Prenatal Parenting: Reframing OB Care from a Traditional Medical Model to a Prenatal Parenting Model

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No Conflict of Interest to Declare

I do not have an affiliation with a commercial entity (financial or otherwise)
Why don’t we talk about stillbirth?

- Statistics USA/Ireland
- Traditional antenatal care
- Prenatal parenting
- Talking to ALL women about stillbirth
Why don’t we talk about stillbirth?

- Is stillbirth really common enough to warrant discussion?
- We don’t want to scare expectant parents about this random, traumatic, unexpected event?

Stillbirth USA

- Definition: fetal death occurring at \( \geq 20 \) weeks gestation
- Stillbirth rate 5.96 per 1000 deliveries
- 1 in 168 deliveries end in stillbirth
- 24,000 babies per annum
- Equivalent to a Boeing 747 crashing every 5 days for one year

Stillbirth Ireland

- Definition: fetal death occurring \( \geq 500 \)g or \( \geq 24/40 \)
- Stillbirth rate 4.5 per 1000 deliveries
- Annual number 300 - 320
- Road Deaths 160 - 190
- SIDS 20 - 25
Stillbirth - random, traumatic, unexpected

- Stillbirth is random, traumatic and unexpected
  .... Just like SIDS

- We don’t like to worry parents about their baby dying before birth yet we tell every new parent about SIDS

BUT...... Stillbirth is 10 times more common than SIDS

Stillbirth – random, traumatic, unexpected

- Stillbirth is random, traumatic and unexpected
  ............Just like a RTA/MVA

- “We never find out why”
  - Inadequate post-mortem protocols
  - Role of specialist perinatal pathologist

- “stillbirth just happens .... we can’t really predict it”
  - The belief that stillbirth can’t be predicted or prevented needs to be eradicated

Professional fatalism
Traditional Antenatal care

Antenatal Care – the origins

"The Dublin Practice of Midwifery"
Henry Maunsell MD

- Published 1834

"to supply an available knowledge of all appliances and means that are known to be requisite for the safe conduct of a patient through the perils and accidents of childbirth"

Antenatal care – the origins

- Used to be focused on preventing maternal death
- Still important BUT
  - Increased fetal surveillance tools
  - Cardiotocograph
  - Ultrasound
  - 7 Newer technology

Need to believe we can prevent baby deaths
Prenatal parenting

Working Alliance

- The process of creating and nurturing a supportive professional-parent relationship for the unborn baby
- Based on mutual understanding of the focus and goals of the pregnancy

Traditional Prenatal Visits in a Normal Pregnancy

- Mother’s weight, blood pressure, urine specimen
- Fetal heart tones and measuring size of uterus
- The relationship between the mother/father and the fetus is not always assumed. Parents think pregnancy but not baby until birth.
- I had never been pregnant. I didn’t really know what was going on. I didn’t really associate the baby with me or as a baby, as a person. I just wasn’t having my period anymore. It was just what was going on in my body, something biological.
- In her next pregnancy: This seems like more of a miracle.
- How the baby is perceived is how the baby will be cared for (O’Leary & Thorwick, 2008).
Prenatal Relationship to the “Inside Baby”

- Rather than conceptualizing pregnancy as a baby to interact with at birth, help parents visualize a baby “already present” (O’Leary & Thorwick, 2008).
- Being held in another’s mind is crucial for the therapeutic relationship (Pawl, 1995).
- When the “it” becomes “You” the dialogue begins (Ferdor-Frieberg, 2002).

Intervention

- Grounded in an infant mental health model of focused relationship-based intervention, “the baby as center” is an essential component of successful prevention (Fonagy, 1998; Fraiberg, 1980; Pawl, 1995; Weatherston, 1998).
- Beginning this model prenatal can make a difference in a child’s life.

What We Know about Development

Throughout our lifetime parents respond to children’s needs based on their developmental age.

A child at three months gestation is the same child at three years, just at a different developmental level, and, just as after birth, parenting behaviors adapt to meet the child’s needs.

From the moment pregnancy is confirmed, the neurological development of the baby is the driving force eliciting changes in the parent, causing physical and emotional responses in the mother and partner (O’Leary, 1991).

The Gesell Institute has done extensive observation of children’s development since the 1920s.

http://www.gesellinstitute.org
Encourage Use of Complimentary Therapies

- “The greatest mistake in the treatment of disease is that there are physicians for the body and physicians for the soul, although the two cannot be separated.” Plato
Low risk = “normal risk”
≠ ≠ ≠ NO risk

How come I didn’t know this could happen?

