Helping the Obstetrical Client Have a Positive Hospital Birth

Sharon E. Delaney, MPH, CNM

Abstract

Birth is a pinnacle experience for most woman. Typically, it is a carefully planned event, and hopes are high for a satisfying experience. The naturopathic physician can empower a client, through education and emotional support, to have a fulfilling birth experience. Sometimes the birth occurs at the client's home, while other times, and for a variety of reasons, birth occurs in a hospital. One challenge for naturopathic physicians is to help every women have a positive birth experience, regardless of the location of birth. This paper addresses issues related to hospital birth and presents means for the naturopathic physician to empower a childbearing woman to ask for and receive the care she wants for herself and her newborn.

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Many factors affect a woman's birth experience. The intent of this paper is to address those issues related to the hospital setting. The health care provider who is knowledgeable about current hospital practices and procedures can provide the bridge that supports birthing women and their families to have a peaceful, spiritually moving, and successful experience independent of location.

The Role of the Naturopathic Physician

There are a variety of ways a naturopathic physician can help assure pregnant clients have a fulfilling birth experience. Helping the mother to maintain a healthy pregnancy through good nutrition and naturopathic wellness prepares her body for birth and prevents complications. A supportive and professional relationship helps her deal with emotional issues and gives her confidence in the process ahead. Education empowers the birthing woman to ask for and receive the care she wants for herself and her newborn.

Montana State University College of Nursing
Missoula Upper Division Campus
32 Campus Drive
Missoula, MT 59812
406-243-2590

The role of education cannot be overemphasized in the naturopathic care of childbearing women and families. Many clients have preconceptions about pregnancy and birth. As a result, they may enter prenatal care with fears, anxiety, and misperceptions. The practitioner can allay these fears by careful presentation of information in such a manner that the woman feels informed and at the same time confident in her ability to give birth. Childbearing must be presented in a manner that promotes it as a normal, safe, and natural process. If this message is communicated to women and their families, their expectations for a positive birth experience are more likely to be realized. Indeed, feelings of confidence, self-reliance, and an internal locus of control are all predictive of a successful birthing experience (1). Further, a practitioner's proactive involvement in planning with a couple for their birth helps assure a fulfilling, growth-enhancing experience with realistic expectations (2).

The next step in preparing to work with obstetrical clients is for the ND to become familiar with the local hospital. A tour with an experienced nurse or maternity unit supervisor provides useful information about the facility. It also helps the doctor determine nursing staff and administrator responsiveness to

home birth and to women who come to the hospital following a home birth attempt. Further, in the event of a future failed home-birth, this interaction opens communication and promotes an atmosphere conducive to problem-solving ways to help women make the transition from home to hospital. To build trust and collaboration, the doctor should remain professional and confident in his/her knowledge and experience as a primary care provider.

Next, the naturopathic doctor should research the medical community to determine which hospital-based providers are receptive to alternative health care. It may be helpful to arrange a meeting with those whose reputations indicate an openness to choice. If the ND attends home births, it may help to share home birth practice protocols, including criteria for referral or hospital transfer. Protocols also should address standards and processes for documentation.

It is important to understand the scope of practice of various providers. A certified nurse-midwife's practice is generally limited to low-risk mothers. She is required to have a mechanism for physician consultation, collaboration, and referral. So, if the naturopathic doctor primarily refers a woman to a nurse-midwife for in-hospital care, the physician with whom she collaborates will be responsible if complications warrant physician intervention.

The CNM typically has a strong client/ family-focus, with an emphasis on health promotion, client advocacy, and client self-determination. Interventions typically are kept to a minimum. Further, CNM-attended births are less likely to be cesarean and neonatal mortality rates are lower. These improved statistics are at least partly due to the fact that prenatal care is quite focused on education, nutrition, and psychosocial preparation. Also, more time is spent with clients at prenatal visits and during labor and birth (3, 4).

