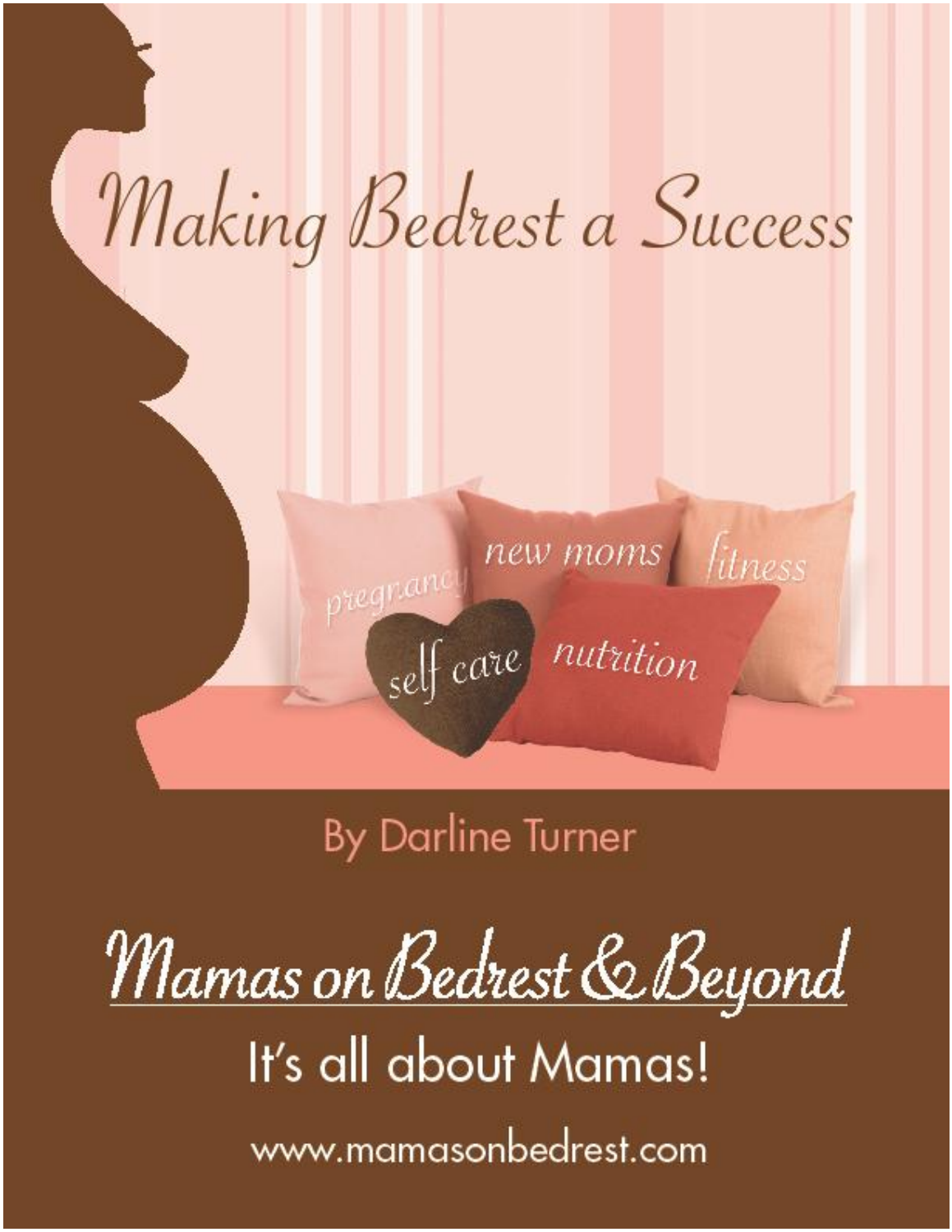
Making Bedrest a Success
pregnancy
new moms
fitness
self care
nutrition
By Darline Turner
Mamas on Bedrest & Beyond
It's all about Mamas!
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Making Bedrest A Success:
An Overview of Bed Rest

Compiled by Darline Turner,
Owner and Founder of Mamas on Bedrest & Beyond

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Introduction

Most women don't plan to be on bed rest during their pregnancies. There are some women who know, usually because of their medical histories, that they are at increased risk for being prescribed bed rest during their pregnancies and may in fact put some organizational plans in place in the event that the bed rest prescription comes to pass. Some women experience preterm labor and once it's halted and stabilized are prescribed bed rest. Again, there was no prior planning, just a precipitating event and the prescription. But the vast majority of women who end up on bed rest are completely blindsided; they go in for a routine prenatal examination, an anomaly is detected and boom, bed rest. The prescription is so unexpected and so immediate that most women have no time to plan, no time to put their affairs in order, no time to prepare. This unexpected monkey wrench thrown into the lives and pregnancies of thousands of American women is what inspired the creation of ***Mamas on Bedrest & Beyond*** and this ***Bedrest Success e-book series***.

When I was facing the prospect of bed rest over 10 years ago, I was not only devastated that I may lose my baby I was also completely clueless as to how I was going to manage. My family and my husband's family both live hundreds of miles away. I was new to my area and didn't have support. My husband traveled extensively domestically and internationally and basically I was going to have to fend for myself. I was terrified. I combed the web for information and local support and there was none. And so my OB and I carefully monitored my progress and my daughter was born at 36 weeks and 6 days.

Things were no better with my son. At age 40 and on my 4th pregnancy (second child), I was again high risk. Bed rest was suggested "as a precaution" but this time I not only had no local support, I also had a 3 year old to care for. Again, we monitored my pregnancy carefully, my son was happy as a clam inside of mama and we literally had to go and get him because he showed no signs of coming out!

After the birth of my son, I vowed to provide support (physical as well as emotional), information and resources for other women prescribed bed rest. So in addition our ***Bedrest Fitness DVD***, website, our Facebook page and various networks and outlets, we now present this ***Bedrest Success e-book series*** so that women all over the world-

and those who love and care for them-can meet their physical and emotional needs while on bed rest. I hope that this guide is a great help to you. If you have questions or comments, don't hesitate to contact me at **info@mamasonbedrest.com.** I answer any and all e-mails. Also, if you haven't already, sign up for our ***Bedrest Success Kit***. It is chalked full of useful information and tips for surviving bed rest. You can access the kit for free from our website, **www.mamasonbedrest.com.**

Medical Disclaimer

The information provided in this publication is for ***informational purposes only***.

