks like, too”. I find I can help the nurse with simple things like holding IV catheters and fetal monitoring wires out of the way or helping to untangle as we move. Just ask nicely if there is anyway to help, and many times there is.

And, don’t forget about postpartum. If the family cannot take a breastfeeding class, help them get a simple understanding of how to work on the “latch” and briefly explain some of the physiology and psychology of a healthy nursing relationship. Let them know that emotional highs and lows come with the territory, but if they experience deep down days and thoughts of escape or harm, tell them to reach out immediately. Postpartum depression is common and there is help, even if it just means speaking with another family who has experienced it and come through the other side. Let the family know the importance of rest and recuperation after the birth and that establishing successful breastfeeding sometimes takes up to 6 weeks. Adjust your fee to allow for them to be able to call on you during this time or hook them up with a trained postpartum doula, this is a critical and tender time and most families need help either from a doula or from family.

Finally, a few words about Experience Level. If you feel called to be with families during pregnancy, labor and birth and postpartum, you are a doula. Your experience level is certainly important, because the more births you attend the more you see the wide variations of normal and the easier it is to be a calm, reassuring presence at someone’s labor, but it is not the only thing you bring to a birth. Your “doula bag of tricks” is very valuable, and classes and workshops and books and videos can teach you a lot about comfort measures in labor. Most doula courses do not teach you the ins and outs of hospital protocol, however, because your “scope of practice” is to remain *even further* out of the way of your clients’ relationship with their care providers than I am suggesting here. Though, if you can use the information here to help a family understand what to expect and how to speak up for choices, you can help them tremendously with finding empowerment in their decisions. This empowerment leads them to a birth that, no matter the twists and turns, they can achieve with peace and confidence about their journey.

Please email me with any questions at:

info@birthonmaui.com

Visit my website:

birthonmaui.com for links and more info

Acknowledgements:
I must always thank my teachers; my children of course, who taught me what labor and birth are all about, my mentors, Kadi Mourningstar, Jan Francisco, Lori Land, Tina Garzero, Debbie Lavin, Susan Castle, Linda Harrison and their families. Deepest mahalo. And, thank you to all the many families I had the honor of serving and learning from, you are the reason we do this work.

Birth Preferences Work Sheet on next two pages…

OUR PREFERENCES Work Sheet

In the absence of complications we ask that the following requests be honored:

____(We would like to request a private postpartum room if one is available.)

_____We wish to be fully apprised and consulted of all risks and benefits before the introduction of any medical procedures or intervention.

____We ask that all members of our birthing team remain with us at all times. This includes our doula, _____, whose primary task will be to assist us.

_____We would like to take home our placenta and ask for the necessary testing and paperwork that need to be completed while we are here.

_____If labor induction or enhancement is required at any time, we would like the opportunity to try all the natural inducers first as long as the baby and mom are healthy.

____If TermPROM occurs and mother is GBS negative, we would like to observe the "expectant management" protocols of absolute minimal vaginal exams and watching for indicators of infection (fever, meconium staining, fast heart rate in the mother or baby).

____We plan to stay hydrated by drinking clear fluids but we are aware that an IV may be required during labor for dehydration, medication installation or other medical needs.

We **are/are not** willing to compromise on the need for an IV by utilizing a heparin-lock for access if medically indicated.

____We wish to have no offer or suggestion of medication or self evaluation of pain level (scaled 1-10) unless requested by us. We will freely communicate with you if we need to describe a pain level.

____We ask that the baby be monitored as per ACOG guidelines for intermittent monitoring (about 20 minutes per hour) rather than continual monitoring, as long as no abnormality or complication is detected to allow for freedom of movement and maternal comfort during labor. (I prefer to not lay down to be monitored, and I reserve the right to decline or delay monitoring if I continue to remain low risk during my labor).

____I reserve the right to refuse any vaginal exams to determine dilation.

_____If I remain low risk during labor, I would like to eat simple foods I've brought from home to maintain energy and stamina.

_____I would like to leave my options open in terms of position for delivery, and ask that suggestions be made only if I am having difficulty bringing the baby down.

_____I would prefer to push to crowning on my own without massage or stretching unless it is absolutely needed for the baby's safety. My preference would be for warm compresses applied on perineum if I desire.

_____Please delay cord-clamping and cutting (at least 2 minutes) (until pulsing has stopped) (and I want to be notified before clamping) and prefer to not be rushed through delivery of placenta.

_____The father/partner/I would like to cut the cord.

_____Unless there is excessive bleeding we would prefer not to have routine pitocin after delivery. or

_____We agree to routine pitocin after delivery.

_____Unless our baby is in crisis, we wish for her to be delivered directly onto the mother's abdomen and remain there for bonding and immediate breastfeeding. We wish to delay any routine newborn procedures (eye drops, newborn exam, Vit K, etc) for at least 1-hour post-delivery, and preferably for 2 hours, (and ask they be performed bedside in our postpartum room.)

_____We prefer our baby not be routinely bathed or We prefer baby goes to nursery for routine bath and exam

_____I strongly desire to not be separated from my newborn.

_____Our baby will be breastfed on demand. We ask to help us establish successful breastfeeding.

_____We prefer routine immunizations (primarily HepB) be completed at our pediatrician's office per their advice and schedule rather than at the hospital OR We consent to routine tests and immunizations. (I would like to be present with my baby for any tests or observations postpartum.)

Thank you for helping at our birth!

Aloha and thank you for reading my Ebook!

Please go to pacificbirthcollective.org and sign up for our newsletter to keep up to date on what our practitioners are doing to make pregnancy and birth on Maui better and better.

Mahalo!

Kristina Statler

and the Pacific Birth Collective Team