There are two primary types of physicians to whom an ND may refer for pregnancy care. An obstetrician/ gynecologist has the most education and experience in high-risk pregnancy management. Therefore, this may be the most appropriate referral if a client has significant health risks or complications. However, a family practice physician might also have substantial obstetrical education and experience. It is essential to assess the individual practitioner's obstetrical preparation, experience with complications, ability to perform cesarean births, cesarean birth rate, as well as total number of births attended each year.

Choosing a Facility

Childbearing families should be encouraged and empowered to gather their own information concerning hospital birth. Information is power, and knowledge gained helps allay anxiety about an upcoming hospital birth. If more than one hospital is available in the area, mothers-to-be or couples should evaluate each one for receptiveness to consumers. If there is only one hospital locally, and it becomes apparent that it is not a family-friendly place, these childbearing consumers can be effective in demanding changes. This is perhaps the most effective way to institute changes in a hospital, far more effective than health care providers' demands. Dollars speak loudly in these days of managed care, and hospital administrators want to encourage business by making their hospitals more attractive.

It is essential that clients know the hospital environment prior to entering labor. An important first step for families is to tour the hospital. Examples of issues to address during a tour include:

- Specifically, where do births take place? (see discussion below)
- Is there a mechanism for waterbirth, such as a bathtub or whirlpool? Many hospitals are retrofitting birthing units with whirlpools for labor hydrotherapy (for more information on hydrotherapy and waterbirth, see 5, 6).
- Is electronic fetal monitoring used? If so, by what criteria? Can monitoring be done intermittently, so the woman can freely ambulate throughout labor?
- Regarding intake, are foods/ fluids limited in labor, or is the client free to make her own choices? Is establishing intravenous access a routine intervention, or is this individually determined?
- Are there other interventions routinely done to laboring women? (e.g., shaving of the pubic area, enema, bedrest); how would one pursue refusing any of these, if doing so has no negative effect on birth outcome?
- What safety nets are in place? Specifically, if an emergency birth became necessary, how long would it take to assemble the surgical team? Is there 24-hour anesthesia coverage? Are all birthing rooms fully equipped for maternal and newborn resuscitation?
- How is the father of the baby involved throughout the birth and hospitalization? Are there any restrictions to his presence? What happens in the event of cesarean birth? (Most hospitals allow and encourage full participation of the baby's father, and most allow fathers to be present for cesarean births. Some hospitals will bring in a bed for fathers to stay overnight during the postpartum period. Others are equipped with double or queen-size beds.)
- Are there visiting hours or is it open visiting? If there are specific visiting hours, to whom do these apply?
- Is there a restriction in the number of support people present during the birth? (Some hospitals limit this, while others leave it to the birthing mother.)
- Siblings: many families who have older children want their child(ren) present for some or a portion of the birth. Is the hospital receptive or restrictive?
- In this day of extended families living so far apart, more and more women are choosing to have a doula (a professional labor support person). Is the hospital comfortable with her presence and active participation? If not, who can the couple talk with to facilitate changing this policy?

In addition, for postpartum care, clients should ascertain the following:

- Are there lactation consultants on staff to assist new mothers and babies with lactation initiation and management?
- Are there provisions for shortened hospital stays, such as a home visit by a nurse and/or phone follow-up? What are typical lengths of stay for vaginal birth and for cesarean birth?
- If the baby is unwell and needs to stay longer than the mother is

allowed (many insurance plans and state medical plans limit stays to 2 days), what provisions are made for rooming-in by the mother? Is there a fee for this? Is the father also allowed to stay?

For families desiring early discharge, there are certain criteria typically that must be met. For the newborn, these include:

- Baby appears normal and healthy per physical exam.
- Baby has voided and stooled.
- Effective breast-feeding is established.

