



COMMERCIAL DRIVE MIDWIVES

WELCOME TO COMMERCIAL DRIVE MIDWIVES

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Welcome to Commercial Drive Midwives

Our Practice:

We are an established midwifery clinic that provides complete and personalized care to families through all stages of pregnancy, labour, birth and to six weeks postpartum. Our goal is to empower women and their families to experience the childbearing year with knowledge, confidence and joy! In addition to providing home birth services, we also have admitting privileges at St. Paul's, B.C. Women's, Burnaby General and Royal Columbian Hospitals.

The first clinic of its kind in East Vancouver, we proudly serve the women and families of Vancouver, Burnaby and New Westminster. Our services are fully covered under MSP. Consultation with other health care professionals is easily obtained for our clients when needed, with midwives continuing to provide supportive care.

Check out our website at: www.commercialdrivemidwives.com, ring our office at 604 875 1899 or drop in during office hours Tuesday, Wednesday, Thursday from 9.30 to 5pm and Friday from 9:30 to noon.

Brief Biography of Commercial Drive midwives:

Grace Brinkman RM

My interest in midwifery began in 1984 at the home birth of my nephew. It was at this birth that I truly understood the incredible support midwives could give to birthing women. In the following years, I gave birth to my three children and educated myself in the Art of midwifery.

In 1995-96 I undertook a clinical internship in a birth center in Texas. And from 96 -98 had a small home birth practice in the Kootenays. I registered with the first wave of Midwives in 1998 and have been actively involved in the MABC, Midwifery Advisory Committee, Midwifery Departments including the Executive advisory committee to the Midwifery Department at BCWH.

I have enjoyed the opportunity to witness and be part of the birth of the diverse families in my practice; they have all enriched my life beyond knowing. I have a strong commitment to women and their families as the women themselves define their family. I believe that education demystifies and helps integrate all the unique aspects of childbearing. It is with this in mind that I look forward to sharing my midwifery knowledge and experience with the birthing families in my practice.

During the last 10 years of practice I have worked all over BC and am now so content to be established in my own neighborhood at Commercial Drive Midwives working with incredible colleagues.

June Friesen RM, IBCLC

When my 3 children were growing, I was a La Leche League Leader. I learned about breastfeeding and to appreciate women's ability to change their lives. In the 1980's I spent 3 years in Zaire, Africa with my family where I viewed first hand the impact culture has on birth. During the 1990's I apprenticed in a midwifery practice, certified as a lactation consultant and practiced as a primary care midwife in Saskatchewan. I have been active in provincial and national midwifery associations.

I've been registered to practice midwifery in BC since 2000. My motivation has been to make the midwifery model of care available to women wherever they choose to give birth. I am pleased to be involved in this growing profession, providing care to women and providing an opportunity for midwifery students and midwives from other countries to experience midwifery practice in BC. I am especially delighted to be established in my own neighborhood at Commercial Drive Midwives with such wonderful colleagues.

Corina Pautler RM

I attended a midwifery assisted home birth at age twelve, and since then I have always wanted to be a midwife. I graduated from Queen's University in Kingston, Ontario in 2001 with a BAH in Women's Studies and Health Studies. Following this education I began the Midwifery Education Programme at Laurentian University in Sudbury, Ontario. I trained in various locations throughout Ontario and was pleased to work with a diverse clientele including Mennonites and newcomers to Canada. I was pleased to complete my studies and clinical practicum in 2007 receiving a BHSc specialized in Midwifery.

I began my career as a midwife in Canada's arctic community of Rankin Inlet, Nunavut located on the Hudson Bay. Working with the predominantly Inuit population was very interesting and rewarding. My trust in natural childbirth was strengthened further in this remote site. It was beautiful to see pregnancy, birth and breastfeeding as such an integrated and accepted part of the Inuit culture. Spending the fall and winter in the Arctic gave me insight into the challenging social and environmental conditions faced by Inuit peoples of Canada.

This past spring I became a proud aunt to my sister's son and enjoyed helping her during the incredible transition from pregnancy to becoming a new parent. In my spare time I enjoy time with friends and family, music, travelling and photography. I am happy I have relocated from Toronto to Vancouver to begin the next chapter in my career. I am very excited to meet and establish relationships with clients of Commercial Drive Midwives.

