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Sarah Trott: [00:00:05] Hi I'm Sarah Trott and welcome to the Fourth Trimester podcast. I'm a new mama and this podcast is all about postpartum care for the first few months following birth. The time period also known as the fourth trimester. My postpartum doula Esther Gallagher is my co-host. She's a mother, Grandmother, Perinatal educator, Birth and Postpartum Care Provider. Fourth trimester care, our topic is [00:00:30] about the practical emotional and social support parents and babies require. And importantly it helps set the tone for the continuing journey of parenting.

Sarah Trott: [00:00:44] And we're here for part three. The final episode about birth plan or birth intentions. so let's pick up where we left off. I wanted to talk a little [00:01:00] bit about induction and C section.

Esther Gallagher: [00:01:03] Yeah so I think it's common for folks to think that if they have to have an induction or have a plan c section or if in the course of their labor they have a c section, then all preferences basically go out the window and they're going to have you know internal experience but I won't just be the person that says out loud that [00:01:30] that does not have to be the case. Induction can be quite natural and can be experienced the way a natural childbirth would be experienced so long as your birth team are people who can really support you in having that natural childbirth. And so all the things we talked about in terms of birth preferences previously could still be the case even if you have to show up in hospital and [00:02:00] go through a process that's mediated by little more intervention.

Esther Gallagher: [00:02:08] It doesn't have to be one that you can't get through with out avoiding where possible, drugs epidural etc. it does mean that you might want to really talk with doula who feels skillful around supporting people during induction and knows [00:02:30] how to help partners understand the importance of intimacy for a mom who's going through induction and all the things we've talked to in the past. So if people can kind take the fear out of it and grieve for that wished for you know going into labor naturally on their own they can kind of process that for the time being set it aside [00:03:00] and just be part of their birth story rather than "The thing that made everything go to hell", I think people can actually have a wonderful experience with

induction so long as everything stays relatively healthy.

Sarah Trott: [00:03:20] And if someone's induced do they have to remain at the hospital?

Esther Gallagher: [00:03:24] Yes. Yeah. Part of the reason for that is that they want to be sure you are responding [00:03:30] to the medicines that they're giving you to get you into labor and move your labor along in a healthy way especially your baby. So typically one of the things we talked about this at the end of last week's podcast one of the things you also have to relinquish is intermittent monitoring because they really to want to be sure [00:04:00] your contractions are normal in strength in duration and your baby can tolerate them because these medicines you know sometimes a woman's body will respond to them in ways that are a little kind of going overboard.

Esther Gallagher: [00:04:18] But I just want to say for the record that i've been at perfectly natural childbirths where women have Labors that just their babies couldn't [00:04:30] tolerate you know everybody's involved in this and everybody needs health care during this process whether it's at home or at the hospital and one of the things that they're going to be careful of on your baby's behalf is that they can actually tolerate the contractions that you're having. So while I think we need new technology for fetal monitoring I think it's right around the corner I hope because [00:05:00] of the discomfort to mothers. I do think that you know babies also need to be attended to during the course of labor and so finding a way to do that in a healthy way. You know there are some indications that go so well that they do intermittent monitoring and in any case it depends on your nurse hands on her doctors midwives what they think is going to be the best route for your course of Labor. [00:05:30] And part of that depends on why you're being induced. So let's move on to Cesarean birth and our preferences for the person this was written for. They've written "should it be necessary, We would like both of us and our doula in the operating room. please perform [00:06:00] delivery respective of as much of our birth preferences as possible. allow parents immediate contact with baby and for as long as possible and allow them to remain together while Surgery is completed. if I'm completely under general anesthetic as ever since I like my husband to be Present for my husband to hold my baby first and throughout my procedure. So it's going to be very very rare that those [00:06:30] preferences as stated are going to be granted and mothers are under general in the OR they don't let anybody in you know

typically. Now do I think that's good practice. Not impressed with that. I think the family should stay together even when things are scary and stressful. But I think the history of this procedure is such that they really reduce any wildcard effect. At certain [00:07:00] hospitals they only allow one care provider in the room with a mother during a C-section when there's not general anesthesia. So if there is an epidural or a spinal then you can have one. Care Provider With you during the course of that. So that's a conversation that you would also have with your [00:07:30] partner and doula to about you know who's prepared to be in the OR what will their focus be. The reason I always think it would be nice when both doula and Partner can be in the room Of course in most families the desire is so a family member can be in physical and emotional and social contact with the baby as soon [00:08:00] as possible.