Mamas on Bedrest & Beyond in no way intends to diagnose, treat or make any sort of medical recommendations. If you have questions regarding any of the information presented and how it may apply to your particular situation, please consult with your health care provider.

The Origin of Bed Rest

Bedrest was first introduced in the mid 1800's during the Civil War by Dr. Silas Weir Mitchell. A neurologist, Mitchell was charged with caring for soldiers coming back from the war with nervous injuries and "emotional maladies". For these soldiers Mitchell prescribed "the rest cure" which consisted of isolation, confinement to bed, a high fat, dairy laden diet, electrotherapy (usually deep brain stimulation) and massage. The rest cure was quickly found to be ineffective for the soldiers suffering post traumatic stress from combat. Prescribed well into the 20th century for medical problems such as high blood pressure, heart disease, spinal and joint injuries, gout and chorea, it was quickly discontinued when physicians noted that their patients got worse-not better.

Once the rest cure was discounted for the aforementioned medical maladies, Mitchell then primarily prescribed the rest cure for women suffering from "hysteria". At this time, it was completely acceptable for women to "take to their beds" for a period of time anywhere from 2 weeks to 6 months when "the difficulties of life became to great". Interestingly, this "hysteria" occurred mostly following the birth of a child and women were actually suffering from Post Partum Depression which went undiagnosed during this time. Unfortunately, many women suffered escalation of their post partum depression symptoms and some to the point of death.

Despite the fact that the rest cure was and is no longer used in most medical specialties, it remained a staple of treatment for depressed women throughout the 19th and into the 20th century, and persists today in modern obstetrics in the United States despite the fact that there is no medical or scientific evidence that it is effective in preserving a pregnancy to term and despite its noted negative effects on the women for whom it is prescribed (more on this in a moment!).

Charlotte Perkins Gilman, a sociologist, writer and feminist in the mid 19th century was prescribed Mitchell's rest cure after the birth of her child and ended up developing full blown psychosis before taking herself off of bed rest. She gives a somewhat autobiographical account of her experience in her short story, **The Yellow Paper**. In Gilman's story, the narrator is taken to a country house by her physician husband to

“rest and recover” from the strain of childbirth. Her husband “locks her away” in the top floor bedroom, the nursery, stating that it’s the best room in the house for her recovery and the only room that will hold 2 adult beds, so that he can “care for her.” This despite the fact that our heroine asks him if she may stay in a room on the ground floor, facing the piazza which is lined with roses and has outdoor access for walks and sitting in the sunshine.” He denies her request and also forbids her to write, her profession and outlet. When she asks to visit cousins or to have them visit her, her husband forbids this as well stating that the prior time they visited she got hysterical when they left. What he neglected to realize and what our narrator tells us is that she was very sad to see them go as they had been the only visitors she had seen in months. The only people this woman saw all day were her caretaker-and that’s only briefly for meals and to help her to dress-and her husband. She is left alone for the bulk of the day with nothing to do and no one to talk to in a place she doesn’t like. Everything is decided for her, she has no say in her care or her existence. In this isolated state, she becomes obsessed with the wallpaper in the room. First she is fixated on the pattern. Then she believes that she sees a woman behind the pattern. By the end of the story, the narrator is convinced that the woman is coming after her, she becomes the woman behind the wallpaper and is clearly psychotic.

This story illustrates some very salient points about bed rest, information that every woman who is placed on bed rest and those who care for her should know and remember.

1. **Physicians don’t know everything**. In this day and age it is acceptable and quite necessary for you to speak up and about what you need.
2. **Find fun things to do to occupy your time**. Keeping busy and mentally/intellectually stimulated will not only help pass the time but will also help ward off worry and depression.
3. **Don’t isolate**. Enlist the help of friends and family to come and visit.
4. **If you feel that something is wrong or strange-physically or emotionally-get help**.
5. **Crying.** If you are crying a lot for no apparent reason, seek help. You may be suffering from depression.

6. **Be honest about your feelings**. Bed rest is not easy. You don't have to "tough it out". Don't be afraid or ashamed to sate your needs and ask for help.
7. **Excessive Sleep**. If you find yourself sleeping more and more during the day and not just from the fatigue of pregnancy, speak with your health care provider. This too may be a sign of depression.
8. **Lack of Interest in Life/activities/loved ones**. In this story, the narrator had no interest in her child. If you find that you have no interest in your pregnancy/child and this concerns you, speak with your health care provider.

Bed Rest: What's The Point?

Now given what we know about bed rest and its history, what's the point of prescribing bed rest to pregnant woman? Many physicians and researchers are asking this very question. To date there is no study that definitively shows that bed rest is effective for the prevention of preterm labor (labor before 37 weeks of gestation) or for ameliorating the common reasons for which bed rest is prescribed. Bed rest is commonly prescribed for:

- A multiple gestation; twins, triplets or higher order multiples
- An "incompetent cervix"; a cervix that begins to open prior to 37 weeks pregnancy endangering the life of the fetus and/or mother
- Preterm labor or a history of preterm labor; labor that begins before 37 weeks gestation
- History of prior miscarriage, still birth (death in utero) or premature birth (prior to 37 weeks gestation)
- Intrauterine growth restriction/retardation (impaired growth)
- Placenta Previa; The placenta presenting first at the cervical opening
- Gestational Hypertension; with or without Pre-Eclampsia (toxemia)
- Gestational Diabetes
- Vaginal bleeding
- Too little amniotic fluid (oligoamnios)

While all of these conditions certainly put mamas and babies at risk, to date there is no solid evidence that prescribed bed rest is effective at stopping or improving any of these conditions. In fact, studies to date show that prolonged bed rest and inactivity actually cause a pregnant woman's physical condition to worsen-especially those considered "high risk". Women on prescribed bed rest may develop muscle weakness, cardiovascular deconditioning, blood clots and emboli (blood clots that dislodge and travel and become lodged in the heart, lungs or brain), fatigue, drops in blood pressure when standing up, backache, bone loss, changes in metabolism, muscle aches, joint pain, difficulty walking (particularly stairs), difficulty concentrating, dizziness, shortness of breath, insomnia, and weight loss. Babies born to mothers on bed rest are often born at low birth weight and many end up in the neonatal intensive care unit (NICU) with complications.