Lindsay Tabah

A Montreal-native I left "la belle ville" and began my educational journeys at the University of Toronto where I studied English literature. After graduating, I worked with street-involved youth and with pregnant teenagers as a doula and counsellor. Soon after that, I decided I wanted to be a midwife. So I joined the Midwifery Education Program at McMaster University in Ontario in 2005 where I studied midwifery in both urban and rural contexts in Canada and also in South Africa.

I have also worked as a midwife in Uganda, where I ran a program called the Teso Safe Motherhood Project, and where I held a weekly radio show about safe pregnancy, breastfeeding and family planning. During my midwifery training I have had the honour of conducting over 100 deliveries (in greatly varying circumstances), both at home and in the hospital.

I am thrilled to be joining Commercial Drive midwives and look forward to meeting you and your family.

BC College of Midwives' definition of a midwife:

A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

Scope of practice of the midwife:

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant.

This care includes preventative measures, the promotion of normal birth, the detection of complications in the mother and child, the accessing of medical assistance or other appropriate assistance when necessary and the carrying out of emergency measures when necessary.

The midwife has an important task in health counselling and education, not only for the woman but also within the family and the community. The work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics, or health units.

This International Definition (2005) is supported by the International Confederation of Midwives (ICM), The International Federation of Gynaecologists and Obstetricians (FIGO), and the World Health Organization (WHO).

Model of midwifery practice:

The midwifery model of practice as developed in British Columbia is autonomous, community-based primary care, and incorporates the principles of continuity of care, informed consumer choice of birth setting, collaborative care, accountability and evidence-based practice. Together with the CMBC *Philosophy of Midwifery Care* and the CMBC *Code of Ethics* these fundamental principles define the midwifery model of practice.

Choosing Midwifery Care

The midwifery model of care focuses on pregnancy and birth as normal healthy process. We provide continuity of care and facilitate your informed decision-making. We work as primary care providers and are fully funded by the government. There is no additional charge to your family.

We provide prenatal care at our clinic on Commercial Drive. For planned hospital birth we will assess your labour at your home and once labour is established organise the move to hospital for

the birth. Most of our clients choose early discharge from hospital and the majority of early postpartum care is provided in your home. Low-risk women may choose to have their babies at home. In this case, a second midwife (back-up) arrives close to the birth of the baby to help out.

Informed choice is a fundamental principle of midwifery care in B.C. The childbearing woman is recognized as the primary decision-maker and it is the responsibility of the midwife to provide you with the information and evidence necessary to make choices for yourself and your family. We anticipate that you will be actively seeking out information, from your midwives and other sources, in order to make informed choices.

Your commitment to ongoing prenatal care gives us the opportunity to share knowledge so you feel in control of your care. A basic tenet of midwifery care is the trust relationship that builds between the midwives and their clients. Our fundamental accountability is to the women in our care. Secondly, we are accountable to our peers, regulatory body and the public to provide safe, competent and ethical practice. If we feel your care falls outside of our scope of practice and abilities, we will refer you to another care provider better prepared to care for you. We work in close collaboration with medical professionals and refer when indicated.

Prenatal Care

Prenatal care plays an important role in preventing and detecting problems that can arise in pregnancy. Your health and your baby's well-being are assessed during prenatal visits which are 30 to 45 minutes in duration. In addition, close attention is paid to the social and emotional aspects of pregnancy and parenthood. You are able to page the on-call midwife if concerns arise between scheduled visits.

Teaching Practice

We provide clinical supervision to midwifery students from the Midwifery Program at the University of British Columbia and midwives working toward registration in B.C., as well as medical students. We will discuss the options available for you to have a student involved in your care.

Prenatal Education

Attending prenatal education classes is recommended as a part of your preparation. We have brochures for many of these classes in our waiting room and prenatal classes are also held on our premises. See our website www.commercialdrivemidwives.com for current and upcoming classes..

Labour and Birth

By the time your labour begins, your midwives are aware of your wishes and plans for this special event. We will have discussed important issues requiring decision-making as well as what to expect at the time of birth and the first weeks postpartum.

Once you are in active labour, the midwife on your call for your team will be with you throughout the active labour and the birth. If a hospital birth is planned we encourage you to

labour in the comfort of your home until labour is well-established before moving to hospital. Your midwife will stay with you following the birth for the first 1-2 hours postpartum.