Esther Gallagher: [00:08:01] Right. And so in the OR once the baby is born baby and the cord clamped They usually take the baby to the warmer and pediatricians are examining the baby. And so the partner can go to the warmer, greet the baby say hello talk to mom who's not very far away and tell her oh you know they're doing well and you know [00:08:30] or whatever. So there's a way of staying in voice contact during the procedure if possible. And then you know there is something we now refer to as Family-Centered C-section where actually they do put the baby on the mom and they do lower the screening. You know you just get to see more and participate in more. That's just such a lovely thing. unfortunately it's [00:09:00] not standard operating procedure. You do have to find the team that's willing to do your C-section birth that way.

Sarah Trott: [00:09:10] I just look at movies and I think that's that's always what happens: Mom's awake, she's sort of out of it, they put the baby on her chest and she says oh my baby first that is like a three month old. what determines why a person would be put under general anesthesia? [00:09:30]

Esther Gallagher: [00:09:35] typically An emergency C-section is going to be one that results from a baby going into deep distress and that they're they're not probably getting enough oxygen for some reason. We typically imagine that that is a cord problem. wrapped around their neck or pinching [00:10:00] between the baby's bones and a mother's pelvis or something like that.

Esther Gallagher: [00:10:10] We can't always determine it in advance but we're imagining there just isn't enough placental oxygen diffusion to keep that baby afloat.

Sarah Trott: [00:10:22] I had friends who told me 35 years ago [00:10:30] and she had her baby born with a cord around the neck and that person is fine. but that they were blue. Yeah they definitely had oxygen issues.

Esther Gallagher: [00:10:44] Yeah. So the thing could have to do with the cord and probably but not always you know it's interesting that babies can be born with tight cords around and recover very quickly [00:11:00] and it wasn't necessarily an issue during the birth. And then of course it can be a real problem if the cord is short or if there's many loops around the baby and therefore the cord doesn't have the runout room to make it all the way out the pelvis then the baby might not emerge. So at some point that's going to show up as this baby's not coming out and maybe isn't going to. maybe now their not having a good time. [00:11:30] So you know a mom who's struggling to push a baby out just isn't descending no matter what is tried is plausibly going have a C-section the baby isn't in distress right. If the assessment is Oh well still way high in the pelvis hasn't descended all you know maybe they're going to capit but there's no bones coming down that [00:12:00] maybe that's narrow. Right now in the old days this was an excuse for a lot of unnecessary C-sections.

Esther Gallagher: [00:12:08] They could just say you know after you push three times oh, your baby can't get out or even your baby can never get out so you might not want to birth. So we're very you know we have this legacy of the past of altogether unnecessary C-sections and a high rate of C-sections being performed. [00:12:30] T I would say in the Bay Area for most part being absolutely corrected. We still have C-sections in cases where we think the labor might have been managed better and we therefore might have had no need for a c section but our c section is being utilized [00:13:00] and in all situations where they are necessary. So that's still a question. I recently heard a Ted talk about are we doing too many unnecessary C-sections and not enough necessary ones. And could we improve our maternal child health outcomes for labor and birth if we were doing more appropriate C-sections and fewer unnecessary. [00:13:30] So this is an interesting question. Out of the world and I think you know anyone who's gonna be having a baby owes it to themselves and their child to really understand what the implications are for a C-section planned or unplanned. You know

many many people to this day still say they would like to have an elective C-section--they're are fearful [00:14:00] of giving birth and they imagine birth is going to change their bodies in ways they don't want to They're asking for C-sections. That's not good public health. That was not good individual health. So we know that labor and birth are good for good for the body good for the mother good for the baby.