What is striking is the lack of attention to the emotional and psychological effects that prescribed bed rest has on pregnant women. When posed to obstetricians their response typically is

"Many of the psychosocial stressors can be dealt with once mother and baby are physically safe."

However, studies have shown that maternal stress and anxiety prenatally can result in significant depression (perhaps leading to post partum depression) as well as mood changes and a sense of confinement and loss of control. These psychological stressors can have significant impact on the course of the pregnancy and the health of both mother and baby. Additionally prescribed bed rest affects a pregnant woman's entire family and can lead to child care problems, strained relationships and financial difficulties.

"Bed rest is ineffective in treating anything"

So reads the title of the clinical POEM presented in ***Essential Evidence*** in January 2000. The poem is a summary of a study published in the Lancet by Allen et al entitled, ***"Bed rest: a potentially harmful treatment needing more careful evaluation"***. In this study, Allen and associates perform a meta-analysis of bed rest studies up to that time and found that bed rest was ineffective in improving outcomes for a variety of medical conditions, including pregnancy complications, and in many instances caused patients to have worse outcomes.

Judith Maloni, PhD, RN, FAAN, a retired nursing professor at the Frances Payne Bolton School of Nursing at Case Western Reserve University studied high risk pregnancy and ante partum bed rest for some 23 years and found that despite its prevalence, there is no scientific basis for the bed rest prescription. In "***Antepartum Bed Rest for Pregnancy Complications: Efficacy and Safety for Preventing Preterm Birth" (2010)*** Maloni looked at 69+ research articles on bed rest and found that there is no medical or scientific evidence that bed rest is effective in preventing preterm births. Maloni's work also shows that in addition to being ineffective at preventing preterm birth, bed rest actually has many negative health effects on both mother and baby. Bed rest strains families and can cause significant financial and professional hardship. Maloni also shows that hospital bed rest is no better than bed rest at home and that bed rest at

home often has better outcomes as mothers feel more secure and comfortable in familiar surroundings. .

As much as we may all be shocked at what these researchers are saying, it is important for us to all take a deep breath, step back and look at the data critically. Much to all of our dismay, bed rest may not be the panacea it is touted to be. Currently there is not strong enough evidence that putting a woman on bed rest with activity restriction prolongs a pregnancy. The research to date recommends that in acute, emergent situations, women should be put on hospital bed rest for stabilization. Once the woman is stable and the complication has been "adequately managed" then women should be discharged home and supported there, but should not be placed on full bed rest. (Goldenberg, 1994, 2002, 2005). Further, researchers advocate considering alternative models as used in other countries which prescribe activity restriction in home and also provide home care programs (housekeeping, childcare, errands/shopping and medical monitoring).

One thing is very clear. The bed rest prescription needs to be reviewed and revised and quite possibly ceased. It may be time for clinicians, especially those in the United States, which has some of the highest rates of complications, bed rest, maternal and infant morbidity and mortality in the world (**WHO**, **Amnesty International**) to rethink how to manage high risk pregnant women.

In the meantime, until we have suitable alternatives, we'll do our best to support ***Mamas on Bedrest***. Support for women on bed rest first began in 1991 with **Sidelines**, founded by Candace Hurley. Hurley herself had been on bed rest with her pregnancies and knew first hand how difficult a task bed rest can be. She started the Sidelines Support Network to assist other women who ended up in her situation. To date, Sidelines has supported over 100,000 women through the bed rest experience with their one on one phone support and online resources.

In 1995, Joanie Reisfeld founded **Better Bedrest** after her own stint on bed rest complete with some financial distress. Better Bedrest provides peer support to pregnant women on prescribed bed rest but perhaps is best known for the micro-grants that it provides mamas in need.

One of my favorite support resources is **Keepemcookin**'. Founded by Angela Davids, KeepEmCookin' is an online forum where women on prescribed bed rest can come and share their stories and get support from one another and from Angela. Angela was prescribed bed rest during both of her pregnancies. She started KeepEmCookin' after the birth of her son. She has been running the forum since 2009

While these negatives and research articles stating that bed rest is not beneficial, we bed rest advocates are concerned that women will simply ignore their bed rest prescriptions, thinking them unjustified. So let's just get some things straight. We are not sure if bed rest is efficacious. We know that it causes some harm to a mama's body, her emotions, disruption to her life and potential harm to the baby. But until there is evidence supporting other treatments, the position of ***Mamas on Bedrest & Beyond*** is

"We will continue to support women prescribed the bed rest prescription as recommended. We recommend that women talk candidly with their clinicians about their concerns and ask when appropriate: what things can be changed, when activities can be increased, etc… Finally, we encourage women to utilize all of the resource and support services available to them."

But there is one more side to this bed rest debate**.** A personal concern of mine is how tightly we (providers and mamas alike!) are holding onto bed rest. It's not clear if it's because bed rest is connected to child bearing, something so visceral and intimate for a woman, but let's all remember that bed rest is simply a treatment, a tool, to help during a pregnancy complication. And while it's understandable that some women are very "attached" to their bed rest experiences, i.e. "Bed rest saved my baby," as Judith Maloni Ph.D aptly put in her publication,

"It is possible that ante-partum bed rest might decrease preterm birth but evidence has not yet been found to support that conclusion. Such evidence may be masked by the complex multi-causal and interrelated factors that contribute to preterm birth."

It is likely that a combination of bed rest, medical treatment, support and factors that we don't yet understand contribute to high risk pregnant women successfully giving birth to healthy babies. But what about the women who go on bed rest and don't deliver healthy babies or live babies? What then?

We must keep an open mind and consider this. Back in the middle-ages, physicians used leeches to “bleed out” infections and poisons from sick people. If you were ill today and went to your doctor and he/she recommended bleeding with leeches as your treatment, you’d consider them crazy as you sprinted out of their office. We don’t do that anymore because somewhere along the way a physician or researcher either realized the practice didn’t work or, more likely, found something that was more effective.

