Fourth Trimester Podcast

Episode 117: Evidence Based Care for Improving Postpartum Recovery - Advice From Dr Rebecca Dekker

Sarah Trott: [00:00:05] My name is Sarah Trott. I'm a new mama to a baby girl and this podcast is all about postpartum care for the few months following birth, the time period also known as the Fourth Trimester. My postpartum doula, Esther Gallagher, is my co-host. She's a mother, grandmother, perinatal educator, birth and postpartum care provider. I've benefited hugely from her support. All parents can benefit from the wisdom and support that a postpartum Doula provides. Fourth trimester care is about the practical, emotional and social support parents and baby require, and importantly, helps set the tone for the lifelong journey of parenting.

When I first became pregnant, I had never heard of postpartum Doulas, let alone knew what they did. So much of the training and preparation that expecting parents do is focused on the birth and newborn care. Once a baby is born, often the first interaction parents have with medical or child professionals, other than the first pediatrician visits, is the six-week checkup with the OB/GYN. *What about caring for mama and family between the birth and the six week doctor visit?* What are the strategies for taking care of the partner and the rest of the family while looking after your newborn?

Our podcasts contain expert interviews with specialists from many fields to cover topics including postpartum doula practices, prenatal care, prenatal and postnatal yoga, parenting, breastfeeding, physical recovery from birth, nutrition, newborn care, midwifery, negotiating family visitation, and many more.

First-hand experience is shared through lots of stories from both new and seasoned parents. Hear what other parents are asking and what they have done in their own lives.

We reference other podcasts, internet resources and real-life experts who can help you on your own parenting journey. Visit us at http://fourthtrimesterpodcast.com

Sarah Trott: [00:00:00] Hi, this is Sarah Trott and welcome back to the Fourth Trimester Podcast. I'm here with a special guest today. Today's topic is evidence-based care for postpartum recovery. And I'll introduce my guest in a moment.

Sarah Trott: [00:00:13] Before I do, I'd like to remind everyone that we have a website which is fourthtrimesterpodcast.com, and you can sign up for our newsletter and get information delivered directly to your inbox from us, as well as hit follow or subscribe anywhere you listen to your podcast so that you can be alerted every time we release a new episode.

Sarah Trott: [00:00:32] So today's topic, evidence based care for postpartum recovery, is something that I'm going to discuss today with Doctor Rebecca Dekker. So just to give you a bit of background on her. So Doctor Dekker had a traumatic birth experience herself. And that was something that really inspired her to pursue her own research and actually led her to found her own company called Evidence based Birth. She's an RN as well. She was an RN for two decades.

And in fact, she opted for a midwife assisted birth for her second child, even though it was illegal in her state. So that's really interesting and speaks volumes. So Doctor Rebecca has really focused on childbirth research. She has been investigating topics around movement, unnecessary interventions, eating well in labor, upright position births, midwifery and pain management techniques. She's also written a book. It's called Babies are Not Pizzas: they are born, Not delivered. Love that title. And so she's here with us today. Thank you so much for joining us, Rebecca.

Dr Rebecca Dekker: [00:02:07] Thank you for having me, Sarah.

Sarah Trott: [00:02:10] Yeah. So I would love it if you wanted to just take a moment and introduce yourself in your own words.

Dr Rebecca Dekker: [00:02:15] Sure. So my name is Rebecca. I'm a mom of three kids. I'm a nurse, and I have my PhD in nursing, and I live in Lexington, Kentucky, and I started Evidence Based Birth in 2012 and it became my full time job in 2016.

Dr Rebecca Dekker: [00:02:33] So what I do for a living is read the research on childbirth and then translate it into everyday language for parents and professionals. And then we make it publicly available on our website, Evidence Based Birth (https://evidencebasedbirth.com/). And we also provide continuing education for birth workers and health care workers. So that's kind of what I do in a nutshell.