Sarah Trott: [00:14:24] I've heard of the mentality of wanting to schedule this birth and so you know what day it [00:14:30] is. And you see the positive aspects of your C-section is necessary then you definitely focus on the positives there. But that itself is sometimes used as a reason for one. Yeah. Just busy schedules or planning for something like that. Yeah it's a major surgery.

Esther Gallagher: [00:14:54] It's a major surgery through the skin of belly. What else. And then [00:15:00] the fascia layer that holds everything between or the lower fat layer and that kind of holds everything inside the belly. And that's after the muscle layer. So you've got skin, fat muscle peritoneum uterus. the uterus is multi-layers a muscle interwoven muscle. So there's something like five to seven layers [00:15:30] that are going to be Gone through. Then the baby emerges and then all of that gets repaired. So it's quick to get in there. Right. The Prep for the c section doesn't typically take very long but then each of those layers has to be repaired with the possible exception of fat. You know I don't think they have to stitch that together but every other layer has to be closed. So [00:16:00] you know that can take half an hour. So a 45 minute to one hour surgery is mostly repair. And what we know is that humans are prone to adhesions which is scar tissue that grows out into the body and tends to adhere to other tissue.

Esther Gallagher: [00:16:27] And that's the legacy of surgery [00:16:30] that's not well informed or well performed but that requires such big incisions that there's going to be a lot of scar tissue. So you know so much of that surgery these days is done laparoscopically so that the actual incisions are tiny comparatively but if you're having a C-section you have to have an incision is broad enough to get the baby out of the body. [00:17:00] it's probably seven centimeters maybe across. I mean I'm thinking that it has to kind of grow circularly right. It's a straight incision that's gonna extend to a circle as the baby's removed. So [00:17:30] probably five centimeters is about all that it takes that I actually don't know I never measured it. Good question. Maybe for different people in baby sizes. Sure. So we were talking about C-section for 10 minutes. Just going to end

with that. The reason for avoiding C section for the mother's health is the long term effects and the possibility of adhesions as well as musculoskeletal [00:18:00] things. And just like we've talked about was getting physical therapy for pelvic floor issues I would highly recommend that anybody who's had major surgery sign themselves up for physical therapy after the fact because the retraining of the musculoskeletal by a skillful professional is really good and obstetricians [00:18:30] don't. This is what they do. They refer referred to a specialist to help you with this then I would say in terms of your recovery. Everyone who's given birth no matter how they have done so if they can have access to physical therapy for assessment and therapy that can probably be good for everybody.

Sarah Trott: [00:18:50] So we have a great set number 22. Suzy Hateley who is a Canadian physical fitness guru and she you [00:19:00] know she had twins and her sister had twins to and it's kinda amazing in her family. So they had first hand experience with that recovery process and she's helped many many pregnant women prepare and recover from pregnancy and childbirth. So listen to that episode too if you're kind of wondering what that recovery physical aspect might be like. You know we don't want to turn this into the C-section episode. I have [00:19:30] to mention that you know some of the considerations around opting for a C-section if it is an option for you and this is something that I don't think is more about the emotional aspect of it. And it's come up in other episodes-- I want to say Chanti Smith episode 26. Yeah and I think Kimberly Johnson talked about it too a little bit [00:20:00] too we had 2 episodes with Kimberly. She's great. the kinds of themes around that are if you have a vaginal birth there's a different kind of connection your body makes it sort of a subconscious connection that if there's a C-section birth then sometimes women have a C-section and their bodies are waiting to give birth still even though their babies have been born I know that's a funny concept and that this won't be true for everyone but it's something to think about that the body is expecting something and our bodies are highly intelligent [00:20:30] organisms that don't necessarily tell us what they're doing --our heart beats without us telling it to do that. So there's systems and processes going on inside of ourselves that we don't consciously control. And Chanti mentioned working with mothers who need to sort of have a somatic experience or mind experience of having the baby gradually so that their bodies can just relax and feel that they have completed the [00:21:00] circuit. Yes. So anyway something to think about.