Likewise, from the 1940′s to the early 1970′s Diethylstilbestrol (DES), a synthetic estrogen, was given to women of child bearing age with the ***mistaken belief*** that it would prevent pregnancy complications and miscarriage without long term consequence. We now know that DES may prevent pregnancy complications and miscarriage in the mother to whom it was given, but it also damages (or inhibits formation of) the reproductive organs of the babies she produces. In friends whose moms took DES, one has no uterus. One had a bicornate uterus (a skinny uterus with two separate sides, not able to hold a pregnancy). A male friend is infertile (makes no sperm) and the origin was traced back to his DES exposure in utero. DES was a product approved by the US Food and Drug Administration in the 1940′s and was finally ordered off the market in 1975. As new evidence became available, we had to change our thinking and our treatment methods.

Wouldn’t it be nice if the same could be said of high risk pregnancy? The Sidelines Support Network was founded in 1991. Better Bedrest was established in 1995. The work that these organizations have done for high risk pregnant women is nothing less than phenomenal, supporting thousands of high risk pregnant women in 20+ years. But it is also a sin and a shame that we can’t say that so much else has changed in the care of high risk pregnant women in the 20+ years since these organizations were established that bed rest is no longer necessary. In what other medical discipline has there been such slow progress? Not heart surgery. Many bypasses are now being done via incisions in a person’s left side and using arteries from breast and upper arm muscles as opposed to the bone cracking, open chest surgeries formerly performed as standard. Breast cancer no longer requires the mandatory, disfiguring radical mastectomy but is often treated with lumpectomy, (much less disfiguring and tissue sparing surgery) chemotherapy and precisely focused radiation. Prostate surgeries today are most often performed via minimally invasive DaVinci Robotic surgery rather than open abdominal surgery. Consider Diabetes. Many patients receive insulin via mini-

pumps which provide pulses of the medication throughout the day enabling more evenly sustained blood sugar levels as opposed to half a dozen or sometimes more individual shots daily. Even birth control pills have been radically redesigned and the dosages and release of hormones manipulated such that some only need be taken quarterly or once a year. I could go on with the advances in arthroscopic orthopedic surgeries and Automatic Implanted Cardiac Defibrillators (AICD's) (which are now so small and compact they fit virtually unnoticed in the small depression below one's collar bone) and other medical advances but you get the picture. Despite all these amazing medical and technological advances in other medical disciplines, high risk pregnant women are still being treated with bed rest, with few new treatment options proposed or offered in more than twenty years, no improvements in outcomes and no reduction in maternal and infant morbidity and mortality. Isn't it time for a change?

Bed rest has been shown to have some fairly major negative consequences and yet no one can definitively say that it is helpful. The truth about bed rest in pregnancy is yet to be elucidated. Until then, everyone who is on bed rest, anyone who supports women on bed rest, or who endured bed rest for one or many children:

- Let's at least be open to the fact that bed rest may not be what we think that it is; it may be better than we believe, it may be more harmful than any of us could have ever expected.

- Let's be open to the fact that there are likely treatments out there-some sitting idly on a shelf or currently being developed-that may be much better than what we are using now to manage high risk pregnant women.

- Let's not hold so tightly to our own experiences and to our own work (those of us who support high risk pregnant women) that we resist changes and advances.

Finally, hopefully, researchers will find alternatives to bed rest and vastly improve the management of high risk pregnant women. I say this selfishly because I have a beautiful daughter and I have concerns about how much of my physiology is in her (i.e. will she experience the same or similar problems I had trying to have children?). I certainly hope that in 20 or so years if/when she is having children, if she does have complications we

have something more to offer her than the same inconclusive bed rest prescription that was offered to her mother some 20+ years earlier!

Is Bed Rest A More Common Occurrence?

Recently while speaking with my mom she asked, “Is bed rest really that common?” For my mom, this is all new terrain. Bed rest was not nearly so common when she was having my sisters and me in the late 50′s and early 60′s. So what has changed?

Bed rest is certainly more common now than when my mom was having kids and there are a myriad of reasons. Just to bring folks up to speed, according to the **CDC** the numbers of women being prescribed bed rest annually in the US are still holding at 750,000. But my mom’s question is one that hounds me. Why are so many women going on bed rest? In an effort to answer this question, we turn to the medical literature.

1. More Diagnostic tools to diagnose conditions for which bed rest is recommended. In the 1950’s and 1960’s, many of the ultrasound machines and fetal monitors that are used today to evaluate a mama and her unborn child simply didn’t exist. If a woman had a short cervix, she simply had a short cervix. Now I can hear the collective cyber gasp at that statement. But at the same time it makes you wonder, ***“How many women over the centuries had a shortened cervix during pregnancy and had a completely healthy baby?”*** **One could give the opposing view, *“Well how many women lost babies due to shortened cervix?”***

2. Bed rest is more common because we have more women having children later in life. I don’t know if I completely agree with this. My paternal grandmother gave birth to my dad at age 43 and he was her 15th child, 13th pregnancy (2 sets of twins, yikes!!) One could argue that her body was accustomed to having kids (one about every 18 months!). But one could also argue that her body was “worn out”. As far as we know, she had no problems during pregnancy, no bed rest and no still births. She did lose the twin boys, one at birth and one to an infant illness.

My reproductive endocrinologist explains it this way, “*Ovarian age can be uncertain*”. By that he meant that some women may be 20 years old yet have the ovarian function of a 40 year old, and some 40 year old women will have more youthful ovarian tissue and function than their much younger counterparts. There is no way to predict which women will have “youthful” ovarian function and which women will not. Likewise, there is no way to predict when a woman will cease to have ovarian function. When we speak of advanced maternal age, we know that in general, as a woman ages, her ovarian function

decreases as well as the quality of her eggs. However, we all know of older women who have had completely healthy, unassisted pregnancies, labors and deliveries and young women in their 30's who have struggled. The best that we can say for now is, relatively speaking, *as a woman ages, her chances of having difficulty conceiving and having complications during her pregnancy are increased and continue to increase as she ages*.

3. Assisted Reproductive Technologies (ART). Today there are thousands of women who become pregnant as a result of assisted reproductive technologies (IVF, GIFT, ZIFT, IUI, ICI and Surrogacy/gestational carrier). The use of ARTs is a relative risk factor for a woman being prescribed bed rest because women who use ART are often older and often have pre-existing reproductive issues that would predispose them to complications any way. Additionally, women who conceive via ART are at greater risk for having a multiple pregnancy which increases the risk of going on bed rest.

