Serving Mothers and Babies since 1982

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Disclosure and Informed Consent for New Clients

It is both my sincere desire and my legal obligation to inform you about midwifery care in general and my midwifery practice in particular. This should help you to make educated and informed choices concerning your maternity care. I hope this informative disclosure will facilitate good communication and lead to mutual trust and respect, as these are important qualities in the provision of safe and satisfactory midwifery care.

Client Information

My Background, Midwifery Training and Experience: I am the mother of three and grandmother of two. I have been a maternity care provider my whole adult life, first as a labor and delivery room nurse, then as an ASPO certified (Lamaze) childbirth educator. I have been providing various kinds of midwifery care since 1982. Originally I was a Mennonite midwife who practiced under the religious exemptions clause, more recently as a state licensed direct-entry midwife (California LM #041), a nationally certified professional midwife (MANA CPM # 96050001) and preceptor to midwifery students.

The formal education for direct-entry midwives such as myself is a three-year didactic and clinical training program in a Medical Board of California approved school. However, as an experienced midwife practicing before the passage of the Licensed Midwifery Practice Act (LMPA) of 1993, I qualified for state licensure thru an official challenge program of written testing, clinical exams administered by the Seattle Midwifery School and by passing California state boards in midwifery. In addition, I am formally trained in neonatal and adult resuscitation, fetal monitoring and obstetrical emergencies. I review these and other skills biennially as a part of continuing education requirements.

Scope of Practice: Standard, community-based midwifery care includes physiological management of pregnancy, labor, birth, postpartum and the neonatal period. Our practice offers home-based services to essentially normal healthy women enjoying a normal pregnancy who plan to labor at home and, assuming (a) continued good health of mother and baby and (b) normal spontaneous progress without complications, give birth at home. I also provide labor support services for planned hospital birth to women with special needs. I offer “second nine months” care – friendly psychological support for new mothers/babies -- with scheduled visits at 3, 6 and 9 months.

Philosophy of Practice: I ascribe to the midwifery model of care, which respects the autonomy of the mentally competent adult woman and acknowledges the healthy woman as the primary decision maker throughout her childbearing experience. I uphold the client's right to make informed choices about the manner and circumstance of normal pregnancy and childbirth and endeavor to facilitate this process by providing complete, relevant, objective information in a non-authoritarian and supportive manner, while continually assessing safety considerations and the risks to mother and baby and informing the client of identified risks.

The midwifery model of care is based on traditional, non-medical principles that have been proven successful throughout the history of our

species. Technically this process is called **physiological management**. 'Physiological' is defined in Stedman's 1995 Medical Dictionary as **"in accord with, or characteristic of, the normal functioning of a living organism".**

Physiological management is the science-based model of normal maternity care and should be the foremost standard for all healthy women with normal pregnancies, regardless of the setting for labor and birth (home or hospital) or the type of care provider (midwife or physician).

Principles of Practice: As a licensed professional midwife, I engage in an ongoing process of risk assessment that begins during the initial consultation and continues through the completion of care. In addition to assessment, this includes risk prevention, risk reduction and referral or transfer of care to a physician or medical facility whenever necessary or at the mother's request at any time during pregnancy, labor or afterwards.

Standards: Our practice abides by the standards of practice, guidelines, policies and protocols, client selection criteria, physician consultation, referral, & transfer of care criteria and minimum practice requirements as published by the *California College of Midwives* (CCM). This 56-page document is available in our office in hard-copy for your review or you may read it on-line @ **www.collegeofmidwives.org**.

Client Selection for Primary Midwifery/Home-Based Birth Services requires the mother to be an essentially healthy woman experiencing a normal pregnancy. An essentially healthy woman is without serious pre-existing medical or mental conditions affecting major body organs, biological systems or competent mental function. An essentially normal pregnancy is without serious medical conditions or complications affecting either mother or fetus (refer to the CCM Standards & Guidelines for additional information).

Non-medical Criteria: Home-based birth services require that the client's living arrangements provide adequate space, sanitation, light, heat, hot water, availability of telephone, transportation and plans for emergency evacuation to a hospital. Client must also agree to read and sign appropriate informed consent or waiver of standard care documents.

Physician Consultation, Referral / Elective Hospitalization: The LMPA requires each LM to be supervised by a physician with obstetrical training. Unfortunately the LMPA does *not* require that any California physician provide supervision to California midwives. In addition, the malpractice insurance carriers in California (all three are doctor-owned companies) prohibit obstetricians from having *any supervisory relationship* with a community midwife. As a result of this legal impossibility, I do not personally have a specific physician with whom I may routinely consult, refer or transfer care to during labor.