Esther Gallagher: [00:21:06] I think it's great. Thanks for reminding us. Actually yeah there's so many levels at which we're simultaneously doing our healing work and our recovery work. However we give birth. Yeah. So the next and last segment preferences plan is talking [00:21:30] about the immediate postpartum. So as the baby actually has emerged. In the next couple of minutes and hours so i'll are read what's written this preferences plan. We'll discuss it a little for each point. So the first point on this plan is upon moment of birth mother and partner would like undisturbed [00:22:00] quiet time to bond with the baby and to start breastfeeding as soon the baby is ready. I think I would love every preferences is planned to state this unequivocally and I would love it if that's what we saw happening in a hospital setting because it's very important.

Esther Gallagher: [00:22:25] There something lactation consultants now get to [00:22:30] study the normal physiological processes of being postpartum. And one of the things that they note again and again is that the natural process of emerging, finding the mother's contact the baby finding contact with the mother and then on it's own, in it's own time in this particular way doing what we like to call the breast crawl right [00:23:00] where the baby kind of moves themselves mostly with their heads and a little bit with those kicky legs you've been feeling on the inside and they basically will move along the mother's body and find a breast all by themselves unassisted latch themselves on and have a good feed. Now, it's extremely rare when that's what gets experienced for the baby and the parents [00:23:30] and there is some theorizing around the fact that so much of the first couple of weeks of breastfeeding is so problematic for so many baby's and moms that this has to do with trauma experienced in those first postpartum moments. So the trauma may be the baby's trauma or maybe the mother's trauma or the diad's trauma and that can include the partner of course. And [00:24:00] so at a recent doula meeting we were discussing breastfeeding and a lactation consultant who is now birth doula said this is how it's supposed to go. All of us who go to births were shaking our heads. Not what we see happening. What we see happening is a baby emerges is put on the mother's belly.

Esther Gallagher: [00:24:28] One or two nurses [00:24:30] moves in on baby and starts rubbing the baby to warm up to get the amniotic fluid off the baby so that the baby doesn't cool down to stimulate baby to cry. So there are all this rationale now around pouncing on a baby with a lot of activity. I've seen residents flick the baby's heels which is extremely extremely overstimulating for anyone. And [00:25:00] it's all to make the

baby cry so that we know it can breathe. you used air quotes when you said warm the baby. Yeah. Well the fear being that they will be cold but you know a mother who's just been pushing me out, i'm sure you remember Sarah is probably easily 98.6 if not a little more as a result of the physical activity pushing her baby out. So a baby who lands on the mom is going to be back [00:25:30] in an environment of 98.6.

Sarah Trott: [00:25:33] Oh yeah. They're a little bit wet but having that little person on my chest is so important emotionally for the mother if possible. But you know with all the physical stuff going on, but just having that moment and then and then mom's body helps keep the baby's body warm and you can put a little blanket over the top of both of them that will insulate.

Esther Gallagher: [00:25:58] Right. And will also [00:26:00] absorb fluids that if it becomes damp you can replace it with another one. So while I understand what I do honestly understand why nurses are doing what they do. But I also understand that is part of a system that's very fearful and does not see the deeper implications for how we're [00:26:30] treating mom and baby in those moments.

Esther Gallagher: [00:26:32] So you know this was an ah-ha moment for the lactation consultant who's never been to birth. Oh. Oh. And then they're diving in and rubbing the mother's tummy. if She doesn't have an epidural, she's going to really feel that it's going to be very painful. They're pulling on the cord. There are all kinds of activities too to [00:27:00] make the placenta deliver rather than to allow the placenta to deliver. So all of this is happening simultaneous to the baby being born/ breastfeeding and can be quite traumatic. I mean I've had moms say i can't hold the baby. I just can't hold the baby while this is going on.