3. Stress. Today more than ever women are balancing the demands of a career, a family that they have created, caring for family members from family of origin (parents or even grand parents) or have other pressing responsibilities not common to women 30 or more years ago. **The work of Kathleen Kendall-Tackett PhD** shows that the stress response has a direct effect on the cervix and preterm labor. Women who are under stress are releasing neurochemicals that soften the cervix and "ripen" it in preparation for labor and delivery-even if it isn't time. Stress also increases a mama's blood pressure and may cause her not to eat or take optimum care of herself so her baby may experience Intra-uterine growth retardation (IUGR). It is critical that pregnant women avoid stress as much as possible not only for their own health but also for the health of their unborn babies.

4. Litigation. It's sad to have to mention, but in our current culture, litigation is probably closer to the top as opposed to the bottom of the list of reasons some obstetricians put patients on bed rest. But as a former clinician, I also understand why obstetricians prescribe bed rest.

If on the off chance an obstetrician discovered an anomaly with the pregnancy, yet did not prescribe bed rest and the pregnancy had an unhappy ending, that obstetrician can count on being sued and would likely lose his or her ability to practice as an obstetrician. At the current time, medicine in the United States (or globally) has not discovered any

other, more effective ways to deal with the complications of pregnancy that often result in the bed rest prescription. Until that occurs, bed rest, effective or not, will remain a “standard of care” in the management of pregnancy complications.

The Effect of Pregnancy Bed Rest on Families

When mama is on bed rest the entire family is impacted and that includes extended family as well. Husbands take on the duties of the household in addition to their external jobs. If there are older children in the family, this can become particularly precarious balancing schedules and meeting their needs. The children, used to the regular flow provided by mama are now sometimes forced to take on more responsibility without that associated support customarily provided by mama. Even pets are affected, missing the time and affection provided by mama on bed rest. All of these areas and relationships in a woman's life are impacted and they all have to be addressed instantaneously and on the fly. Not an easy task.

Bed rest is also very hard on the extended families because while they are concerned about the baby, their thoughts are often with the mama (who is daughter or sister, etc…) and/or the father (son/brother). If family members are far away, it can be even more nerve wracking because they are getting reports after the fact, they cannot be there to see what is going and to help.

Let's not ignore the impact that bed rest has on a family financially. Today 52% of the US workforce is female. Of those, a large percentage of women are of childbearing age, many will become pregnant and several will go on bed rest. In a time when many families rely on both incomes to survive, the sudden drop in a salary can be devastating financially. Add to that fact many women earn more than their husbands and often carry the medical benefits. So if mama loses her job which frequently occurs because there is no guaranteed job security or paid sick leave in America, and bed rest can be devastating financially for a family.

Thankfully today there are websites and even organizing programs that help families settle into a bed rest routine, help with job communication and financial planning. Families can set up **Care Calendars** listing specific needs and times and then friends and loved ones can sign up for tasks and times to help. It's all done online and there is minimal intrusion to the family in need. There are also support networks for mamas, dads and even kids who are experiencing bed rest. There are books and videos. And in certain cities there are services that provide in home services for mamas on bed rest.

A Word about Older Mamas

As an older mama, I am always sensitive when I see reports indicating the problems and complications associated with being an older mama. A Reuter's Health Report states that pregnancy is more risky for older moms having their first child over the age of 45, but it's not impossible. Even if a woman is not able to carry her own child, there are surrogates (women who will donate an egg to a pregnancy and then carry the pregnancy) as well as gestational hosts (women who will carry a child for a couple) and adoption. Older women can have the children their hearts desire.

The study was conducted in Israel and found that pregnancy and childbirth in Israeli women over age 45 has nearly tripled over the last decade. The study looked at 131 mothers ranging in age from 45 to 65 who gave birth between 2004 and 2008. Forty percent developed gestational diabetes and 20% had preeclampsia. One third of the babies were born prematurely and nearly all were delivered by cesarean section. All but 5 of the women had become pregnant with assisted reproductive technologies.

Caplan and Patrizio ask the question, ***"Are You Ever Too Old to Have a Baby?"*** In their research, they examine the ethical and moral dilemmas of older mamas (some as old as 65 years old!) having children. Most all of the women in their study became pregnant as a result of some sort of assisted reproductive technology and Caplan and Patrizio state,

"We argue in this article that there are reasons for concern when older persons seek to utilize fertility treatments, including the safety of pregnancy for older women, risks posed to children delivered by older mothers, issues around what constitutes safe conditions for having a child relative to the age of parents, and the importance of guaranteeing that someone will serve in the parental role should an older parent or parents become disabled or die. To protect the best interest of children created by technology in new familial circumstances, internationally recognized and enforced standards for fertility clinics to follow ought to be enacted in making decisions about treating older parents seeking infertility services."

To those statements a fair retort is,

“Is it any better for a 13 or 14 year old girl to give birth to a child? Is she any more competent to parent? Are she and the teen father any more able to financially provide for the child? Are they any more competent at coping with a child with special needs? Can anyone guarantee that parents of any age won’t become seriously disabled, won’t face financial ruin or won’t die leaving a child orphaned?

It’s safe to say that mamas at the extreme ends of the reproductive spectrum are at increased risk of pregnancy complications. But trying to enact some sort of limits on who may have a child and who may not begins treading into some dangerous moral and ethical territory. Looking at the physical safety of mother and child is one thing. How are we, as a society, to determine who should and should not be allowed to try to have children?

Why is it so much more difficult to have a child, especially a first child, over that age of 45? First and foremost there are the physiological changes going on with a woman. If a woman has never been pregnant, the quality and number of eggs that her ovaries will produce will be lowered. At 45 years old many women are approaching menopause and their bodies are responding to hormonal fluctuations. In particular, she may have uterine changes such that she is unable to sustain a pregnancy. Women are also at risk of having developed hypertension and Type II diabetes by age 45. Researchers in this study recommend counseling against pregnancy if an older woman already has a pre-existing condition.

While the researchers acknowledged the increased risk to older mothers and their babies (increased risk of being born prematurely, at a lower birth weight, requiring intensive care in NICU and having developmental problems) they did not make being over age 45 and absolute contraindication to attempting pregnancy.

