



## Information About Your Care During Labor and Birth

Having a baby is a natural event. Most patients and babies go through labor and birth without serious problems. Even so, certain situations may arise near the end of your pregnancy, or in labor, that can affect the care you or your baby need.

Described below are some of those situations. This form also includes some common practices you might experience during your time at the hospital. If you have questions, be sure to ask your clinician.

### *Labor*

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1. A nurse will work with your doctor or midwife to take care of you. In some hospitals, doctors training in obstetrics or anesthesia (residents) may also help care for you.
2. Other clinicians in-training (i.e., medical students, student midwives, nurses, or physician assistants) may be involved in caring for you. Students are always supervised by your doctor, midwife, or nurse.
3. You may have a blood test during labor to measure your blood count or for other purposes.
4. When you arrive at the hospital in labor, a nurse will usually put a fetal monitor on your abdomen to check the baby's heartbeat. If the heartbeat is normal, the monitor may be removed. The baby's heartbeat will be checked from time to time during the labor.
5. Sometimes a baby's heartbeat needs to be checked more closely and a mother will wear a fetal monitor on her abdomen for part or all of labor. Normal fetal heart rate patterns are reassuring. Sometimes there are variations in the fetal heart rate pattern that cause concern, even when the baby is fine. Studies have shown that these patterns are difficult to interpret and may lead to an increased chance of cesarean or forceps delivery. Fetal monitoring does not prevent cerebral palsy or birth defects.
6. In certain situations, more information about the baby's condition is needed than can be obtained from the external monitor. If this happens, your doctor or midwife will place an internal monitor electrode on the baby's head. Very rarely, this can cause infection of the baby's scalp.
7. In less than 0.5% (one half of one percent) of deliveries, a blood sample from the baby's scalp is needed to find out more about how the baby is tolerating labor. The sampling is like having your finger pricked. On rare occasions, the area from which the sample is taken will bleed or get infected.
8. Sometimes abnormalities in the baby's heart tracing can be corrected by an amnioinfusion. In this procedure, the clinician places a small plastic tube into the uterus and fluid is added to the amniotic fluid. This may take pressure off the umbilical cord in some situations.
9. You may have an intravenous line (IV) during labor to supply extra fluids, provide certain types of pain relief medications or antibiotics. Not all women require an IV.
10. There are many forms of pain relief for labor such as walking, use of the tub or shower, breathing and deep relaxation techniques, and massage. If you feel you need additional pain relief, your doctor or midwife can offer you other choices that are safe for you and your baby. These include:
  - Medication: You can be given a medication as a needle injection in your muscle (a "shot") or directly through an IV line. You might get a little drowsy. Allergic reactions are rare, but can happen.
  - Epidural: An epidural is the most common form of pain relief for labor and birth. An anesthesia specialist will place a thin flexible tube in your back. This procedure will take about 20 minutes. You can then receive pain relief medication through the tube. This will diminish most of the pain of labor.

11. If your labor slows down, your doctor or midwife might give you the hormone-like drug oxytocin (Pitocin®) through an IV to make your contractions stronger and closer together.

12. Sometimes, before a person starts labor on their own, their health or the health of the baby makes it necessary for labor to be induced. In the United States, about a quarter of labors are induced. Some reasons for induction of labor include a baby that is overdue by more than a week or two, a baby which has not grown well, infection, high blood pressure, diabetes, or a rupture of the bag of waters. Your doctor or midwife can help get labor started in various ways. If the cervix is soft and stretchy, oxytocin (Pitocin®) given through an IV will most commonly be used. If the cervix is not ripe, medications called prostaglandins are usually given first.

13. Sometimes, labor may be induced for non-medical reasons after 39 weeks gestation but before your due date. Induction for non-medical reasons may not be scheduled before 39 weeks gestation without establishing or confirming ability of the fetus to breathe room air upon birth (fetal lung maturity), before scheduling the induction of labor.

