Midwife Shadowing Experience

Contributed by Brandy Puskas

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Brandy Puskas is a nursing student who spent a day "shadowing" Beth during one of her prenatal days. This was an assignment for her Anatomy and Physiology class and this is the report she turned in. The client's names have been changed to protect their privacy.

The following is a log of my afternoon spent with Beth Overton, CPM. The name of her practice is “Gentle Beginnings” and her office is located behind her home. The office is very cozy with several chairs with fluffy pillows and the rooms are painted in warm colors. The actual “examination” portion of her office also consists of warm colors and a cozy daybed where the patients lie down to be examined. It makes for a very comfortable, non invasive setting. There are pictures on the walls of babies that she has delivered and gifts made from moms that she has helped deliver.

Her days are pretty slow going, and very relaxed for the most part. She allows each of her patients one full hour of her time. Beth gets to know most of the mothers pretty well; two out of the three patients we saw on this particular day had already delivered a baby previously with her.

At 11 a.m. we saw our first patient, Terri* who is 38 weeks pregnant. The first thing we did was ask her to use the restroom and to provide us with a clean catch urine specimen. Beth allowed me to chart the patients for her on this day and we both examined Terri’s urine, using a urine strip. We both noted that she had protein in her urine. I recorded the protein in the urine. We went to the “waiting area” of Beth’s office, where Terri was relaxing on the fluffy chairs. Beth then asked her some questions regarding how she was feeling and told her about the protein in her urine. Terri admitted to not drinking enough water that morning, but that she was feeling fine. She said she was not feeling overly swollen nor was she experiencing any vision problems.

We then moved to the examining area, where Terri was weighed and examined. Terri weighed 136.5 pounds. She then stretched out on the bed and we listened to the baby’s fetal heart rate, which was recorded as 144. Beth, with Terri’s permission allowed me to feel the baby’s head low in the pelvic region and the back of the baby and the baby’s “bum”; I was also taught how to feel the fundal height. Beth examined Terri’s legs and ankles; she noted that she had slight edema but that it was “WNL” (within normal limits). Beth encouraged her to drink more water and to relax with her feet elevated and to let her know of any changes. It was a wonderful learning experience.

The second client was a postpartum patient named Faith*. It was a quick appointment, as we asked Faith several relevant postpartum questions. Faith stated that the baby is sleeping about five hours through the night, and is nursing about every two and one half to three hours during the day. In addition, the baby is making about eight wet diapers and at least two to three bowel movements a day. Faith said that she was not experiencing any pain and that she was only spotting a little. The baby was weighed and examined. I did not get to chart these findings as thoroughly as I would have liked, because Faith also has a very busy two year old, who was into EVERYHING. I helped distract him so that Beth could complete the new born exam. Everything looked and seemed normal; however the baby was slightly jaundiced so Beth made some recommendations, including sunning the baby in the window.

The third and final patient of the day was Hannah*, who was accompanied by her husband. Hannah is a beautiful young woman and who was recorded as 12 wks and 1 day. Because she is so early in her pregnancy, she of course will still be examined, however Beth knows that a greater portion of her time will be spent counseling her and answering questions and concerns. This is especially true being that this is Hannah’s first pregnancy. Hannah did complain of round ligament pain. Beth told her to be careful when turning and stretching. Beth also discussed with them the option to have a sonogram now or to wait and have her order a medical sonogram. Beth explained that with a medical sonogram it will go in the patient’s records and could be very helpful down the road. For being such a young couple they seemed very intelligent beyond their years.

While speaking with Beth Overton, she shared with me a common midwife technique that is out of practice in most hospitals today, delayed umbilical cord clamping. Beth does not clamp the umbilical cord right away. I was fascinated by this, so I start asking her all kinds of questions. She shared with me that most midwives who practice home births do not clamp the cord until it stops pulsating. She told me that this blood belongs to the baby, so why should it not be given to the baby? She also said that the placenta will deliver a lot easier if it is emptied of its blood. The body’s normal response is for the placenta to detach once it has given the baby all the nutrients.

Beth gave me a specific example of a patient of hers. It was a water birth and the baby came out and there was no crying or chaos, he just looked around, but did not appear to be breathing. Normally, Beth would have been disturbed but the baby’s cord was pulsing and within a couple of minutes was breathing fine on his own with no intervention. He just took longer than most to transition from his environments. If Beth had clamped the cord they would have had an emergency on their hands, yet because of the delay in cord clamping the baby was nourished the whole time.

I was fascinated by this so I went home and did some research of my own. It seems that Beth is on the right track. According to the website www.gentlebirth.org/archives/cordNFM.html, the cord clamping debate has been around for a while. In the article Erasmus Darwin saw no need in early cord clamping. In fact he stated that it might be injurious to the

baby, he said that it was better to wait until the baby was breathing regularly on their own. The article also states that resuscitating a newborn who still has their cord in tact would be a much safer practice, because the baby is still receiving oxygenated blood.
Dr. M. Jeffrey Maisels states, “If the cord is not clamped, the placenta gives the infant the equivalent of 20cc of blood per kilogram of body weight within these first 3 minutes…. When cords are not clamped early, the third stage of labor is one-third shorter and the total mean blood loss after delivery is substantially less than when cords are clamped early. This might be because when cords are not clamped, the placenta is allowed to give up its volume of blood. It thereby contracts and separates more easily from the uterine wall.”
This whole topic relates so beautifully to Anatomy and Physiology. If anatomy is the structural organization between body parts, then pregnancy would be the biggest anatomical miracle. The body and its “organization” support not only itself, but a whole other “body” as well. Physiology is how all those parts work together, from the very first cell, to the development and creation of a whole other body of cells. It is truly amazing, and it does not stop there. Once the baby is born, that baby’s connection to its mother’s anatomy and physiology is so tightly linked that one is sustained even longer than necessary just because it feels like the most “natural” thing to do.
When I interviewed Beth, we discussed mostly how home births work. She explained to me that she has had a few emergency situations, but that she is watching the baby and mom so closely that she can usually be well prepared for making the best and safest decision for mom and baby. Beth explained to me that if one of her moms get sick, she will “transfer” her care, if it happens before labor has started. If labor has started and she ends up having her patient “transported”, then the care switches from her to the hospital.
She also shared with me that when she transports (which is about 12–15% of the time), she does not get full payment from insurance companies. I asked her if this bothered her, and she told me that she never wants it to be about the money, that she always wants to remember the patient and baby are most important. She receives around $2400.00 for each birth.
Beth also is responsible for setting up and establishing “Birth Grants, Incorporated,” which provides financial help for expectant mothers. It gives both financial support and information for women who would like midwives, but can not afford them.
My experiences with Beth were fascinating and inspiring; she is an excellent midwife who is kind and gentle. She is also a wonderful listener and very supportive. These qualities I would like to possess when I am a midwife. I learned a great deal about home births. I appreciate them and what they offer their patients, however that is not the type of midwifery I would like to go into. I am going to school to become a Certified Nurse Midwife. This career path differs quite a bit in qualifications and experiences, and unfortunately the two types of midwifery are often battling over minuscule things. Beth taught me that although we will be different in our fields, our goals are the same: we want safe, life changing birthing experiences for everyone.

* Editor’s note: We used fictitious names in this article to protect the privacy of Beth’s clients.