I can attest to the fact that the older you are having children, the more risk there is to you and your baby. My first pregnancy at age 35 ended in miscarriage. The second was high risk, fraught with complications and resulted in my daughter being born at 36 weeks and 6 days at 5 lbs 3 oz. I suffered a miscarriage of my 3rd pregnancy at age 38 and had my son, my 4th and last pregnancy at 40 yrs and 4 months. I was not as old as the women in the study in Israel yet did experience more complications than women say 5-10 years

younger than I was at each age. If I had it all to do over again, would I? Absolutely, but I have to admit that I would do it a lot smarter.

Before each pregnancy I would engage in a 3 month pre-conception "conditioning program" where I'd take exquisite care of myself; priming my body with exceptional herbs and supplements, getting lots of rest, making sure that I was at ideal body weight for my height and that I was fibroid free. In preparation for complications, I'd have a support system in place-either my mother, mother in law or friends in the community at the ready and available to assist me with my activities (especially with my second/fourth pregnancy with my son where I had a 3 1/2 year old to take care of as well).

While complications are expected in older women having babies, they aren't an absolute given and they don't have to be horrendous. As researchers in the Israeli study pointed out,

"Starting motherhood at an advanced age may carry risks, but they're not prohibitive risks. People of all ages are interested in having a child and completing their families."

It can be done.

Technology and Mamas on Bedrest

Mamas on Bedrest are at increased risk of labor and delivery complications due to their high risk pregnancies. Pre-Eclampsia, Gestational diabetes, multiple gestation, placenta previa and preterm labor along with other complications put a mama on bed rest at increased risk of having a cesarean section delivery, which in turn puts them at increased risk of hemorrhage, stroke and intra-partum death.

Although childbirth is one of the most natural processes in all of human nature, women have died in childbirth since the beginning of time. While much has been done to improve maternal morbidity and mortality surrounding childbirth, the very methods used to save women are also the very ones at increased odds of killing them.

Consider this. Despite having incurred the wrath of God and being banished from the Garden of Eden Eve, with only Adam at her side and no medical intervention whatsoever managed to give birth to twin boys Cain and Abel. (Genesis 4:1-15)

Fast forward hundreds of years to Nazareth, "the first Christmas". A young couple is seeking lodging because the wife is large with child. The young Virgin Mary had been impregnated by God. (Luke 1:26-38) After she and her betrothed Joseph go to Bethlehem to register for the census, Mary gives birth to the Christ child in a stable-on her own with only Joseph and the animals to help her. (Luke 2: 1-7)

Now many people are skeptical about the accuracy of these biblical accounts. Yet one cannot deny that in earlier times, women did have very natural births, were attended by midwives or family members and were cared for by the women of their tribes, villages and family members. Yes many women and babies died, but we as humanity have survived, so the process has worked-without mankind's assistance-for millennia. Despite the natural occurrence of childbirth, there are inherent dangers in childbearing.

California has come under intense scrutiny as their maternal mortality rate has steadily climbed since 1996 and is at an all time high of 16.9 in 2006, the last year for which data has been compiled. Physicians and researchers who are analyzing the data note that there are several contributing factors to the increase:

- obese mothers
- older mothers
- fertility treatments
- better reporting of outcomes and better record keeping
- Preterm labor inductions
- Rising Cesarean Section Rate

None of the people who have read the reports can deny the impact that cesarean sections may be having on maternal mortality not only in California, but also nationwide. In California, the cesareans section rate doubled between 1996 and 2006, the years for which maternal mortality showed its dramatic increase. Additionally, the rate of pre-term labor inductions also increased in the same time period and preterm labor induction is known to increase the rate of cesarean section. Many ask the question, “Can these results be extrapolated to other states?”

Obstetricians, midwives, birth professionals and concerned citizens are all trying to determine the proper role of cesarean section in childbirth. While no one wants to go back to the middle ages when women routinely died during childbirth, we can’t ignore that today’s infant and maternal mortality rates are rising at an alarming rate despite all of the medical advances.

The first successful cesarean section on a live woman is said to have been performed in the 1500′s in the Roman Empire by **Jacob Nufer**, a pig farmer who performed the procedure on his wife. Interestingly, the procedure initially was not widely performed because of its high mortality rate-some 85%. But with the advent of anesthesia and aseptic technique, cesarean sections became safer and more widely performed and accepted. Today in the United States a full1/3 of children are born via cesarean section. Conversely, it is reported that many of those surgical births are not medically necessary.

In response to this growing number of cesarean sections, in 2002 **Dr. David Lagrew**, the medical director of the Women’s Hospital at Saddleback Memorial Medical Center in Orange County California set a rule: no elective inductions before 41 weeks of pregnancy, with only a few exceptions. The results, the operating room schedules opened up, the hospital saw fewer babies admitted to the neonatal intensive care unit, and fewer hemorrhages and fewer hysterectomies occurred.

While no hospital can be accused of performing cesarean sections as a way to increase revenues, few hospitals have been quick to adopt a “no preterm induction” policy. Likewise, hospitals that have adopted a no preterm induction and/or a low cesarean rate policy have been primarily non-profit facilities (click here to read blog post on **Indian Health Service**). These hospitals have cesarean section rates more in line with the World Health Organization’s 10-15% and lower maternal and infant mortality rates.

So what is the answer? Clearly no one wants to sit by and watch US maternal mortality rates rise yet the medical community is very reluctant to completely change from its current structure. This country has already lived through treacherous times for childbirth during its infancy. The advent of technology, which initially led to a decrease in infant and maternal mortality, now poses a threat to mothers and babies nationwide. Despite the inevitable outcry from those who benefit from the use of technology (Dr. Lagrew noted in his own hospital, revenues go down when procedures go down) it is patently evident that its use has to be reined in.

You're the Team Captain, You Call the Shots!

Mamas, now that we are clear on the origins of bed rest, why it is prescribed and some of the good and not so good aspects of bed rest, you may be asking, "How do I navigate this crazy ship so that I have the best possible experience and the greatest possibility of success?