Client-center Arrangements: Until this glitch in the law is fixed, each client must either receive concurrent obstetrical care *or* identify a physician or clinic to consult with should a problem or possible complication requires medical evaluation or treatment (refer to the CCM Standards & Guidelines for specific criteria for referral & transfer of care). Parents must also identify a hospital that they are willing to be transported to during labor or immediately after the birth. The family's healthy insurance (or MediCal) coverage and the realities of the political situation between midwives and physicians will also figure into the specifics of these arrangements.

Medical Referral: Kaiser Permanente always provides care to their own patients. On the SF peninsula and Santa Clara valley, nurse-midwives and physicians at UCSF and SF General are the most friendly and cooperative with home birth clients and available for consultation and referral. Other tertiary hospitals on the peninsula accept transfers as needed, primarily Stanford/LPCH in Palo Alto and Valley Med in San Jose.

Emergency Transport: In a true emergency, the EMTs will transport mother &/or baby by paramedic vehicle to the closest appropriately equipped hospital, regardless of your personal preference or identified medical provider (this is true even if you have Kaiser coverage).

Midwifery Care for Unplanned Hospital Birth: Responsibility for the mother and baby's medical care will be taken over by the physician and hospital staff if a client is transferred to obstetrical care during labor. I will accompany the mother to the hospital as an advocate and support person and remain until after the birth. After release from the hospital, I will (at the mother's request) resume normal midwifery care during the postpartum and

new baby period, including home visits, routine office visits & second nine months care.

Newborn Medical Care: We recommend that you make arrangements for newborn evaluation and on-going care with a pediatrician or family practice physician before the baby is born. We can give you the names of pediatric care providers that are philosophically compatible with your choice of community-based midwifery care. If problems or possible complications are detected at the time of the birth or immediate afterwards a pediatric evaluation or hospital transport will be necessary (refer to the CCM Standards & Guidelines for specific criteria for newborn referral).

Alternative Midwife Arrangements: I am one of a small group of professional midwives attending out-of-hospital birth in the SF peninsula/Santa Clara valley area. I am rarely unavailable but I do occasionally take a vacation, attend midwifery conferences, medical board meetings or become ill. It may be necessary to utilize an alternate plan if you should need services during those times. I will ensure that you have the names and phone numbers of other credentialed, well qualified and experienced midwifery colleagues if I am unavailable for any reason. Should you be unable to contact a suitable replacement for my care and need immediate attention, it will be necessary to contact your medical provider or to **go to the hospital of your choice** for obstetrical services.

Specific Services: I see clients regularly on Wednesdays, 11am to 4 pm, and overflow appointments Thursday afternoons, 1 to 5 pm. My appointments are scheduled on the hour to allow a leisurely 60 minutes for each visit. Between appointments you can reach me by phone or pager.

First Prenatal Visit: After our consultation, I will schedule an intake interview and initial prenatal assessment which includes your personal and family health history, a pregnancy-related exam and (with your permission) drawing or arranging for necessary lab work. If you so desire or if there is a serious concern about the pregnancy (including due date) or about the baby, I will refer you for ultrasound and/or genetic counseling and associated tests as appropriate.

Please note -- I do not perform a full-scale physical exam (eyes, ears, throat, listen to your heart and lungs, breast exam, etc) nor do routine gyn exams such as pap smears. If you are not seeing a physician concurrently during your pregnancy and/or have not had a physical exam or routine tests such as a pap smear within the last 12 months, we recommend that you schedule a medical appointment with a doctor, nurse-midwife or clinic in order to receive these important services.

Scheduled Care: Prenatal visits are scheduled every four weeks from 12 to 28 weeks, every 2 weeks from 30 to 36 weeks and weekly there after. About 3 weeks before the baby is due a prenatal home visit is made. After the baby is born, a minimum of two postpartum (PP) home visits are made (more as indicated). They include help to establish breastfeeding. Both mother and baby are seen in the office at two and six weeks PP. Scheduled visits for second nine months care are at 3, 6 and 9 months.

Routine Antepartum Care: I schedule routine prenatal visits on a regular basis, with a full assessment of maternal and fetal wellbeing at each visit. This includes an interview on your physical and psychological wellbeing -- appetite, sleep, any illness, signs of complications or pre-term labor, how often the baby moves, any emotional or family upsets, etc. Then I do a standard prenatal assessment including blood pressure, deep tendon reflexes, tracking uterine height, fetal heart tones, fetal position & size, amniotic fluids levels and additional lab tests if indicated. Return prenatal visits usually takes about 25 minutes, leaving plenty of time to discuss social and psychological topics, answer questions and address your concerns about labor, birth or the new baby.

Standard diagnostics evaluations during 2nd & 3rd trimester: AFP at 16 weeks, ultrasound at 18 weeks for fetal anatomy, gestational diabetes screening at 24-26 weeks, antibody screening at 28 weeks for Rh-negative mothers, repeat CBC at 30-32 weeks (blood test for anemia & platelets), GBS culture at 35-37 weeks, herpes culture if indicated, additional ultrasounds as needed, NST if questions about fetal wellbeing, biophysical profile for post-dates. With appropriate informed consent, you may decline the above listed tests unless critical to my continued care.