Dr Rebecca Dekker: [00:02:52] But really at Evidence Based Birth, we're focused on our mission, which is helping families around the world get empowering, evidence-based care. And as you know, Sarah, there's a lot of places around the world where it's still difficult to get evidence-based care. So it's what I'm excited to spend my life working on now.

Sarah Trott: [00:03:15] Yeah. You've had such a tremendous positive reception to your work, not only from perinatal professionals, but from new and expecting parents and caregivers in general, because you're providing a lot of information directly to them as well.

Dr Rebecca Dekker: [00:03:29] Yeah. It kind of has a twofold impact, because we're trying to improve the care delivered by health care workers and birth workers, and then also educate parents at the same time. And it kind of levels the playing field because I really do believe that information can be powerful. And when parents can have access to the same information that their doctors or midwives have, then that kind of levels the playing field a little bit so that they can be more active and engaged in their own health care.

Sarah Trott: [00:03:59] Yeah. I mean, even understanding some of the language, I mean, for people who are finding themselves first time pregnant or entering becoming parents in some other way, it can be really helpful just to know some of the language that is being used in hospitals, or that the midwife might be using that they've never heard before. So even just starting that is huge.

Dr Rebecca Dekker: [00:04:19] Yeah, it's true. And most research has traditionally been locked behind paywalls. So if you want to get a single article, sometimes it'll cost you $30 or $40 or even more now. And even if you do get the article, it can be hard to understand what it's saying, because researchers also have their own jargon and ways of saying things that other people don't understand. So we try to serve as that bridge between the research community and everybody else.

Sarah Trott: [00:04:49] Yeah, just simplify it. Boil it down to the takeaways. That's amazing. so I would love to hear more about your own fourth trimester experience because that was some of your inspiration for your work.

Dr Rebecca Dekker: [00:05:03] Yeah. So my first postpartum or fourth trimester experience, I think, is a really good example of how the birth can impact your postpartum recovery. So I had a very difficult first birth. My water broke at 39 weeks and I went into labor on my own. But my labor took about 24 hours. And during that time I was not allowed to eat or drink or get out of bed. And they gave me a lot of IV fluids. I had a lot of interventions done. I had a vacuum assisted delivery after pushing for three hours. So as many of your listeners can probably identify with, if you have a long, exhausting labor and 24 hours isn't that long, it's pretty typical for a first time parent. But I wasn't allowed to eat for 24 hours and I couldn't sleep.

And I actually went into labor at like around 10 p.m. one night. So I hadn't slept when I started labor. And so by the time I had my baby, this was going on my third night without sleep and my baby was jaundiced. We were separated shortly after birth for about three hours, which meant I didn't get the golden hour. I didn't get that bonding time. the nurses did not know how to help me with breastfeeding. And by the time I got my baby back, she was really sleepy and had trouble latching. So then I dealt with pain and damage from that. And so when I got home I was engorged everywhere because I had had so many IV fluids, I felt like I had been run over by a truck because I'd pushed for three hours, had a vacuum assisted delivery, and just every muscle in my body was sore and my baby had jaundice and couldn't breastfeed.

Dr Rebecca Dekker: [00:06:51] Well. So this is kind of typical American though is you don't get a lot of help once you get home. Right. So I was out trying to take my baby outside in the sun and get her some natural light therapy because she wasn't severely jaundiced, but it still needed some light therapy. And I eventually had to find my own lactation support. So I used a peer support group with La Leche League, which they don't have a group in my town anymore, but at the time they did, and at the time there were no IBCLCs I could go see. My pediatrician didn't know how to help anyone with breastfeeding. My OB didn't know how to breastfeed. So if I hadn't found this community of other mothers who helped me, I would have been really lost. But as it was, once we fixed my baby's latch and we got the engorgement to go away and I had an oversupply, then I really relaxed and I actually loved my postpartum experience.