Postpartum Care

Your midwives will be caring for you following the birth and for the first six weeks of your baby's life. We will visit you at home 3 to 4 times in the first ten days as needed and also make contact by phone to answer any questions. We then ask you to schedule visits to the clinic for 2, 4 weeks at which time we offer group post partum visits, please feel free to ask your midwife for a private consult if you feel the need. We offer a private wrap-up visit at 6 weeks postpartum completing your care and discharge you and your baby back to your family physician. You are able to page the on-call midwife if concerns arise between scheduled visits.

Client Records

Your records are confidential and the information in them belongs to you. You may read and/or copy your chart at any time. At the last postpartum visit you will receive a set of records of your care for yourself and your family physician.

Lending Library

Please feel free to browse and borrow from our library. All the books and information in our waiting room are for lending and have library cards in them. With one \$20.00 refundable deposit, books can be borrowed from one prenatal visit to the next.

Reading Suggestions:

Jack Newman's "Guide to Breastfeeding", La Leche League, Sheila Kitzinger, William Sears Penny Simpkin's "The Birth Partner", Ina May Gaskin, Marie F. Mongan's "HypnoBirthing"

How to Contact Us

Our office staff are in the office Tuesday to Friday and will do their best to answer your calls. At other times, calls are forwarded to our 24 hour answering service and voice mail. These calls are processed on a daily basis.

If you have a question that cannot wait until your next appointment please page the midwife on call. If you are in labour or need to speak with your midwife urgently please page the midwife on call.

Changing Appointments

Please give us as much notice as possible. Appointments can be changed by calling our receptionist. Outside clinic times, please leave a message on our voice mail

Tips for nausea during pregnancy

1. Eat!

- Never allow your stomach to be fully empty.
- Keep a snack with you at all times. This keeps your blood sugar from dipping too low and triggering nausea.
- Protein is your best source of sustained energy and will help you in preventing nausea. Eat some just before bed to avoid feeling queasy in the morning.

2. DRINK!

- Dehydration is a cause of nausea and headaches. Aim for around 2 litres of water, unsweetened juices and herbal teas. Avoid soft drinks and caffeinated beverages.

3. AVOID!

- Smells, tastes and textures that trigger your nausea.
- Foods that can cause gas and bloating.
- Sucking on candies on an empty stomach. Although this may temporarily relieve nausea, the digestive juices you stimulate could make matters worse.
- Taking vitamin supplements on an empty stomach. Stop taking them if you find your nausea not improving, though continue with your folic acid supplement.

4. TRY!

- Acupressure with “Seabands” designed to assist with motion sickness; or firmly press an acupressure point that lies 1/6th of the way between your wrist and elbow, (approx. 2 finger widths), in the middle of the inner side of your forearm.
- Sleeping – exhaustion can aggravate nausea.
- 250 mg Ginger 3 – 4 times a day in capsule form (do not exceed 1 gram) or drink 5-6 cups of the tea throughout the day.
- Vitamin B6 25 mg throughout the day, not exceeding 150 mg.
- Homeopathic remedies. These are usually prescribed on an individual basis but Nux Vomica, homeopathic ipecac and sepia may help. Ask for assistance when purchasing.
- teas such as fennel, spearmint and chamomile.
- Digestive enzymes such as Papain and Bromelain at mealtime to aid digestion.
- Activated charcoal (2 capsules up to twice a day) may also help relieve a ‘sour’ stomach.
- Herbal remedies from a herbalist may also help.
- Aromatherapy oils are off-limits during the early stages of pregnancy. However lavender essential oil, when inhaled, may help relieve some nausea.

5. Keep active!

- Exercise such as walking and swimming may help.

Warning Signs in Pregnancy

Please page the midwife on call for the following:

- Anytime you feel the need for medical attention
- Unusual vaginal discharge
- Abdominal cramping
- Painful contractions before 37 weeks
- Severe nausea, vomiting or diarrhea
- Fever or infections
- Severe headaches not relieved by acetaminophen
- Severe persistent itching all over
- Dramatic decrease in baby's movements once a "norm" is established
- Depression, anxiety or emotional instability which decreases your quality of life

This list is not finite.

Other situations may prompt you to page us, such as a bad fall or involvement in a car accident.