For the mother:

- There have been no complications and she had a normal labor, birth, and immediate postpartum course.
- She is afebrile with stable vital signs.
- Fundus is involuting and spontaneously maintains firm tone with scant/moderate lochia flow.
- She is out of bed and eating, drinking, and voiding without difficulty.
- Pain is manageable either with pharmacologic or nonpharmacologic methods.
- She is educated about breast-feeding and the process is well initiated.
- She has knowledge of normal newborn care.
- Both mother and baby have excellent supports at home.

In addressing the specifics related to place of birth, there are many possibilities. A few hospitals continue to have mothers labor in one room, give birth in a delivery room (which looks similar to an operating room), transfer to yet another room to "recover" then finally move to a postpartum room until she goes home. However, most hospitals now have a birthing suite (also known as a labor-delivery-recovery-postpartum room, or LDRP), in which the mother gives birth and has her postpartum stay in the same room. There also is a modified version of this standard, known as a labor-delivery-recovery room (LDR). Following birth, the birthing family transfers to a separate unit for the postpartum portion of their stay. In both the LDR and LDRP, nursing care supports the mother-baby concept. This standard of care encourages and promotes baby-friendly care by keeping mom and baby together and encouraging and fully supporting breast-feeding.

Regardless of the hospital's physical structure, a woman can request to birth in the same bed in which she labors. However, this request should be discussed with her practitioner well in advance of labor, and it may need to be clearly written as a physician/nurse-midwife order in her chart to prevent a patient's request from being ignored.

Pain Management

In anticipating a birth, an issue about which many women are concerned is intrapartal pain management. Any woman approaching childbirth can benefit from the information and coping tools provided by attending a childbirth education course. Education is the cornerstone to readiness for childbirth, and a well-taught course will help the mother and those supporting her feel more prepared for labor. Prepared women are less likely to use pain medication and more likely to have a spontaneous vaginal birth (7).

Pain relief interventions should center on the use of nonpharmacologic techniques, such as therapeutic massage, water therapy (5, 6), music (8), acupuncture (9), and hypnotherapy (10), with medications being used only as needed to supplement these techniques. A woman who knows about her options approaches childbirth from a positive and self-empowered perspective. She is more likely to be an active participant in her birth and the decision-making that occurs at various junctures throughout the birth process.

As part of the patient education process, it is necessary to understand some factors related to labor onset and the role of narcotics in labor and their potential effects on a fetus. Oxytocin receptors are uterine receptors that coordinate and intensify uterine contractions. These receptors significantly increase in number during or just prior to labor onset. In the latent phase of labor (the phase in which the cervix dilates to 4-5 cms.), the uterus still has relatively few oxytocin receptors. As a result, contractions are not well organized and can easily be disrupted by exogenous influences. Narcotic administration is one such influence that can disorganize contractions, making them weak and ineffective. Therefore, unless the intent is to disrupt labor progress (as with preterm labor), narcotics should be reserved for active labor, when the uterus is less susceptible to disruption of contractions. Medications more appropriate for latent phase labor are ataractics, such as hydroxyzine or promethazine. These reduce anxiety, are moderately sedating, and do not slow labor progress.

There is an exception to the rule of not giving narcotics in early labor. When a woman has had a prolonged latent phase without cervical dilation, it may be effective to administer a narcotic to break the current contraction pattern. The usual outcome in this case is that the woman sleeps for several hours, allowing time for an increase in oxytocin receptors. She then awakens in active labor, with improved synchrony of uterine contractions and a more effective labor pattern (11).

A potential adverse effect of narcotics is fetal respiratory depression. Some narcotics, in particular meperidine and morphine sulfate, agonize the pain receptors (specifically, mu and kappa) which also affect respirations. In the doses used, and for the short term, the mother rarely develops respiratory depression. However, the newborn can be significantly depressed, necessitating newborn administration of naloxone, a narcotic antagonist. To minimize the risk of this, narcotics such as butorphanol are frequently used in labor. Butorphanol is an agonist/antagonist. It exerts its effect on pain receptors, but acts as an antagonist to prevent stimulation of the pain receptors that also cause respiratory depression. (A caution, though: agonists/antagonists should not be used if narcotic addiction is suspected, as their use can precipitate acute narcotic withdrawal.)