Dr Rebecca Dekker: [00:07:50] So everybody's postpartum is so different. I am one of those really strange people where I am on an emotional high for my entire fourth trimester, so I am just glowing. I have energy, I am happy, and it's almost like an unnatural happy, like above and beyond my normal level of I'm a pretty content person, and I don't know if it's because, like, I tend to have really painful pregnancies with migraines. And so once the baby's born, I'm like, oh, I don't have any pain. And plus, I think hormones affect me differently and everybody's unique. So I always felt really good. But other than that, the immediate recovery was really difficult.

Dr Rebecca Dekker: [00:08:30] And so with my second baby I made a lot of changes because I wanted a better birth experience. I wanted evidence based care, and I changed literally everything about my next birth. So when my next baby was born, three and a half years later, I had an easier, less complicated birth because of the new support I'd gotten and the new ways of I had a midwife and other methods of support. I was rested. I made sure to sleep during labor immediately after my baby was born, after the golden hour, and I had help with my older child. So my second "fourth trimester" was actually really beautiful, just very easy. I knew what I was doing. There's something to be said for it not being your first anymore. Although every baby is different you never know what kind of temperament your baby will have.

Dr Rebecca Dekker: [00:09:23] Then I had one more child. My third "fourth trimester" went smoothly physically, emotionally. But I did not have help with my older children, and so that was the main difference. I think my second experience was the best because of the support that I had.

Sarah Trott: [00:09:41] And I like that you took your experiences, even though they were very challenging from your first time around, and translated those into a much better outcome for your second and third experiences.

Dr Rebecca Dekker: [00:09:51] Definitely learn a lot. Sometimes you have to learn the hard way. I prefer not to learn the hard way. I'm the fifth of six children and I always preferred to learn from my older siblings mistakes rather than to make them myself because I felt like it was less painful that way. But at the time, I was the first in my friend group to have a baby. I didn't have family nearby, and so with my first baby, it was really challenging.

And I'm a big believer, though, in community and in learning from podcasts and other places like that, so that when you get to that postpartum period for the first time, you're not shocked by it. And I don't want people to expect it to be terrible too because everybody's fourth trimester is really unique. And I like to tell my story because then sometimes people are like, oh, like, you don't have to have postpartum depression in the fourth trimester. Even though it's common, it doesn't happen to most people. So that can be encouraging too.

Sarah Trott: [00:10:52] Yeah, exactly. I think that anyone who's listening can take heart, and the fact that they're listening means they're doing their research and they're learning not necessarily from older siblings, but from many people, such as yourself, who are using evidence based information to help influence the outcomes for others for the better. So that's really wonderful. And you know, the purpose of your work.

Sarah Trott: [00:11:16] So tell me a bit about your health care providers as part of that experience and if there were any takeaways that you had when it comes to selecting your care team or even like selecting care for your child?

Dr Rebecca Dekker: [00:11:30] Yeah, I think I'd love to talk about selecting care for your child, because I don't think it's talked about enough. And I'm really fortunate in that my sister, who's one of my closest friends, is a doctor. She practices family medicine and she's a professor as well and teaches residents and medical students. And she has a practice taking care of all the way from preconception to babies to to elderly people. And I love watching and learning and listening from her because she tells me a lot about what's going on behind the scenes in hospitals and what your listeners might not be aware of is that there is a national shortage in the US of pediatricians.

So there was just a big article, I think, in the New York Times about it recently. And people don't want to go into PEDs as a profession, which is really interesting because when I was a nurse, I just desperately wanted to be a pediatric nurse. My mom was a pediatric nurse practitioner. I love kids, I thought it would be the perfect fit. It ended up not being a good fit, mainly because I can't stand watching children be in pain, which is what happens when they're in the hospital.

Dr Rebecca Dekker: [00:12:43] You know, you often see that. But what I did learn from the fact that there is this shortage is that often your baby will just be automatically assigned to someone in the hospital. And so particularly after birth, you might not know the care provider they're going to see. If you've been able to, you might have picked out the practice, you know.

But what my sister tells me is that most people don't realize they can see a family doctor for their baby. So even though there is this shortage of pediatricians, you need to open up your mindset about what kind of provider because you could see a nurse practitioner like my mom was a pediatric nurse practitioner and a really excellent one, or a family practice doctor who is comfortable and experienced with babies or a pediatrician. So you kind of have a range of options that most people don't think about.