Sarah Trott: [00:27:18] So by stating clearly ahead of time i want some quiet time. I want hold the baby assuming that's safe they have the [00:27:30] time to relax. It's really really painful to have your baby rubbed.

Esther Gallagher: [00:27:35] It's very painful and distracting. And the fact is that from my perspective and perspective based on my training which I know is shared by probably now a minority of obstetricians but I know that there are some obstetricians who are trained by some obstetricians who knew better than to manipulate the uterus

and the placenta. [00:28:00] That allowing the mother you know an hour or two for her uterus to gather itself. It's had you know a seven pound baby taking up the space and now it's kind of a floppy bag and it's going to take time for the oxytocin to build up and squeeze that back down into size and with enough pressure to naturally [00:28:30] peel the uterus off the face of that muscle mass.

Esther Gallagher: [00:28:36] This is normal. Yes exactly. The placenta is going to peel away from the face of the uterus and get pushed out by the uterus. But there is a time frame around that. And so allowing for that time frame. So when you have your preferences document, be specific: we want to [00:29:00] allow up to at least 30 minutes for the years to do its own best job of releasing the placenta.

Sarah Trott: [00:29:11] And does nursing help?.

Esther Gallagher: [00:29:13] Absolutely. That's again the natural course of things. If you're messing with my mom in such a way that she feels she can't hold her baby you are thwarting the best way to get the uterus to gather itself and push that placenta out. [00:29:30] It's just letting your baby nuzzle that nipple and mess around. There's a lot of stimulation when little kid's bobbing their head all over your chest. think of this they're kicking their way out there kicking his little feet and getting traction in your belly. They themselves are massaging the uterus.

Sarah Trott: [00:29:57] in a way that feels like the most glorious sensation in the world vs someone who just maybe invading your personal space. [00:30:00] So if a baby latches on and there's something that happens like it there's a reaction in the uterus. That's that's sort of nature doing its work.

Esther Gallagher: [00:30:12] Right. In an integrated fashion in a timely fashion. So I'm it all fits together beautifully. And you know frankly if mom has an epidural, you know it's not physiologically more room for them to do that just because [00:30:30] you can feel it. And that's my experience that obstetricians are walking in and out of the birth room without actually noting whether or not a mom has an epidural. that there should be a sign on the door that says no epidural in big red letters so that when somebody wants they [00:31:00] don't treat the body in front of them as if it can't feel anything because frankly even if they can't the body knows- it will be experiencing what is happening.

Right. So there's that. But especially because many of my clients don't have epidurals so when that resident walks in the room and assumes that mom can't feel anything and without asking [00:31:30] puts a hand into their belly and causes deep pain that they cry out about. And then turns around and says I'm sorry I just have to do this. I mean it's a form of. Torture. It's just not right. I have a real problem with this. Sarah can see it in my face.

Sarah Trott: [00:31:55] We wouldn't let someone on the street do that. doctors are like respected [00:32:00] and wonderful people .

Esther Gallagher: [00:32:01] It is just a consciousness Like the consciousness on this is not well developed in most obstetricians sadly. And because the epidural rate is 85 percent one would say that's a pretty good assumption when they walk into the room. Unfortunately it's not right. It's not correct to [00:32:30] assume that they're to assume that they have an epidural but also to behave in that way. Yeah. I mean there are instances where massaging the uterus is going to be appropriate and necessary. And mom is going to feel it. So let's help her cope. if I see it you know if my clients are having baby time together I'll sit [00:33:00] back and allow them my space and I pick up my knitting and then listen. Now if a doctor steps in and does something like that I don't have time to step in and say OK Sarah There's a little difficulty here that we're going to address. It's not going to be easy and I want to help you through it. So I'm going to make eye contact with you while we're doing this and I'm sorry this is going to be painful but we're going to get through it together. [00:33:30] So I can do that work as a doula but not if nobody cares. of course my clients would like to have that. Right. There's no reason why an obstetrician can't learn the same skills and say I'm sorry I'm going to have to do this procedure. It's not me comfortable look in my eyes and I will help you through it. while they do this thing with their hands. That's by feel. They don't need their eyes on the mom's belly button to do this procedure I promise you I've [00:34:00] done it myself many times successfully.