Although the long term effects of narcotics on the fetus/newborn are not known, their use can inhibit early maternal-newborn attachment. Both mother and baby may be sleepy, a condition which makes initial interactions, including breast-feeding, more difficult and less satisfying. Some narcotized newborns have difficulty maintaining their body temperature, which can result in hypothermia. Also, some narcotics prevent metabolism of a newborn's brown adipose tissue, which can inhibit both thermogenesis and gluconeogenesis, leading to hypothermia and hypoglycemia (11).

However, narcotics do have a role in labor, and should not be universally maligned. Labor causes a release of catecholamines that, among other effects, enhances maternal oxygenation and makes the newborn more alert and responsive at birth. However, severe and unrelenting pain and stress from a long or difficult labor can result in a fight-or-flight response, with its corresponding excess maternal catecholamine release. Blood flow is reduced to the viscera and redirected to skeletal muscles. Uterine blood flow is diminished, resulting in insufficient utero-placental oxygenation and fetal distress. Therefore, when indicated, administering narcotics can improve fetal oxygenation by reducing pain perception and subsequently breaking the cycle caused by pain, stress, and subsequent catecholamine overload (12, 13,14).

Many hospitals also offer epidural and intrathecal analgesia for pain relief. If these are offered, the client would be wise to speak with an anesthesiologist prior to labor both to determine his/her experience level and the safety, efficacy, risks, and benefits associated with each method. Also, a well-informed naturopathic physician can be a source of substantial information which will assist the client's decision-making. Nicholson (15) and Taylor (16) provide excellent overviews of epidural anesthesia and the medications used.

It is essential that a laboring woman understands that accepting regional analgesia (anesthesia if she has complete neuromuscular blockade) may activate a somewhat inevitable chain of events. In essence, when a woman accepts one intervention, the very act of accepting a procedure or intervention may necessitate her accepting another and then another, and so on. For example, if a woman decides to have an epidural, she then will have an IV placed, with a fluid bolus to offset the likelihood of drug-induced hypotension. Continuous fetal monitoring is initiated and she will have a BP cuff placed for frequent vital sign measuring. She may have a pulse oximeter applied to her finger to measure oxygen saturation which, in turn, may lead to a diagnosis of hypoxia and subsequent initiation of oxygen therapy by face mask. Medication-induced hypotension can lead to transient fetal distress with another set of interventions. Urinary retention may necessitate use of a urinary catheter.

In regard to labor progression, regional analgesia/anesthesia commonly reduces contraction intensity, which then necessitates intravenous pitocin to augment labor. During second stage, pushing may be ineffective with an anesthetized pelvic floor. In unmedicated birth, pressure of the fetal head on the pelvic floor triggers Ferguson's Reflex, and the woman experiences a natural urge to push. However, regional anesthesia abolishes this reflex. The resulting diminished pushing efforts may require coached pushing or interventions such as a vacuum extractor or forceps (17).

Of course, many women choose to use analgesia when giving birth, usually with no adverse outcomes, and with substantial relief from pain. However, fully informed consent is essential to a woman's making an optimal choice for herself and her newborn. Ultimately, the decision is her own, and should be fully respected and honored.

Herbal-Drug Interaction

If a client has been given herbal preparations to promote labor or cervical ripening, she should bring to the hospital a list of those she has recently used. A few herbal preparations can interact with medications, leading to confusing vital signs or symptoms. For example, in one instance a woman who had planned a home birth developed extended prodromal labor with failure to progress and was subsequently transferred to hospital. When she arrived, her blood pressure was elevated and she had a severe headache. Pregnancy-induced hypertension was suspected. Upon questioning, she related that she had been taking high doses of *Caulophyllum thalictroides* (blue cohosh) to stimulate labor. Had this not been discovered, she may have been misdiagnosed with pregnancy-induced hypertension and subsequently treated inappropriately.