Sarah Trott: [00:13:43] And how would you delineate a family practice doctor from a pediatrician Just to make that really clear.

Dr Rebecca Dekker: [00:13:49] I should say on their website so they can be board certified in family medicine or board certified in pediatrics. So either one is capable of caring for infants. Now, some family medicine doctors, though, might go in to spend more time in geriatrics. Like they might take care of more older people, whereas some they should say on their website if they see babies.

There's been almost this erasure of the general practitioner, but they can be really helpful because not only do they care for your baby, but for you and your whole family, and they really get to know you and build a relationship with everyone. And they can also help with your prenatal care. So that's something that most people don't realize. But there's also a lot of. You know, warning signs or, or good signs when you're looking for a healthcare provider. Are you okay if I talk about that for a little bit?

Sarah Trott: [00:14:43] Yeah. Yes, please.

Dr Rebecca Dekker: [00:14:45] Yeah. So I was thinking of. Often at EBB Evidence Based Birth, we talk about red flags for obstetric care providers. But when it comes to picking a care provider for your child, I would tend to think more about green flags. And then I guess you could say the opposite would be a red flag. So these are the things that I would look for as a parent and somebody who has I'm a nurse and I have family members who are medical professionals, first of all, being positive reviews.

So I know you've had the founder of the Irth app on your podcast. Kimberly Seals Allers. And people might not realize that on the Irth app you can look for reviews on doctors and including pediatricians, so you can look at the Irth app, you can look on Yelp, you can Google the name of the doctor, the doctor's practice, ask around in your community if anybody has used them or has somebody that they personally recommend. And I guess a red flag would be if you see lots of negative comments, there's some really disturbing comments on their reviews. So that would be the first one.

Dr Rebecca Dekker: [00:15:51] The second one, which a lot of people don't think about, especially if you're a first time parent, is do they have evening or weekend hours or a way to contact them? And the reason I say this is because babies can get sick any

time of the day or night, on any day of the week. But they tend to get their symptoms get worse at night if they have an illness, and if you have no way of contacting them and if your only option is go to the emergency room. I mean, thankfully you have an emergency room, but it's better if there is a way for your baby to be seen that's not in just a standard emergency room. And a lot of doctors' offices don't have that. So looking to see if there is a weekend option. My oldest had lots of ear infections and she almost always came down with them on a Saturday or Sunday. So you know, once you're if your baby's crying and miserable and in pain, it's you can't just wait. You know, you have to see somebody. So that would be the second one.

Dr Rebecca Dekker: [00:16:54] A third one is does the care provider have lactation knowledge and training. So most people think, well a big part of the baby's first year is their feeding, right? But a lot of pediatricians have very minimal training or knowledge in lactation. It's a very small part of their medical education, and they're not required to have the same level of education, for example, as an IBCLC, an International Board certified lactation Lactation consultant. So a lot of times they will be helpless to help you if you need help. And they often will immediately. If you want to breastfeed, they'll still immediately recommend supplementing with formula because they don't realize that there are ways you can troubleshoot breastfeeding issues. So that would be the third thing.

Dr Rebecca Dekker: [00:17:43] And a lot of times you have to find one that has breastfed like their own babies because it's not covered. If they haven't gone on to get continuing education and additional training and lactation, then the next best thing would be if somebody if a pediatrician has breastfed their own children.

Dr Rebecca Dekker: [00:18:02] Then the fourth green flag would be if they care about your health as the parent as well as the baby because that directly impacts the baby's health. And again, that's another example of why somebody like a family care practitioner who cares about the whole family dynamic is important. so they care and they're screening you for postpartum depression, and they're asking you how you're doing, and they give you encouragement and reassurance and tips. As a parent, that's really important.