Esther Gallagher: [00:34:04] So you know this is another point where what I love about this podcast is hopefully it's another little needle in the voodoo doll of culture change I don't know. I'm hoping. But You know it means raising the consciousness of birth practitioners.

Sarah Trott: [00:34:26] It's called Bedside manner.

Esther Gallagher: [00:34:29] Bedside manner we [00:34:30] do in this country. So let's turn to other matters. So to be fair if no one's ever approached this person and said it's important that you proceed in this emotional social fashion while you're doing this procedure on a live human being they don't know enough to them either. So what's next.

Sarah Trott: [00:34:56] Well I wanted just to highlight the stuff that we're talking about rubbing [00:35:00] the belly to help give birth to the placenta and that's what's referred to as active management in document That's about like aiding the placenta delivery. outside of what the body would do on its own.

Esther Gallagher: [00:35:18] Let me just correct what I have in the past thought was active management which was all that belly rubbing and pulling on the cord and things of that nature. [00:35:30] And it turns out that active management is actually limited to only getting a shot of pitocin . all that other stuff that's not included in medical active management. An official medical term. But people do it all the time as part of quote unquote active management.

Sarah Trott: [00:35:52] So it needs to be added into the document so anyone is customizing can say please let me know if you're [00:36:00] going to rub my belly or pull on the cord I would prefer those not happen. Yes. But if you do something then please tell me before you do so I prepare my body. Even if it's 10 seconds. Yes. Right. Yeah.

Esther Gallagher: [00:36:17] And this document says as a matter of fact please only give the routine otherwise routine pitocin [00:36:30] shot if there is hemorrhaging. OK so now you may have had pitocin during the course of your labor for some reason and they're they're just open the pitocin the end of your labor day run by of getting your uterus to clamp down. And right now that's what your body would do you would send out a flood of oxytocin the baby would breastfeed that would get more going and then your placenta would deliver. So there's nothing particularly [00:37:00] incorrect about that extra pitocin at the end of labor. the Active Management protocol was developed based on studies that showed that malnourished women were extremely prone to hemorrhage at the end of labor prone to hemorrhage kinds of hemorrhages that could

really be health and or life threatening. And so this [00:37:30] idea that OK we will just prophylactically give these women a shot of pitocin in order to prevent this. Well of course as with so many things in terms of public health particularly for women it was determined that gosh why don't we just give it to everybody so it doesn't matter if at the end of your pregnancy you're not anemic you're physically fit etc.. [00:38:00]

Esther Gallagher: [00:38:00] Right. And you're going to get shot pitocin. So specifically saying I made it to the end of pregnancy in good health. And I would like to let my body you know do this last thing it does by way of ending my pregnancy. Without the pitocin unless there is actual evidence of hemorrhaging is fair [00:38:30] you're not asking for anything that isn't fair. And unfortunately we also have to add this other thing that is ubiquitous which is this manipulation of the uterus and the placenta please refrain from doing that. unless i am hemorrhaging . all [00:39:00] these things are interrelated and lovely. Please save the placenta for us to take home for good encapsulation. We have provided Tupperware container preferably glass with a plastic lid for catching the placenta when delivered. refrain from routinely suctioning the baby either in the nose or mouth. That's to help a baby not become overstimulated in the part of the body that needs to latch on to [00:39:30] a nipple. don't rub the baby vigorously to stimulate unless the baby is in actual distress or it isn't breathing and needs to be stimulated. allow the cord to pulse out before clamping and ask the partner if they like to cut the cord.

Sarah Trott: [00:39:50] The pulsing out is allowing that baby to get that last nice juicy blood from the placenta .