There may be other herbal medications that interact with pharmaceutical medications, and it would be of great benefit for the ND to provide this information to the MD or CNM. Collaborative management such as this substantially enhances care to mothers and babies.

Interventions to Promote Vaginal Birth

As a primary care provider, the naturopathic physician is in an ideal position to help prepare a pregnant woman for an optimal birth outcome. By educating her about potential obstacles and methods for improving labor progress, the ND provides tools that help the woman make decisions concerning her labor and birth. Below are terms and related management strategies for some of the more commonly found scenarios.

Failure to progress is a too-common rationale for cesarean or other operative birth intervention. This term very generally refers to labor that lasts longer than 24 hours, although wide variations exist in defining this term. According to Friedman, abnormal length of labor occurs in primiparas when latent phase is greater than 20 hours and active phase exceeds 14 hours. Parameters for multiparas are 14 hours and 6 hours, respectively. In addition, second stage upper limits are 2.5 hours for primiparas, and 1 hour for multiparas. However, rather than following these time limits, many practitioners feel that steady progress is a more important predictor of labor outcome. The upper limit rates of labor progress in active phase are 1.2 cm/hour for primiparas and 1.5 cm/hour for multiparas. Secondary arrest of dilatation is diagnosed if two hours in active labor pass with no cervical change. Delay of descent is diagnosed if the station of the fetal presenting part does not change for at least 2 hours (18). Any one of these diagnoses increases the likelihood of interventions and the mother is at risk for exhaustion and dehydration.

Because delayed labor progress is associated with increased risks to both mother and baby, attempts typically are made to improve contraction strength, rotate the fetus to a more optimal position, or hasten labor progress and birth through operative means. However, some of the interventions themselves are associated with increased morbidity, so initial efforts should center on natural means to encourage labor progress.

Early rupture of membranes can lead to a fetal presentation not conducive to good labor progress. The fetal head enters the pelvis in a transverse position. If membranes are ruptured before the head has

rotated to occiput anterior, the head can become wedged into a position which inhibits normal descent. Therefore, when avoidable, rupture of membranes is best avoided or delayed until active phase of labor with the fetal head well engaged in the pelvis in the anterior position.

To facilitate early labor progress in the latent phase of labor, there are several options. Assuming a healthy mother and fetus (which must be assessed in collaboration with the client's birth attendant), walking is an effective method for strengthening contractions. Also, when a woman is walking, the force of gravity enhances dilation by applying the primary force of the fetal presenting part directly on the cervix, allowing for more effective dilation. Another intervention that naturally augments labor is nipple stimulation, accomplished either by a willing partner, a breast pump, or manual self-stimulation. Nipple stimulation promotes the release of endogenous oxytocin, which helps ripen the cervix and causes uterine contractions. Sexual intercourse may also stimulate contractions, both through maternal orgasm which causes uterine contractions, and the introduction of prostaglandin (found in semen) into the vagina, which encourages cervical ripening (intercourse is not recommended once membranes have ruptured, however). Other options include administering a warm water enema, drinking castor oil, or taking herbal preparations such as *Cimicifuga racemosa* (black cohosh), *Anthemis nobilis* (chamomile), or *Oenothera biennis* (evening primrose) (11).

Pharmacological intervention for prolonged latent phase labor is to administer a sedative/hypnotic. The effectiveness of this is enhanced by having the client first take a long warm bath, then swallow the medication and go to bed. Her support person then gives a relaxing massage as she drifts to sleep (11).

Note: latent phase of greater than 20 hours for a primigravida, and 14 hours for a multigravida, may indicate an abnormal progression and needs to be evaluated with the woman's care provider to assure fetal and maternal well-being. Fatigue and dehydration can ensue, which can lead to maternal morbidity and fetal distress.