Please inform your midwife of all hospital and/or medical office visits while we are your primary caregivers, so we may assist you in getting the best possible care.

Summary College of Midwives of BC Indications for Discussion, Consultation and Transfer of Care

	Initial visit	Pregnancy	Labour	Post Partum	Newborn
Discussion: with other midwives providing care (may consult)	History: Uterine malformations or fibroids Poor nutrition, adverse socio-ec Smoking, serious psych problems <17y or >40y, obesity, hypertension ≥5 th pregnancy, baby ≥ 4500 g. 1 late miscarriage or preterm, 1 low birth wt, 1 lower segment CS < 12 mos. last to next due date, Previous ante or postpartum haemorrhage; Hypertension in pregnancy	Presentation other than cephalic 4 wks prior to due date No prenatal care before 28 wks Uncertain due date	No prenatal care Thin meconium		Feeding problems ₁
Consult: (condition could impact on pregnancy)	Current Medical disease: cardiovascular, pulmonary, endocrine, hepatic, neurological, severe g.i., rubella in first trimester History significant medical illness, uterine surgery Family hx: genetic, hereditary, or significant congenital anomalies Obstetrical history- cerclage or incompetent cervix, repeated spontaneous abortions, >1 late miscarriage or >1 preterm, >1 low birth wt baby, Eclampsia, >1 CS Neonatal mortality or stillbirth, Postpartum hemorrhage requiring transfusion, <14 yrs, Significant use of drugs, alcohol or other toxic substances	Medical conditions arising: Endocrine, hypertension, renal, Significant infection Hyperemesis Isoimmunization, blood dyscrasia Hemoglobinopathies Serious psychological problems, STD, Obstetrical condition arising: Placenta previa without bleeding Repeated vaginal bleeding Other than spotting Poly or oligohydramnios Anemia unresponsive to therapy Inappropriate uterine growth Suspected or diagnosed fetal anomaly that may require physician management Twins Presentation other than cephalic at 37 wks. Documented 42 weeks	Preterm labour (34-37 completed weeks) Breech, Twins Suspected placental abruption or previa Prolonged rupture of membranes Unengaged head in active labour in primipara T > 38C more than once Prolonged active Phase Prolonged Second Stage Retained placenta	Persistent hypertension T > 38°C more than once Uterine infection Signs of urinary tract infection Wound infection Serious psychological problems ₁ Breast infection unresponsive to therapy	34-37wks, < 2500 g weight <3 vessels in umbilical cord, Excessive moulding and cephalohematoma Abnormal physical exam findings excessive bruising, abrasions, unusual pigmentation or lesions birth injury requiring investigation Congenital abnormalities: cleft lip or palate, congenital dislocation of hip ambiguous genitalia abnormal heart rate or pattern T <36°C or >37.9°C unresponsive to therapy Persistent poor suck hypotonia or abnormal cry, Persistent cyanosis, pallor jitteriness abnormal respiratory rate/pattern Failure to pass urine or meconium within 24 hr of birth Jaundice in first 24h, Suspected problem jaundice > 24h Weight loss > 10% body wt Infection of umbilical stump sight Vomiting or diarrhea Failure to regain birth wt in 3 wks Failure to thrive
Transfer	Current serious medical conditions: cardiac or renal disease with failure insulin dependent diabetes	Serious medical conditions arising Cardiac or renal disease with failure with failure Insulin dependent diabetes Gestational hypertension with proteinuria, or eclampsia Multiples other than twins Symptomatic placental abruption	Active genital herpes at labour Preterm labour < 34 wks, Abnormal presentation other than breech Multiples other than twins Gestational hypertension with proteinuria or eclampsia Prolapsed cord Placenta abruption, or previa, Abnormal fetal heart rate unresponsive to therapy, Thick meconium,	Hemorrhage unresponsive to therapy Uterine prolapse, uterine rupture Postpartum eclampsia Thrombophlebitis Thromboembolism	Apgar < 7 at 10 mins Suspected seizure activity Significant congenital anomaly requiring immediate medical intervention – omphalocele, myelomeningocele T instability

₁ Notwithstanding the requirement for discussion with a physician or midwife, discussion may be with another appropriate health care professional, for example a lactation consultant, a clinical psychologist or mental health worker.