Esther Gallagher: [00:39:57] And by the way many [00:40:00] babies you know placenta could keep pumping oxygenated blood into the baby for sometimes 10-20 minutes after the baby has been delivered. if that baby isn't breathing on their own with their lungs yet, that can be critical but what we do in our culture is when we see it a baby in distress we clamp that, Cut that and stimulate the hell out of them. So there's real questions about is [00:40:30] that appropriate or not. Right. Like can we assess whether this baby's doing fine and whether they're getting oxygenation first before treating it like a dire emergency. And it doesn't have to be one or the other like if you know just don't clamp it and if you want to help the baby in some way do it. It doesn't hurt to have that cord going. And even once it stops pulsing there's no reason it has to

be immediately clamped and cut. [00:41:00] you say just hang out like that. the placenta can get delivered and you could still hang out like that. Right. So there is no immediate need to you know separate a baby from its placenta. Yeah and I mean you take your time.

Sarah Trott: [00:41:22] I mean it's just again it doesn't hurt and there's a potential benefit even if it's not proven or whatever then you know if it's not happening you might as [00:41:30] well give it a shot for the first like 10 minutes or while the baby's on your chest.

Esther Gallagher: [00:41:39] Yeah. All right. So the next I guess delay routine tests and vaccinations for the first two hours in California those routine procedures are erythromicin in the eyes hepatitis B vaccine and vitamin K shot. this [00:42:00] plan asks that they performed in the room with one of the parents holding the baby. it says the only exception is the vitamin K shot which can be administered within the first two hours so long as one of us is holding the baby. So Vitamin K is a clotting factor that we make in our stomachs and we need a microbiome to produce [00:42:30] it. It takes about seven days before our bodies actually are absorbing VitK. And it's a a blood clotting factor. So the reason why VitK is given as a shot routinely in America is is to provide the baby with a clotting factor to help avoid stroke believe it or not brain damage. So I think in the case of the baby [00:43:00] who's had a particularly traumatic labor and birth, if there were forceps or Vacuum used anything that could break a vessel in the head I think I would actually want it given in that case as fast as possible.

Esther Gallagher: [00:43:23] If it were to be we do have this prophlyaxis we can use. Some people want to use oral drops [00:43:30] but the problem with that is that babies actually do vomit quite a bit. You know they have a lot of mucus in their stomach they can vomit it out. So there's no guarantee that that oral doses can actually make it do its job in a timely fashion. I mean it's ok to try it and you know my kids were born at home and i didn't want it. they don't seem to [00:44:00] have strokes you know but it's probably fair to say. Next item we do not want our baby bathed. leave amniotic fluid on it. Keep us warm with blankets. mother will breastfeed. Mom and partner will stay close to baby as much as possible during [00:44:30] the hospital stay. No pacifier or bottle for the baby. no fingers in the baby's mouth. Fingers in the baby's mouth is particularly important to discuss because one of the things that pediatricians are looking for when

they do the full body examination of your baby is whether or not your baby's palate is closed. So they're actually feeling for a closed palate. when [00:45:00] we're fetuses our bodies are being created sort of like this: two sides coming together in the middle.

Esther Gallagher: [00:45:16] And so when we see spinal cord defect we see it showing up as holes at one end or the other of the spinal cord and the associated organs and structures in the middle can sometimes have holes in them. [00:45:30] That's a kind of gross way of putting it. And one of the places where that can happen is in the palate. the palate doesn't close completely over the sinuses. There may be skin there but the bones aren't together. The roof of the baby's mouth if it's not patent can single issue and [00:46:00] that's why pediatricians stick a finger in and feel around your baby's mouth. Now of course it's my opinion that for most babies who don't have this just this problem that's overstimulation at a critical time when babies are learning to breastfeed. And I would like if no babies have to undergo that in the first week but of course on the other hand I would certainly want to know if [00:46:30] my baby has a central nervous system issue as soon as possible. So we are weighing those two things and I think it's fair to ask say a pediatrician comes in to examine your baby when you do the oral exam Could you be just as delicate as you possibly can while doing that.