Dr Rebecca Dekker: [00:18:33] And then the fifth green flag would be that they listen to your concerns because if they're dismissing or not listening to your concerns that's difficult when your baby is healthy. But if your baby gets sick and needs more intensive care or any kind of medical treatments that could also be a red flag because things could get missed and the baby might not get the care they need, so making sure they are listening to you.

Sarah Trott: [00:19:02] Yeah, that's a really great list. And people can use that immediately when they're thinking through who they want to select as their family doctor or their pediatrician. And what's nice about this is that if someone's actually being proactive in using this information to find their health care provider then that's someone who they can bring in for that first visit in the hospital.

Dr Rebecca Dekker: [00:19:24] Exactly. Yeah. And that's it's you get a different level of care when it's somebody you've already built a relationship with or they get to be the one to see your baby. And then they continue to see your baby after you've gone home. You get that continuity of care. If you just wait and let them randomly assign someone, you definitely won't get continuity of care.

Sarah Trott: [00:19:45] No, it may not be the same person who you end up being with long term. Certainly. They don't have any context. No, I really appreciate that list. It's really helpful because it's one of those things just like if you're proactive, you can put some thought into it about what's right for you rather than leaving it to chance.

Dr Rebecca Dekker: [00:20:06] Right.

Sarah Trott: [00:20:08] Cool. So for postpartum recovery, you've done a lot of work in research into evidence based practices for that immediate period. What would you recommend, given all of the research you've done on how parents can ensure they're receiving the best care and recovering as quickly as possible?

Dr Rebecca Dekker: [00:20:33] Yeah, I think some of the things you want to think about with postpartum recovery, you obviously start planning beforehand. And you know how earlier I talked about how the birth makes an impact on your fourth trimester? So does the third stage of labor. So most people think of labor as you have the your contractions and then you push the baby out. But there's actually that third stage is between when the baby is born and when you deliver the placenta. So that can also impact your postpartum recovery, because if you have a postpartum hemorrhage or a really difficult third stage, that could then make your recovery more difficult.

Because if you start postpartum with low blood levels, anemia, that just makes you more exhausted, more tired. So the third stage of labor is when you're delivering the placenta. And there's basically two ways of managing that. There is the active management, which is also called hands on management. That's where the provider is using different interventions to try and prevent severe blood loss or postpartum hemorrhage. And and this typically involves giving a shot of pitocin either into your muscle or through the IV just with the birth of the baby, or right after the birth of the baby to help the uterus contract and stop the bleeding.

Dr Rebecca Dekker: [00:22:04] It also used to include clamping the umbilical cord early, but that is has been removed from a lot of the active management practices and then using controlled traction on the umbilical cord and putting a little bit of counter pressure on the outer part of your abdomen to help aid the birth of the placenta. So that's called active management. And this is typically used by physicians.

Dr Rebecca Dekker: [00:22:30] And then we have expectant management that is also called watchful waiting or hands off management. And this is typically used more by midwives. It's also popular in some European countries and New Zealand, and with this you wait for the birthing person's own body to expel the uterus with their own contractions, and you give birth to the placenta with the aid of gravity. Pitocin is not given unless there seems to be some excess bleeding. they do not clamp or cut the umbilical cord until the cord has stopped pulsating, and they do not use that traction or controlled pulling on the umbilical cord.

Dr Rebecca Dekker: [00:23:14] Then you also have mixed management where people pick and choose what they want. So maybe you don't want anybody to pull on the cord, but you do want the pitocin and you do want delayed cord clamping. So there's ways you can mix it up.

Dr Rebecca Dekker: [00:23:32] And the evidence is tricky. So with the third stage, the evidence on expectant management versus active management a lot of doctors tend to be more comfortable with active management. So that can sometimes influence the results of research. And compared to expectant management, active management tends to have lower blood loss and fewer use of additional medications and less use of blood transfusions. So 1% need a blood transfusion with active management versus 3% with expectant management.