Home Visit at 37 Weeks: I do a home visit in order to find your house, meet your spouse (and other family, friends who may be present during labor), do your normally scheduled prenatal care, discuss what supplies your need, how to recognize labor & time contractions, when to call me,

what to expect during labor, etc. Last but not least, I conduct a 'practice labor', which is a walk-thru, talk-thru of the stages and phases of labor and how to help your family help you to best cope with early labor. This is meant to compliment, not replace, standard childbirth education classes.

Early Labor: I ask mothers to call me whenever they think they might be going into labor. This phase normally lasts from 4 to 48 hours, during which we will be in frequent telephone contact and I may even make a house call(s) to evaluate the situation. You must continue to eat, drink, void regularly, walk about during the day, rest at night and, as much as possible, retain your sense of humor.

Intrapartum care: I and/or a qualified assistant will come to your home to be with you from the time your labor is well-established (usually about 4 centimeters cervical dilation, earlier if needed) until you and your baby are in stable condition after the birth (approximately 2 to 4 hours). Midwife presence for a first time mother usually spans 10-15 hours.

Equipment and Supplies: We bring standard midwifery equipment and disposable supplies for normal labor, birth & immediate postpartum. This includes fetal/maternal monitoring equipment (Doppler, BP cuff, stethoscope, etc), portable electronic fetal monitor, sterile delivery instruments, local anesthetic, sutures, baby scales, oral vitamin K and comfortable measures such as drinking straws, heating pad, shower stool, birth stool and various other supplies. I also carry standard emergency drugs, sterile needles and syringes, oxygen, IV fluids, pulse oximetery and neonatal resuscitation equipment for first-responder care in case of a maternal, fetal or neonatal emergency.

"Nativity Card" ~ Birth Record for Baby's Doctor: To facilitate the immediate interface between the midwifery and pediatric care system, a one-page synoptic record of birth and newborn care, called a nativity card, is filled out after the birth and left with the parents. This permits you to carry a brief neonatal record to the baby's first pediatric appointment or to provide a record to paramedics should emergency medical care be required. Photocopies of the baby's entire chart will be available later.

The new baby's nativity card provides my name and phone number, parents name and address, elemental information on the mother's health history, blood type & Rh, diagnostic tests during pregnancy, GBS status, time the water broke, the length of the labor, circumstances of the birth, any interventions required, baby's 1 & 5 minute Apgars, immediate neonatal care rendered by the midwives, findings of the newborn exam, (including weight and other measurements), whether Vitamin K and eye prophylaxis were administered and relevant information from any house calls during the immediately postpartum/ postnatal period.

Postpartum/Postnatal Visits/Birth Certificate: I and/or a qualified assistant will provide home visits 30-40 hours postpartum and again (3^{rd} or 4^{th} day), unless a complication requires earlier home visits or referral to

between 72-90 hours problem or possible or more frequent medical care. see mother and baby schedule an county Office of baby's birth

Assuming no problems, I will at two and six weeks. I also additional appointment at the Vital Records to file the certificate.

Outcome Statistics for Planned Home Birth Clients: During the previous 4 years (2000-2003) our small practice provided midwifery care for a planned home birth (PHB) to an average of 20 families a year or a total of 79. Nine mothers risked out before labor due to prematurity (4) or postdates pregnancy with hospital induction (3). The final PHB cohort had a total of 70 women, 39 expecting a second or subsequent baby (multiparas) and 30 expecting a first baby (primiparas).

- Total normal vaginal birth rate for ***all PHB clients*****: 96 %** (68 out of 70)

Stats for mothers who began labor at home in anticipation of a PHB:

- Completed planned home birth rate was **84 %** (58 out of 70) of which 39 were multiparas and 18 were primiparas, obviously a 100% NSVD for home
- Spontaneous birth rate @ **hosp** (NSVD) **84 %** (10 out of 12)
- Cesarean rate for all PHB moms: **6** % (2 first-time moms or a ratio of 1:35)
- Material choice cesarean 3 % (1), medically necessary **3** % (1)
- Total hospital transfer during labor or immediately after birth: **20** % (total # 14 >> 12 during labor, 1 neonatal, 1 PP/retained placenta, out of 70
- Elective transfer rate/number for multips: **0**
- Elective transfer for first-time mothers in labor **40** % (12 out of 30 moms)
- Emergency transport of mothers or newborns: 0.7% (1 newborn)
- NICU admission of newborns 0.7% (1, for evaluation only)
- The reasons for transferring mothers in labor or immediate afterwards are 1. prolonged ROM / non-progressive labor (t. 7) 2. desire for pain medication (t. 5) 3. retained placenta (t.1) 4. newborn evaluation (t. 1)