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|  | **Special Circumstance Informed Consent/Informed Refusal** |
| **ACDM** | **Twin Gestation, vertex at Term in Multip** |

**Mennonite Order Of Maternal Services**

*"Sevire Humanitas Est Servire Deo"*

**Special Circumstance Informed Consent/Informed Refusal**

RE: Twin Gestation

[Outcome](#30j0zll)

May 12, 1995

Mother: Maggie R, Gr.2, P.1, EDC 5/30/95

Father: Darin M

After receiving extensive information regarding risks and current medical criteria for managing multiple gestations, the parents have declined prophylactic hospitalization & obstetrician care for labor and delivery. The mother is a gravida II who is free of pre-existing disease and has completed 37 weeks of pregnancy. Her first child was a normal spontaneous vaginal birth at home under the care of a midwife. Sequential ultrasounds reveal a normal twin gestation without evidence of congenital anomalies. There has been no antepartum bleeding or polyhydraminosis. Placenta is in the upper pole of the uterus and without evident pathology. Fundal height was 41 cms on 5/3/95. According to ultrasound examination, both neonates are approximately 6# each and in a vertex position with twin "A" being well engaged in the pelvis.

No California state law defines childbirth to be a medical or pathological condition or requires a mother to seek out medical or midwifery care during the pregnancy or to be attended a doctor or midwife during labor and birth. Neither residency nor status as a bona fide citizen of California obligates the state of California to provide care or payment for care rendered to pregnant women. Any voluntary arrangements made by the mother for ante or intra or postpartal or postnatal care are above that required by California law.

After appropriate informed-consent discussion, the parents have requested domiciliary maternity care under the religious exemptions clause (Article 3, Section 2063). It was emphasized that Maggie's situation does not fall within the generally-accepted definitions of low-risk pregnancy. However, in the presence of full disclosure of risks, it is acknowledged that the final decision properly belongs to the parents. They remain committed to home-based care except in the event of a bonafide emergency or evident pathology of either mother or neonates.

The major identified risk associated with a twin gestation is prematurity. Secondary risks include increased incidence of congenital malformations (co-joined twins) and intrauterine death due to dysfunctional circulation in which the blood from the smaller/weaker twin is transfused into the dominate twin. A subclinical variety of this may result in great difference in the size of the two babies, with one being seriously anemic and the other polycythemic (excessive number of red blood cells). Identified maternal risks include anemia, toxemia and polyhydraminosis. During labor the major identified risks are a dysfunctional or non-progressive labor due to the over-distention of the uterus. Maternal-infant risks associated with the birth are breech or non-deliverable positions of one or both babies, cord accidents affecting the second twin and fetal distress caused by placental dysfunction resulting from of significant delay (30+ minutes) in delivery of second twin. Maternal complications are primarily excessive bleeding due to larger surface of the double placenta and uterine atony secondary to over-distended uterus.

Of the above listed risks and complications, only those associated with cord accident, delay in delivery of second twin and increase risk of postpartum bleeding are germane to Maggie's uncomplicated term pregnancy. Intrapartal risk category is moderate.

Narrative:

This is to document the nature and content of informed-consent conversations with the parents regarding the known and unknown risk factors associated with twin gestation which could result in serious and/or life-threatening complications.

Background:

This mother's first child was born at home 7 years ago. She sought out domiciliary midwifery services for this pregnancy but changed to hospital-based obstetrical care when the twin pregnancy was discovered. She is being followed antepartally by a group practice at \_\_\_\_\_\_\_\_\_ Hospital. Dr. \_\_\_\_\_\_\_\_\_\_\_ is her primary careprovider. She was last seen by him on 5/10 (37 weeks,+1 day). According to Maggie, he reported that her pregnancy continued to progress normally and that both babies remained in a vertex position, performed a vaginal exam and striped her membranes. She also took a tour of the hospital facilities.

Maggie initially contacted me at 32 weeks to arrange for home-labor, hospital-birth support. In our initial phone conversation she expressed an expectation that her pregnancy would conclude in a premature birth as she had been told that early delivery of multiple gestations was the norm. I talked at length to her about the desirability of carrying her twins to term to avoid the need for them to be admitted to the Neonatal Intensive Care Nursery. I suggested that it was appropriate to expect a normal, 9-month gestational period and discussed diet, mental habits, life-style adjustments and prayer as methods to facilitate the continuation of her pregnancy to term.