14. Induction has certain risks including creating contractions that are too strong or too frequent, which can stress the baby. In almost all situations, this risk is manageable and the contractions can be decreased. Induction of labor may not be successful and can increase the risk of cesarean birth, especially if this is your first baby and/or your cervix is not ripe (not ready for labor).

## ***Vaginal Birth***

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1. Labor contractions slowly open the cervix. When the cervix is completely open, contractions, along with your help, push the baby through the birth canal (vagina). Usually, the baby's head comes out first, then the shoulders, followed by the rest of the body.

2. About 10–15 percent of pregnant patients need some help getting the baby through the birth canal. A doctor or midwife may apply a special vacuum cup or forceps to the baby's head to help the mother push the baby out. Large studies have shown that the vacuum cup and forceps are safe.

3. In approximately one percent of births, the shoulders do not come out easily, a condition called shoulder dystocia. If this happens, your doctor or midwife will try to help free the baby's shoulders. Shoulder dystocia may cause a broken collar bone or arm for the baby or nerve damage to the baby's arm. Most often, these problems heal quickly. Shoulder dystocia may cause tears around the vaginal opening and bleeding after birth.

4. Many patients will get small tears around the vaginal opening. Sometimes a doctor or midwife will cut some tissue to make the opening bigger (episiotomy).

5. Most people with tears or an episiotomy will need stitches. The stitches will dissolve over a few weeks during healing. The area may be swollen and sore for a few days. Rarely, infection may occur. Infrequently, a tear or cut may extend to the rectum. Most often, after repair, this heals with no problems.

6. Normally, the uterus will expel the placenta soon after birth. In about one percent of births, this doesn't happen and the doctor or midwife must reach into the uterus and remove the placenta. If this happens, you may need anesthesia so he or she can remove the placenta.

7. All patients lose some blood during childbirth. A patient is more likely to lose a lot of blood if:

- the placenta doesn't pass on its own,
- one is having multiples as in twins or triplets, or
- labor lasts a very long time.

8. Pitocin can help reduce bleeding after birth. If bleeding is very heavy, other medications may be used to help contract the uterus. Very few people (less than one percent) need a blood transfusion after vaginal birth.

## ***Cesarean Birth***

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1. Approximately one third of patients give birth by cesarean. Some cesareans are planned, while others are unexpected.
2. During cesarean birth, a doctor delivers the baby through an incision in the abdomen.
3. The most common reasons for cesarean birth are:
  - the cervix doesn't open completely,
  - the baby doesn't move down the birth canal,
  - the baby needs to be delivered quickly because of a problem for mother or baby, and
  - the baby is not in a position that allows for a vaginal delivery, and
  - the mother has had a cesarean section before.
4. Anesthesia is always used for a cesarean section: most are performed using regional anesthesia such as a spinal, epidural, or combined spinal-epidural technique, so the patient is awake during the procedure. The rest are performed using general anesthesia.
5. Blood loss is greater with cesarean birth than with a vaginal birth. It is still rare (12 in 1,000) to need a transfusion.
6. Infection is more common after cesarean birth. Often, doctors give antibiotics during the birth to help prevent this.
7. A thin tube called a urinary (foley) catheter will drain the bladder during the operation. It will usually remain in place for 12–24 hours afterwards.
8. In less than one percent of cesarean sections, the operation may cause damage to the bowel or urinary system. Most of the time these problems will be recognized and corrected during the operation.
9. In less than one percent of cesarean sections, the baby might be injured during the birth. When this does happen, it is usually minor.

