Our Labor and Birth Philsophy, designed for the safety of you and your baby:

At Volusia OB/GYN, we are avid and firm believers in having an educated, informed, and engaged patient population. We are also passionately ardent believers in the importance of evidence-based medicine. For those reasons, we have outlined our philosophy regarding the general, overall plan for the birth of your child. This generalized birth plan is designed with over 80 years of combined experience caring for mothers and their babies. We ask that you review it carefully and ask questions as early into your pregnancy as you can. By reviewing this early in your pregnancy, we can ensure that we are the right practice for you, help make referral suggestions if we are not, and avoid unneeded stress and misunderstanding at the end, when it counts to most.

1) **IV ACCESS:** IV access is critical and a must have. Obstetrics is a specialty where there is potential for emergencies such as excess bleeding. Even when things appear to be going well, significant blood loss can occur without much warning. Obtaining IV access once a hemorrhage begins can be difficult. Having early IV access keeps the risk of bad outcomes associated with bleeding to a minimum. IV fluid is also one of the tools we utilize to help babies that go into distress.

2) **FETAL MONITORING DURING LABOR:** We are aware of, and understand, our college's (ACOG, The American College of Obstetrics and Gynecology) position on intermittent auscultation and monitoring in low-risk labor patients. This, however, requires a 1:1 labor nurse to patient ratio, which we cannot guarantee on our labor unit. Thus, we will monitor mothers in labor with continuous fetal monitoring, as we strongly believe this is safest for mom and baby. Our labor unit has wireless monitors available. These provide greater freedom of movement and are water-resistant in case our moms wish to shower.

3) **RISK-REDUCING INDUCTIONS:** As stated above, we practice up-to-date, evidence-based obstetrics. Current, well-designed research has shown, and has been confirmed to reduce many risks associated with pregnancy and birth by proceeding with labor induction after 39 weeks. Of course, this is not mandatory, but the evidence (see addendum) speaks for itself. We will be happy to discuss this in detail with you as early as you would like during your pregnancy.

4) **GOING PAST YOUR DUE DATE:** We do not recommend that pregnancies progress past 41 weeks, as data shows that placental function deteriorates quicker once that gestational age is reached. This increases risks to the baby. If the pregnancy progresses to 41 weeks, induction of labor will be scheduled.

5) **ELECTIVE CESAREAN SECTION:** We support an open discussion with those patients that would like to consider this option. Although we don't recommend it in general, we understand this may be something that some patients might want to explore and we are willing to review the pros and cons in individual cases.

6) **THE PROCESS OF INDUCTIONS:** Medically necessary or risk-reducing labor inductions are usually performed with a combination of methods. No two inductions are identical. Medications are usually required. The type of medication needed will depend on how favorable (dilated/effaced) your cervix is at the time of induction. Pitocin (Oxytocin) is frequently used at some point to start or augment labor. We consider it a very safe drug with minimal potential adverse side effects when used correctly. Thus, if a medical or risk-reducing induction is scheduled, please trust our judgment regarding which methods are better in your case to get you safely and effectively into labor and hopefully achieve a vaginal delivery. We practice evidence-based obstetrics.

7) **THE USE OF FORCEPS OR VACUUM FOR VAGINAL DELIVERY:** We will on occasion recommend an operative vaginal delivery (vacuum or forceps). This is offered if we believe we can safely and quickly deliver your baby in case of an emergency or if you become too exhausted to push your baby out. This would avoid a cesarean section and get the baby out quicker than an emergency cesarean. All the physicians at VOG have had extensive training in operative deliveries and will of course discuss it with you if we think one is necessary.

8) **EPISIOTOMY:** We do not perform routine episiotomies.

9) **TOLAC / VBAC:** We do selectively offer trials of labor in patients with 1 prior low transverse cesarean section (TOLAC) in hopes of achieving a vaginal delivery (VBAC). Not every patient is a good candidate for TOLAC. We will gladly review each case individually and review the benefits and risks involved. If we do not believe you are a good TOLAC candidate, we will recommend a repeat cesarean section. We are aware of ACOG's position on possible trial of labor after low vertical, classical and/or multiple previous cesarean sections. We believe these circumstances warrant delivery at a tertiary care center. Given that our labor unit is not, we will not support a trial of labor in these patients.

10) **PAIN MANAGEMENT DURING LABOR:** Your pain management will be your choice, not ours, not your family's, but yours. We will not agree to anyone but you making pain management decisions. We will not push any pain management modality but will gladly educate you on options.