If back labor is pronounced, the fetus is likely in the occiput posterior (OP) position. This presentation occurs in nearly 25% of vertex presentations. Unfortunately, it misdirects the force of contractions, leading to slower cervical dilation and increased maternal pain, stress, and fatigue. Fetal distress can develop, increasing the likelihood of operative birth. Uterine fatigue increases the risk of postpartum hemorrhage. Interventions for back labor are aimed at encouraging the fetus to spontaneously rotate to an occiput anterior position, which occurs about 70% of the time. Intact fetal membranes are optimal, so avoid early artificial rupture of membranes if possible. (It is noteworthy that OP presentation is associated with early spontaneous rupture of membranes.) Positions that promote fetal rotation are on hands and knees, sidelying (on the side which places the fetal back up), and standing in a forward-leaning position with legs slightly apart, swaying gently side to side. Spontaneous rotation of the fetus may occur at any point in labor. If the fetal head is low in the birth canal, the nurse-midwife or physician can attempt manual rotation. Forceps may be used to rotate the fetal head if it is low in the pelvis. Excellent relaxation of the pelvic floor musculature helps the fetus turn. This is promoted with a whirlpool bath, warm packs to the sacrum, suprapubic area and perineum, or regional analgesia, such as an intrathecal (19).

Newborn Care

Care of a newborn following birth involves several interventions. Some of these will briefly be addressed here. A mother should know that she does have the right to keep her newborn with her at all times. Provided a newborn is healthy and without complications, there is no need to go to the nursery for "observation." Determination of newborn well-being is made with apgar scoring and a physical assessment, both of which can be done at the bedside. Newborn medications can be administered in the birthing room. A chilled baby (a condition which can occur fairly rapidly with a wet newborn, especially if the room is cool) can be placed skin to skin with the mother or father. Breast-feeding can be initiated at this time, which is both a wonderful opportunity for bonding and also provides needed calories.

Apgar scoring is a rough assessment of newborn well-being at 1 and 5 minutes. A score of 0-2 is given for each of 5 areas: heart rate, respiratory effort, reflex irritability, muscle tone and color. A score of greater than 7 is considered normal. Apgar scoring is of limited value in making prognostic predictions. However, its use is fairly universal, and it does provide some indication of how quickly the newborn has adapted to extrauterine life.

Typically, the newborn is administered both a vitamin K injection (Editor's note: see related article, p. 62) and antibiotic eye ointment prophylactically. Vitamin K is administered to prevent hemorrhagic disease of the newborn. Synthesized by the intestinal flora Escherichia coli, vitamin K is a necessary precursor of prothrombin. Since the newborn gut is sterile at birth, production of vitamin K does not begin for several weeks. The injection is given to allow more rapid synthesis of prothrombin. Some health care providers are using oral vitamin K, a practice which is gaining popularity. Antibiotic eye ointment is administered to prevent ophthalmic infection, and possibly blindness, caused by gonorrhea and chlamydia. Administration of both vitamin K and antibiotic ointment are mandated by state health regulations. However, parents have the right to refuse these medications for their newborn, provided they are willing to sign a waiver.

Sugar water feedings are unequivocally outmoded. In the past, some pediatricians mandated a baby's first feeding be glucose water. This was wrongfully thought to be a safer fluid in the event of a tracheo-esophageal fistula. Now, it is known that it is the aspirated gastric acid contents which are harmful, not the type of feeding. In addition, glucose water can contribute to development of hyperbilirubinemia. Its use is inappropriate, and parents should refuse it for their baby (20).

In the event that a baby develops low blood sugar (due to poor ability to feed or illness), administration of formula or expressed colostrum is an appropriate intervention. To prevent nipple confusion in breast-fed babies who need supplementation, cup feeding is now the recommended feeding mode. This is easily accomplished with a small medicine cup in which a few ccs at a time of milk are dribbled into the baby's mouth (20).