## ***After Birth***

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1. The chance of uterine infection after a vaginal birth is 2–3 percent; after cesarean birth, the chance of uterine infection is 20–30 percent. Antibiotics can lower the risk, but won't guarantee that you won't get an infection.
2. You may have cramps as the uterus returns to its normal size. This cramping gets stronger with each birth. You may notice it more when breastfeeding.
3. If your baby is delivered vaginally, you will probably have discomfort around the vaginal opening. If you have a cesarean birth, you will have pain from the incision in your abdomen. Ask your doctor or midwife for pain relief if you need it.
4. Vaginal bleeding is normal after birth. It will lessen over 1–2 weeks. About one percent of women have heavy bleeding and need treatment. Sometimes this type of bleeding can happen weeks after birth.
5. Most patients feel tired and weepy after birth. For about ten percent of new patients, these feelings don't go away or get worse (postpartum depression). If this happens, ask your doctor or midwife for help.
6. Various factors influence when you go home from the hospital. These include your health, your baby's health, and the help and support you have at home.

## ***Newborn***

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1. At one minute after birth, and again at five minutes after birth, the baby will be assigned Apgar scores. The scores reflect the baby's heart rate, breathing, color, muscle tone, and vigor. These scores assist your pediatrician and the nursery staff in planning the care of your baby.

2. About 3–4 percent of babies are born with birth defects. Many do not hurt the baby (such as extra fingers or toes). Some, such as some heart abnormalities, can be serious.

3. Approximately 7–10 percent of babies are born before term (less than 37 weeks of pregnancy), or have a problem that will require some form of special care, i.e., treatment in a Special Care Nursery or a Neonatal Intensive Care Unit. A small percentage of babies born after 37 weeks also may require some form of special care.

4. About 12–16 percent of babies pass meconium (the first bowel movement) into the amniotic fluid before delivery. When this occurs, the baby's mouth and airway will be suctioned at the time of delivery to remove as much of the meconium as possible.

5. After your baby is born, he or she will be given eye ointment to prevent infection of the eyes and an injection of Vitamin K to prevent bleeding. Using only a few drops of blood from his or her heel, tests will be done to screen your baby for 29 different diseases. The results will be sent to your pediatrician in the community. Your baby's hearing will be checked while in the hospital. You will also be encouraged to have your baby receive the first immunization against hepatitis B before going home.

6. Three to four of every 1,000 newborns have serious bacterial infections of the blood, lungs, and—in rare cases—the surface of the brain and spinal cord. If you carry Group B Strep, develop a fever during labor, or if your membranes (bag of waters) are ruptured for a long time, you may be given antibiotics during your labor to reduce the risk of infection to your baby.

7. If your baby is at increased risk of infection or shows signs of infection, your pediatrician may decide to send blood or cultures to the laboratory for analysis. Your baby may also receive antibiotics.

## ***Infrequent or Rare Events***

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The following problems occur infrequently or rarely during pregnancy:

1. A few babies are born too early to survive, or they have serious medical problems. Of every 1,000 babies born, about 6–7 die in utero after 20 weeks gestation (stillbirth or fetal death); and 4–5 per 1,000 babies born die shortly after birth or within one month of their birth.

2. About 3 out of every 1,000 mothers develop blood clots in their legs after giving birth and require treatment. This is more likely to occur after cesarean section than after vaginal birth.

3. In about 1–2 out of 1,000 births, a doctor must remove the uterus (hysterectomy) to stop heavy, uncontrollable bleeding. This means a patient cannot become pregnant again.

4. About 6 out of every 1,000 patients receive blood transfusion after giving birth. The risks associated with blood transfusion include an allergic reaction, fever, or infection. The chance of contracting hepatitis from a transfusion is 1 in 100,000; the chance of contracting HIV is less than 1 out of 1,000,000.

5. Very rarely (less than 1 in 10,000), patients don't survive childbirth. Causes might include extremely severe bleeding, high blood pressure, blood clots in the lungs, and problems caused by other medical conditions.

## ***Summary***

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Most babies are born healthy and most patients go through labor and birth without serious problems. You should realize though, that pregnancy and childbirth have some risks. Many of the possible problems sound very frightening. Remember, most of these problems are uncommon, and the most serious events are quite rare.

Your health care team will watch carefully for signs of possible problems. They will do their best to identify them early, explain them, and offer you treatment. Your health care team looks forward to caring for you during labor and birth, and to delivering a healthy baby.