Esther Gallagher: [00:46:50] Could you please do that right here. I'm concerned that my baby have the least amount of oral stimulation that is not related to [00:47:00] breastfeeding.

Sarah Trott: [00:47:01] Yeah. What the first time I thought maybe it's just about people kind of playing with the baby or pacifying the baby.

Esther Gallagher: [00:47:07] And it is about that it's it's very common for nurses to do it themselves while messing around with the baby or to tell a partner here if they're crying to stick your finger in and they'll be quiet. Well why don't we examine why they're crying and see if there's something we can actually do about the crying. Are they hungry. [00:47:30] Are we subjecting them to a procedure like a diaper change. I mean they do not love to be put on their backs. For them it feels like an attack to have a diaper change especially if they're hungry. if they've awakened and they're in readiness for feeding, they're not expecting a diaper change. They will become apoplectic. Just really really sad. Which is gonna mean that when mom finally gets them to the breast, they

are going to [00:48:00] be very tired and very upset. They're not necessarily going to be in readiness for breastfeeding. So one of the first things I tell my clients about their hospital stay is unlike what you're going to be told don't wake your baby to breastfeed and don't start with a diaper change. have your baby close when they stir have the breast in proximity.

Sarah Trott: [00:48:29] Maybe they just want a wakeup [00:48:30] latch on and kind of back to sleep.

Esther Gallagher: [00:48:32] Right right. And that's good for them and it's good for mom. They've latched on and that's good for uterine stimulation. All of these things are good for moms and babies so you know swaddling your baby up with three blankets and a hat and sticking them in a bassinet across the room from you isn't necessarily going to be the thing that promotes a healthy breastfeeding relationship. But it's standard [00:49:00] operating procedure in the hospital and they will frighten you about whether or not to hold your baby in bed with you.

Sarah Trott: [00:49:07] Yeah I mean I remember being encouraged to have a lot of skin to skin contact what I thought was wonderful it is wonderful. Yeah.

Esther Gallagher: [00:49:14] They're worried that if you fall asleep with the baby in your bed bad things could happen. But if there are two of you three or four. Somebody can always be holding the baby who's not sleeping.

Sarah Trott: [00:49:29] OK. We've [00:49:30] gone through everything in the document. If you have questions you can e-mail either of us go on the air about page on our website for our master podcast dot com. Email one or both of us and we'll be sure to answer your questions. We also had someone reach out recently through our Facebook page so please join our Facebook page if you didn't know it exists in one. And sign on it. And joining me now we share a lot of cool stuff all the time. As a final reminder sign up for our newsletter at fourthtrimesterpodcast.com. and [00:50:00] sponsor us.

Sarah Trott: [00:50:04] Yes Thank you so much for listening.

Esther Gallagher: [00:50:09] that would be so nice for Sarah. And me. if Every body who listened to a show could pitch us a buck. We would appreciate it. Think of the things we can do for meeting cost and having some little extra you know do go to interesting conferences and present for you guys. . [00:50:30]

Sarah Trott: [00:50:31] Or produced more episodes. So that's something else that we'd probably be able to do. So just a few incentives there. Thank you so much once again and thanks for listening and we wish everyone a very happy and well resourced pregnancy and postpartum.

Esther Gallagher: [00:50:47] Yes thanks Sarah! always lovely.

Sarah Trott: [00:50:53] Likewise. See you Esther. You can subscribe to this podcast. [00:51:00] In order to hear more from us. Thank you for listening everyone and I hope you'll join us next time on the fourth trimester. The theme music on this podcast was created by Sean Trott. Hear more at soundcloud.com/SeanTrott. Special thanks to my true loves my husband Ben daughter Penelope and baby girl Evelyn. Don't forget to share the fourth trimester podcast with any new and expecting parents. I'm Sarah Trott. Bye for now. [00:53:00]