The Alliance for the Improvement of Maternity Services has outlined the rights of pregnant patients in their document, **The Pregnant Patient's Bill of Rights**. In a very thorough and easy to understand (albeit long) document, the Alliance has clearly outlined the difference between consent and ***informed*** consent as well as the specific rights of a pregnant patient regarding her medical care and that of her baby. ***I think it should be required reading for all obstetrical patients!*** While there are numerous salient points in the document, I want to focus on one in particular, the right to decline treatment.

Previously, the American Congress of Obstetricians and Gynecologists (ACOG) as well as the American Medical Association (AMA) believed that because a physician presented a treatment and procedure to a patient and a patient signed a form consenting to have the procedure that meant that the patient had given informed consent for the treatment. But in 1974 with their ***Standards for Obstetric-Gynecologic Services*** publication, ACOG acknowledged that there is a big difference between giving consent and giving *informed* consent. **Informed Consent** means,

- That a patient has actually been given information about the treatment
- The Patient understands the treatment's efficacy
- The Patient understands why the treatment is being proposed
- The patient actually understands how the treatment works and the intended outcomes
- The patient has been informed of all the potential risks and complications, the expected recovery and any long term potential complications
- The patient has also been advised of any alternative treatments

What I want to emphasize is the fact that once a patient has all this information or even if they don't have all this information, **A PATIENT MAY REFUSE TREATMENT AT ANY TIME.**

The best way for women to safeguard their health care is to take an active role. I always tell my clients to choose their providers wisely. Find providers who are not only highly skilled but also keep up with the latest advancements within their discipline. Once they have found someone who is qualified as far as expertise, I advise them to choose a provider who *they* like and trust. While referrals are great, you can't always rely on the recommendations of others. Your neighbor may love her OB, but you may find that your personality clashes with that OB. Everyone is different. Find a provider who you feel puts your interest-medically and personally/emotionally-first.

Next, you as a patient have the responsibility to know what is going on. This is a foreign concept to many women. Many women of my mom's generation for example, feel that it's the doctor's job to tell them what is wrong, how to treat it and also how to feel. My mother rarely questions her doctor about anything. Even if something isn't going well, she doesn't want to call and "bother her doctor". Many patients don't want to upset their providers by questioning their instructions or disagreeing with a treatment plan-even if they don't feel good about it. Speak up! Most times your provider has alternative options, but you won't know if you don't ask. A phone call is often a good way to get your fears and concerns addressed.

If you are uncomfortable with something, get more information (get some literature to read or even a second or third opinion!). A really good idea, if possible, is to have someone go to with you to your office visits and take notes. Typically when we are ill or have a medical problem, we are not at our intellectual best to make decisions or to even hear all of our options. A companion can be more objective, can focus on the information being relayed and ask (or encourage you to ask) questions you may not have thought to ask. They can remind you of important information later, when you are at home and more relaxed. They can also help you to remember instructions that will enhance your care and ultimately your recovery.

Health care can be intimidating. It's foreign territory for many people especially those who have never been ill or in the hospital, which is sometimes the case for a first time pregnant mama. For a woman who has never been ill, a complicated pregnancy can prove to be overwhelming. But keep in mind, everyone involved is there to help ***YOU***! ***YOU*** are the center of attention and all decisions and treatments should be guided and directed by what works best for ***YOU***. Clinicians are there to provide you with their best

medical advice, what they believe to be the best thing for you at that moment as they know it. You don't have to agree and if you feel really uncomfortable, you have the right to refuse the treatment.

Always remember, even in the trickiest of situations, **you ultimately call the shots!** A mama once posted on our **Facebook Page** that she had some concerns about her pregnancy and she wasn't sure she'd be able to have as natural a birth as possible. The mamas in this community really encouraged and empowered this mama to stand her ground for as natural a birth as possible. They gave her sage advice to be very clear on her desires for her birth and to make sure that everyone knows what she wants and is on board to provide that care. One must always remember that **the health care staff works for YOU!** And while in our current paradigm health care providers often act as if they know what is best for us, in the end, we have the choice to say what treatments we receive.

The most important rule of thumb is to **make sure that you understand each and every medication, treatment and procedure that is proposed. If you have questions, make sure they are answered to your satisfaction BEFORE you sign any consent form.** (Truly make it informed consent! See above.) Here are some other suggestions for being a competent captain of your health care team:

- **Have an advocate.** Having someone who knows what you want and who can express your desires if/when you cannot express them yourself is critical. Also, having someone there who is "all for you" is a tremendous emotional boost. This person has to be strong, knowledgeable, able to speak up to hospital personnel and yet someone who will first and foremost have your best health interest in mind, someone who may be able to help translate difficult information so you can make informed health care decisions if necessary. A doula is an excellent option if you don't have a family member or friend who can do this or if you prefer someone without the emotional ties and has some training in this area.

- **You can refuse to be induced.** Now this is a bit sticky. For example, in Gestational Diabetes, there is always the risk of having a larger baby. However, if neither you nor the baby is in distress, there are no complications and you are not post dates, there really is no medically necessary reason to induce. You have

the right to a trial of labor. Discuss this you situation with your obstetrician and get the exact, specific reason he/she wants to induce your labor. If you have questions, you have the right to consult with another obstetrician for a second opinion. Just be sure that an induction is truly indicated as it carries with it increased discomfort, the increased likelihood of an epidural, the increased likelihood of you having a c-section and an increased risk of your baby needing intensive care in the neonatal ICU (NICU).

- **You don't have to have an epidural.** You don't have to have an epidural. Again, if every thing is progressing without complications or distress, and you feel comfortable and competent to manage your pain, you are well within your right to refuse an epidural.

- **You don't have to have an episiotomy.** An episiotomy, a surgical cut in the perineum is not necessary. Many obstetricians perform this to "prevent tearing". However, there are methods of perineal massage that allow for natural stretching of the tissue in this area. Most Midwives know these techniques and most US obstetricians do not. Ask a midwife or doula if they can share methods of perineum softening/stretching to ease delivery.

- **Make Friends with the L & D staff.** If you can, visit the Labor and Delivery floor at the hospital at which you intend to deliver. Chat with the staff; get a feel for how the nurses care for the patients. The more you know up front, in terms of how the floor is laid out, the shifts, the nurses, how many patients per nurse and the nurses themselves the better will be your experience.