11) **DELAYED CORD CLAMPING:** We will attempt to delay cord clamping and cutting for 60 seconds, as recommended by the ACOG. If we, or the nursery/pediatric personnel, feel that the baby has to be attended to immediately, delayed cord clamping will not be our priority. During a cesarean section, if the situation allows, we can attempt to delay cord clamping as well. Please understand, however, that sometimes this is not possible.

12) **SKIN-TO-SKIN:** Skin to skin contact and breastfeeding will be supported, even during cesarean sections, as long as it is safe for mom and baby.

13) **MEDICATIONS/VACCINATIONS FOR BABY:** Medication concerns regarding your baby (vaccinations, antibiotics, vitamin K, etc.) are for you to discuss with your pediatric team. We will gladly offer advice but will not be a part of this decision making process.

14) **PLACENTAL PRESERVATION:** Although no current data support placental preservation for later consumption, we will gladly help you procure yours if you decide to keep it. You should be aware that the CDC specifically advises against the consumption of dried placenta capsules or any form of placental ingestion.

15) **VAGINAL SEEDING:** We will not perform "vaginal seeding" or any procedure to introduce vaginal organisms to your baby. This practice is currently being discouraged by ACOG.

16) **VISITORS DURING LABOR:** We generally do not limit visitors to your labor room. Having said that, if an emergency were to arise, we hope you understand we may need to remove visitors in order to make room for critical personnel. One person is generally allowed in the operating room during cesarean sections.

17) **EATING/DRINKING DURING LABOR:** We will generally allow small amounts of clear liquids during active labor. Your IV fluids will keep you well hydrated. Remember nausea is common during the advanced stages of labor and we want to avoid a full stomach. If a need for a cesarean section were to arise, a full stomach increases anesthesia risk.

18) **ASSISTANCE BY FAMILY MEMBERS:** We welcome assistance from family members as patient advocates and coaches. We appreciate your help with patient positioning and comfort

measures. We will absolutely do our very best to have the designated family member cut the umbilical cord. Please understand that sometimes this is not safe and trust us to make that decision for you and your baby. We occasionally receive requests from a family member to aid with the delivery of the infant. Babies are precious and delicate. Babies are slippery. We will deliver your baby.

19) **PHOTOGRAPHY, LIVE STREAMING AND VIDEO:** Photography is allowed in the delivery room as well as the operating room. The hospital has a strict no video, no live streaming policy during procedures.

We are available to answer any questions regarding our birth plan. If, after reviewing it, you feel our practice philosophy is not for you, we completely understand and wish you and your family the best.

Sincerely,

Your VOG Physicians

ADDENDUM:

Based on randomized trials and observational studies in which patients undergoing induction at ≥39 weeks were compared with those undergoing expectant management, it appears that labor induction among low-risk patients at ≥39 weeks is a reasonable option. Potential advantages include:

- ●Reduction in cesarean birth
- ●Reduction in other adverse neonatal and maternal outcomes (eg, preeclampsia)
- ●Reduction in macrosomia (and its consequences)
- ●Reduction in stillbirth
- ●Ability to control the time of birth when this could be important (eg, patients with a history of rapid labor or who live far from the hospital and thus risk of out-of-hospital birth)

Evidence

- ●In the multicenter ARRIVE trial, which evaluated planned induction of labor at 39+0 to 39+4 weeks of gestation versus expectant management in over 6100 low-risk patients across the United States, induction resulted in:
  - •Reduced risk of cesarean birth (18.6 versus 22.2 percent).
  - •Reduced risk of hypertensive disorders of pregnancy (9.1 versus 14.1 percent).
  - •Reduced risk of neonatal respiratory support (3.0 versus 4.2 percent).
  - •A similar frequency of perinatal death or severe neonatal complications (4.3 versus 5.4 percent).
- ●Planned secondary analyses of data from the ARRIVE trial found that, compared with patients assigned to expectant management, patients induced at 39 weeks had:
  - •Fewer antepartum visits, tests, and treatments
  - •Longer duration on the labor and delivery unit (by approximately six to seven hours)
  - •Shorter postpartum maternal and neonatal hospital durations
  - •Similar total costs
  - •The lowest rate of cesarean birth: 17.3 percent at 39 weeks, 22 percent at 40 weeks, and 37.5 percent at 41 to 42 weeks of gestation
  - •The lowest rate of adverse perinatal outcome: 5.1 percent at 39 weeks, 5.9 percent at 40 weeks, and 8.2 percent at 41 to 42 weeks of gestation.