Stillbirth

“I never thought it could happen to me”
- Population education about stillbirth
- Risk reduction advice pre pregnancy
- Risk factor identification at first visit
- Talk to every woman about stillbirth
Patient Education

- Sleep
- Appointments
- Feeling the baby move
- Early attendance for expert advice
  Warland et al, 2014
- Pre-conceptual visit
- Quit smoking and recreational drugs
- Get healthy
- Know your family history
- Know your risk factors
- Sleep position
- Listen to your baby

Sleeping position

- 155 women with non-anomalous stillbirth > 28 weeks gestation and 310 controls
- Sleeping on left side had lower risk of stillbirth vs. sleeping in non-left position (1.96 per 1000 vs. 3.93 per 1000 p<0.05)
- Getting up to go to the toilet once or less vs more frequent wakenings had increased risk of stillbirth a 2.28 (95% CI 1.40-3.71)

Appointments

- Reach out to vulnerable women
- DNA policy
- Outreach clinics in low socio economic areas
- After hours clinics
- Improves likelihood of FGR detection/ hypertension/ diabetes
- Attending builds trust with HCP
- Makes patients more likely to confide if they feel “a bit off”
- Continuity of care
Growth Restriction and Stillbirth

- Antenatal recognition of fetal growth restriction - poor (160/195 – 82% not detected)
- Overall stillbirth rate 4.2/1000 births
- Pregnancies without FGR 2.4/1000 births
- Antenatally detected FGR 9.7/1000 births
- Undetected FGR 19.8/1000 births

Gardosi et al, BMJ 2013

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Fetal movements

- N=275 Mums with singleton, non anomalous pregnancy
- Presented to ER with reduced fetal movement > 28/40
- 4 IUFD (i.e. rate 14.5 per 1000)
- 59 (21%) delivered on first presentation
- Overall IOL more likely in the RFM cohort (42% vs. 28% P < 0.05)
Guidelines on fetal movement

- Pregnant women should be routinely provided with information regarding normal fetal movement.
- Women should be advised to contact their health care provider if they have concerns about fetal movement.
- Women who are unsure whether movements are decreased should be given guidance on how to know their baby’s movement.
- Clinicians and home visitors should emphasize the importance of maternal AWARENESS of FM’s at every visit.
- Encourage ways to connect with the baby; “Tell me about your baby.”

Fetal movements, talking to patients

- What is your baby’s normal? Vs. is your baby moving?
- You are the best judge of what is normal for your baby. ... I want you to tell me if you notice a change in “your normal.”
- If your baby isn’t behaving normally, here is some advice...

The EXPERT - Maternal intuition

- Expert – trust maternal intuition
  - Mums are experts on their baby!
  - Encourage them to contact HCP if concerns
  - Two stories with take home messages
First pregnancy
28 years old
Booking BMI 29.6
Non smoker
Manager in grocery store
36/40 routine Antenatal clinic
37/40 woke up feeling “a bit off”
Didn’t go to work
Attended GP - borderline elevated blood pressure
Reattended next day - BP settled
feeling nauseous and pelvic pressure
“baby a bit quieter than normal”

Two days later, started getting pains
Rang hospital - Advised to get into the bath until pains stronger
37+4 Born Before Arrival later that morning
Stillborn female infant
2.2kg (5th centile)
Postnatally
• elevated blood pressure/ increased urine PCR
• pre-eclampsia

Postmortem
• Structurally normal female
• Normal cytogenetics
• Placental hypoplasia (<3rd centile)
• Fetal vascular malperfusion
• Umbilical vein thrombosis
• Severe distal villous immaturity
Normal maternal bloods (thrombophilia screen, ACLA etc)
Missed opportunities

- Non-detected IUGR
- Reassured re blood pressure
- Did not really ask Mum about how she felt

“Denise”

- First pregnancy
- 37 years old
- Booking BMI 35
- Non smoker
- Hairdresser
- Routine Antenatal care
- 36+6 attended for routine visit
- Feeling “a bit off”
- “baby is a bit quiet but everyone is telling me that’s normal because he’s running out of room”
- Borderline BP 149/89/ pedal oedema ++/ no proteinuria

“ You are really not yourself”
- “I feel really really anxious and I don’t know why”

- What would you do???
- CTG normal
- USS – Doppler normal
  - AFI 6cm (borderline reduced)
- IOL
- ARM at 12
- SVD at 18.10
- Female infant
- Apgars 9/10
- BW 2.5kg (10th centile)

Opportunities taken

- Pattern recognition
- "Intuition"
- Over intervention

When a Mother Calls the Hospital

- Reflect back questions to glean more information
- Ask about previous 24 hours
  - How she felt
  - How baby moved
- If she is still anxious => ask her to come in
Induction of labour

- Induction focussed on higher risk groups may help lower the stillbirth rate
  - Advanced maternal age
  - FGR/Slow down in growth
  - Post term
  - Reduced fetal movements
  - Borderline BP
  - Multiple risk factors

Model for decreasing stillbirth

- Improve HCP identification of Risk Factors
- See the fetus as a "real" patient in society
- Engage Maternal intuition

Stillbirth Risk Assessment

- Population – encourage risk reduction prior to conception
  - obesity/advanced maternal age/diabetes/hypertension/smoking
- Encourage staff to identify risk factors
  - share this knowledge with women
  - Individualised care pathway
  - Salicylate acid, growth scans, induction of labour in high risk groups
Ongoing Stillbirth Risk assessment

- Reach out to vulnerable groups
- Identify changes in fetal and maternal characteristics that warrant closer monitoring +/- delivery
- Empower patients to know their baby and speak up if worried
  - Mobile Applications
  - Blogs/Forums
  - Twitter/ Facebook

Believe we can – there is room for further improvement!

Foundations of Antenatal Support and Intervention After a Previous Loss

- Reflective practice
  - Listen to their stories!
- Understand the continued parenting relationship with the baby who died while helping them parent the surviving children
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