- **Bring things from home to make your surrounds more comfortable and "homey"**. Most of the mamas advised that mama bring her own gowns, robes and slippers, candles, music, pillows-anything that she finds soothing and that will make her surroundings feel more like home and less like a hospital room.

Finally mamas, when you are confronted with major medical complications during your pregnancy, assemble your very own "dream team" of medical providers.

"But I have an OB!" you may be saying.

Yes and your obstetrician is a very important part of your team in that s/he will likely be the point of contact for all of your other "team members". And while the obstetrician will be your #1, your right hand Man (or woman), always remember that **YOU are the captain of this team!**

Complications tend to arise in bundles. While this is flat out scary, it doesn't have to render you powerless. Assemble your dream team. Here's an analogy that helped me, using one of my favorite hobbies/resources, HGTV. If I am remodeling my kitchen and during the process I find some structural problems what do I do? Well, on HGTV, they call in a structural engineer and make sure that there is nothing that needs to be done to assure the integrity of the structure. If repairs are needed they are made. In this case, the obstetrician has noted placental complications, so carrying on with the HGTV analogy we need to call a "structural engineer" or a Maternal Fetal Medicine Specialist (MFM). These obstetricians specialize in obstetrical complications. They see and treat the "weirdest of the weird". So if you have obstetrical complications, a consultation with a MFM should be at least considered if not undertaken to make sure "the underlying causes of the problem are managed with the greatest skill and expertise available."

Now I know that many of you may be wondering,

"Is it really necessary to see a specialist? Why can't my OB manage my problems?"

Let's go back to our HGTV analogy. If the contractor notes an electrical problem, he doesn't try to fix it himself, he calls in an electrician. If there are plumbing or sewage issues, he calls a plumber. If we'll utilize specialists for our homes, why not for our bodies? Some of you may be saying,

"But my insurance may not cover all those doctor visits? What do I do?"

I wholeheartedly recognize that seeing specialists is expensive and time consuming (especially getting the referral and pre-authorizations) but it is so worth it! Because specialists identify and treat the issues you are facing daily, they are more up to date on the latest treatments, the latest research evidence and the latest nuances of your

condition. In my experience, they are well worth the time and expense for the consultation.

Lastly, I want to add a little word here about obstetricians. I have had more than one mama write and tell me that when she asked for a referral to a specialist that her obstetrician got angry with her for questioning their judgment and expertise. At least one mama had her obstetrician "fire" her from the practice for questioning his judgment. To this I say **YOU** have to be the captain of your team and at all times, you have to guide your treatment! Not only should you ask questions about your care, if you have any reservations or even a desire to just know more, you are well within your rights to seek another opinion. And **DO NOT LET YOUR OBSTETRICIAN BULLY YOU!!** If an obstetrician threatens to fire you or withhold medical care or refuses to share your medical information, they are in breach of the Hippocratic Oath that says "First do no harm" as well as acting illegally (in the case of the medical records). You may want to really consider if this is the person you want taking care of you and your baby. A really good obstetrician will play a vital role in your care, but just like everyone else, they don't know everything and you want an obstetrician who is willing to admit that they don't know everything and has no qualms or ego issues about consulting and working with specialists.

I cannot stress enough the importance of assembling a dream team and assuming the role of team captain. Mamas, your pregnancies are very likely going to be the most significant medical issues of your life. Their outcomes can have significant health ramifications for you and your child down the road. This is no time to be shy or to ***assume*** that your obstetrician knows what is best. Ask questions, stay informed and by all means, always make wise, informed health care choices! "Pro-Action" All the way!!

Must Haves for Mamas on Bedrest

A writer for the Huffington Post inquired of ***Mamas on Bedrest & Beyond***,

"What would you consider essential for a mama on bed rest?"

Besides internet access, a television with remote, books, crafts and handy snacks, there are 4 things **EVERY *Mama on Bedrest needs***, **"Must Haves"** for bed rest success.

Help. While issues such as bleeding and preterm labor can occur emergently, the bed rest prescription often comes out of the blue and as a complete surprise to mamas. A mama arrives at the OB for what she thinks is a routine office visit, a complication is noted and then she is either sent home on bed rest or admitted to the hospital. From that point on, she is in reaction mode. She has to deal with her job, make arrangements for childcare, make arrangements for household care….Mama needs help. If you can assist mama with childcare, house keeping, shopping, or managing any of her other myriad of obligations, you will be bringing mama much needed relief.

A Body Pillow. Pillow support is a must for mamas on bed rest. At any given time I had about 6 pillows wedged around me, including a full body pillow, my "main squeeze" at the time. (Didn't leave much room for the husband, but I was comfy!!) Body pillows have come a long way since my pregnancies but one that I like is called the Snoogle® This large c-shaped pillow is long enough so that mama can wrap herself around the pillow and support her knees, hips, belly and neck. It is reasonably priced and can be shipped just about anywhere. Covers for Snoogles are also available. For tips on how to best position yourself while on bed rest, check out our **videoblog** on the subject.

Massage. Contrary to popular belief, being on bed rest is not fun nor is it restful or comfortable. Even with a body pillow for support, mamas develop various aches, pains and stiffness. Additionally, since they are not very mobile, they don't have their usual circulation and may develop distal extremity swelling. If at all possible, I recommend that mamas on bed rest have massages at least once a month-2 times a month or even

weekly if possible (but that can be pricey!!). ***A skilled prenatal massage therapist*** can not only soothe mama's sore and achey muscles, she can stimulate circulation so that

blood is flowing back up towards the heart and reduce swelling-especially in mama's lower legs and feet. A skilled massage therapist can also massage to stimulate lymphatic drainage, again moving fluid out of the distal extremities (hands and feet) where it tends to pool.

Exercise. ***Mamas on Bedrest***, like all pregnant mamas need to move. The problem is they are on restricted activity so most mamas have no idea what they can do. When I was facing bed rest, this was one of my major concerns, especially since I was a prenatal fitness instructor. So I produced **Bedrest Fitness**, a set of modified prenatal exercises for women on prescribed bed rest.

Now that you know the basics of bed rest and have a clear idea of the arguments for and against the bed rest prescription, it's time to craft your personal bed rest road to success. It can happen. It happens for thousands of American women each year and it can happen for you!

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