Prior to hospital discharge, states mandate that hospitals draw blood for newborn metabolic disorders screening. For the test to be accurate, newborn feeding must be initiated prior to the blood draw. Therefore, the blood draw must be done after 24 hours of age. Disorders that are identified include galactosemia, hypothyroidism, phenylketonuria, homocystinuria, maple syrup urine disease, and sickle cell anemia. Parents should be instructed that this is a screening, not diagnostic, test. Further testing would be needed to make a diagnosis. However, in most cases, these disorders can be controlled with medication or dietary modifications. Therefore, screening is optimal because adverse outcomes, which include mental retardation, physical disabilities, or death, can be prevented by early detection (20).

Physiologic newborn jaundice is a normal condition in which a newborn, typically a breast-fed baby, develops jaundice at 3-5 days of age. Early onset, rapid onset or progression, or marked jaundice, with or without other signs of illness, is abnormal and mandates further evaluation. Anytime a baby is either lethargic/ difficult to awaken or irritable/ inconsolable, has yellow skin tone over most of its body, is feeding poorly, is not voiding or stooling, has a fever or low temperature (>100 or <97.8 degrees F) or appears ill, the pediatrician must be consulted immediately. However, for normal physiologic jaundice, frequent feedings stimulate the gastrocolic reflex to encourage passage of stool. Since bilirubin is excreted in the stool, this helps prevent and resolve jaundice. Also, it is essential that an experienced practitioner monitors breast-feeding effectiveness, as dehydration can lead to dangerously high levels of hyperbilirubinemia, a condition that may result in phototherapy, hospitalization, and intravenous rehydration therapy.

To monitor breast-feeding effectiveness, ask these questions: Is baby well latched on? Are there observable sucks and audible swallows? Does baby fall asleep after a feeding, then awaken at a normal interval ready to feed again? Are there 8-10 wet diapers in a day (4-6 in the first 5 days is normal)? Walker (21) and Chute (22) provide detailed information to help health care professionals evaluate breast-feeding effectiveness.

Next, if there is a draft-free sunny window in which to place the baby, do so. Undress baby so as much skin as possible is exposed. If there is concern about maintaining warmth, have the baby lie skin to skin with a parent or older sibling. The sunlight helps resolve jaundice by facilitating biliary excretion of bilirubin (20).

Conclusion

The decision to have a hospital birth may be made early in pregnancy or, if home birth was anticipated and complications develop, late in labor. It can be a carefully planned process or a rapid decision made in the moment, under less than optimal conditions. Regardless, practitioners owe it to their clients to be knowledgeable, approachable, and technically proficient. This helps assure a positive, safe, and spiritually enriching experience. Both home birth and hospital birth experiences can be richly rewarding, provided the atmosphere is warm, caring, and respectful of a woman's right to self-determination and informed consent. A team approach, in which a woman benefits from the expertise of her naturopathic physician as well as her nurse-midwife or MD, can provide safe, satisfying, and holistic care. The pregnant woman and newborn can only benefit. And, the practitioners can feel satisfied that their collaborative efforts have helped another family get an optimal start in welcoming a new family member into their lives.

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Biography

Sharon Delaney is an assistant professor of maternal-newborn nursing at Montana State University and a certified nurse-midwife in private practice at Missoula OB/GYN Associates in Missoula, MT. She received a Bachelor's degree in Nursing from Duke University and a Master's in Public Health from the University of North Carolina at Chapel Hill. Her nurse-midwifery education and certification is from the Frontier School of Midwifery and Family Nursing in Hyden, KY. She is Board Certified through the American College of Nurse-Midwives (ACNM) Certification Council.

Ms. Delaney has been published in Pediatric Nursing, and has been a special reviewer for maternal-newborn nursing and other health care publications. Research interests include maternal adaptation, breastfeeding, and children of divorce. She is an active member of ACNM and the Association of Women's Health, Obstetric, and Neonatal Nursing (AWHONN).