I saw her at 33 weeks (4/12/95), 35 weeks (4/26/95) and 36 weeks (5/3/95) in preparation for home/hospital support. During this time I spoke with her several times on the phone and made a home visit. We discussed the relative benefits and risks of prophylactic hospitalization at length, as Maggie frequently expressed concern about medical care for normal childbirth.

Benefits of prophylactic hospitalization were noted to be immediate access to operative delivery should a cord prolapse occur after the birth of the first baby. Maternal risk was identified to be increased possibility of excessive bleeding during the immediate postpartum period due to over-distension of the uterus and the larger placental surface. Maternal benefit of hospitalization for labor and delivery were identified as prophylactic IV fluids with immediate accesses to intravenously administered oxytocin, plasma-expanders and blood transfusion.

It was noted that hospitalization would *not* change or reduce the incidence of maternal-infant complications such as failure-to-progress, malposition of the second twin, cord accidents, respiratory distress, infection, genetic defects, cerebral palsy or the rare complications of childbearing. However, more immediate intervention or treatments of some of the conditions listed above is statistically associated with improved outcomes.

Also discussed were the unpredictable risks associated with hospitalization for normal childbirth -- ie. increased use of pitocin augmentation of labor resulting in iatrogenically induced fetal distress, and operative delivery, particularly cesarean section; nosoconical infections of mother and/or babies; medication errors, drug reactions, anesthetic accidents; surgical mistakes such as inadvertent cutting of bladder or bowel, tying off a ureter, surgical laceration of baby; neonatal respiratory distress; wound infection; operative or post-operative maternal hemorrhage necessitating blood transfusion with concomitant risk of allergic reaction/shock and exposure to diseases carried by blood products (hepatitis, HIV). This latter category of complications could conceivably put the father and siblings at risk due to their communicable nature and untreatable status. Very rare neonatal complications of hospitalization include mix-up of babies or abduction from the hospital.

**Management plan for this family is as follows:**

1) Continued OB consultation, with prophylactic hospitalization in the presence of an identified medical complication.

2) Due the added complexity of twin birth, the presence of second experienced midwife & and a double oxygen set-up is planned. Contact with district paramedics to establish safe protocols for emergency transfer in case of a cord accident (mother in knee-chest position). Parents live within 5-7 minutes of a major medical center (\_\_\_\_\_\_\_\_\_ Hospital) and there are no physical barrier to their home nor inclement weather or road conditions that would delay emergency transport.

3) Criteria for domiciliary birth defined as SOOL of a briskly progressive nature, accompanied by progressive dilation of cervix and normal decent of fetal head. Absence of indicators of normalcy will result in intrapartal transfer to hospital.

4) Presentation of second twin in vertex position with NO evidence of fetal umbilical cord prolapse. Re-establishment of labor should occur within 30 minutes

5) Criteria for elective transfer of care or emergency transport by EMTs -- inadequate forces of labor, non-progressive labor, other standard indications of diminution of fetal or maternal wellbeing, such as antepartal bleeding, neonatal respiratory distress, retained placenta or excessive postpartum bleeding

Parents have agreed to abide by these criteria and precautionary measures. Dr \_\_\_\_\_\_\_\_ is to be apprized of the change of plans.

Prayer requested by parents for:

Continued normalcy, timely and spontaneous onset of a briskly-progressive labor, normal birth of both babies, speedy expulsion of the placenta with no excessive postpartum bleeding

Prayers by practitioner for:

Good outcomes for mother and babies and practitioner guidance regarding management of the situations present during the intrapartum, and wisdom in carrying out caregiver functions

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Midwife: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Outcome: Twin babies born at home, 39 wks 6 days after a 3 1/2 hour labor. Eight pound baby boy at 7:11 am, second baby, 7 1/2# boy at 7:22, huge placenta at 7:39 am. No drugs or treatments of either mother or babies required.**

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