Dr Rebecca Dekker: [00:24:24] The risks, though there are some drawbacks to using that active management. It can be uncomfortable. There's higher rates of vomiting, higher rates of the after pains, and higher rates of needing to come back to the hospital later postpartum for excessive bleeding. And for babies, the early cord clamping, if it's used, has been known to cause harm by leading to lower blood volume, lower iron levels, fewer stem cells, and a higher risk of anemia. Also, one of the issues with active management is that it does not seem to help reduce blood loss if you are at low risk for postpartum hemorrhage.

Dr Rebecca Dekker: [00:25:05] So if you fall into a low risk category, active management does not seem to make a difference. And low risk is defined as never having had a history of postpartum hemorrhage, no placental abnormalities, no forceps or vacuum, no epidural, no heart disease, no high blood pressure, no multiples, and no breech. So if you do not have any of those things, then you would be considered low risk for postpartum bleeding. And active management does not seem to add any benefits. So that's kind of something that people want to start thinking about in pregnancy. Like which path do they want or do they want to mix it up?

Look at the research on maybe just getting the pitocin, because there is some research that pitocin alone after birth can lower the risk of postpartum blood loss. But avoiding

blood loss during that third stage, like I said, it can really impact your fourth trimester because I've had several students from our childbirth class who did end up having severe postpartum hemorrhages, and it left them pretty weak for several weeks. In one case, one of our students was unable to breastfeed because her body was so depleted by the postpartum hemorrhage. So whatever you can do to learn about what are my risk factors for postpartum hemorrhage is important. That's one key thing I would say.

Sarah Trott: [00:26:27] I included some of that in my choices in my birth planning document. I don't like to call it a plan, but more of a birth intentions plan.

Dr Rebecca Dekker: [00:26:43] The nature of plans is that plans change. So I don't think there's anything wrong. I think people started moving away from that terminology to make it seem more appealing to the doctors, because sometimes a doctor might feel or a nurse might feel threatened. If you say, this is my plan for birth, and then they're kind of like, well, how dare you plan your birth? I'm the one in charge, you know? So we kind of renamed it to preferences.

But whatever you call it, I think for sure, knowing talking with your care provider prenatally, what do you want? You know, what is their practice, what is their preference. And if you do want to avoid some of the pieces of active management, making sure your provider is on board with that, also kind of knowing you know what your risk factors are for postpartum hemorrhage, although you can experience a postpartum hemorrhage without any risk factors. So that's why some care providers prefer to use the pitocin part, at least with most of their clients.

Sarah Trott: [00:27:44] Right, because it's contracting the body back and it's reducing the risk, restricting the opportunity for blood flow. Yeah. I mean, for me, it was something that I talked through with my doula beforehand and certainly you know, if you're working with a doula who's going to be there for the birth and indeed possibly also postpartum care, it's something you can discuss with them and they can help advocate for you in the moment.

Dr Rebecca Dekker: [00:28:09] Yeah. Because especially if you don't want the pitocin, then you probably need to have somebody on your support team watching out for that. Because especially if you already have IV fluids running, they'll just inject it into the tubing and you won't even know it's happening. So if if your preference is to not have pitocin with the third stage, then you need to be prepared to monitor that you're not receiving it.

Dr Rebecca Dekker: [00:28:31] And also be prepared that if things change, you might need it because it is possible that you'll fall into that category where you have no risk factors, but you still have excess bleeding, in which case it would be appropriate for sure. And risk factors can change. For example, one of the risk factors for postpartum bleeding is a vacuum assisted delivery. So maybe you did not want the pitocin shot, but then you had a vacuum assisted delivery, in which case that might change your benefits and risks ratio for sure.

Sarah Trott: [00:29:06] We have a template for a birth plan, which we call our birth intentions document. Because to your point, you can plan all you like, but it may not go the way you planned. And so just having that mental preparedness around the different things can happen. But we do like to advise people to at least go through the exercise for their own education purposes. so if anyone's interested, we have that on our website.

Sarah Trott: [00:29:31] But I also want to go back to what you said about cord clamping, because it sounds like in any scenario, the evidence is pointing towards benefits of delayed cord clamping.

Dr Rebecca Dekker: [00:29:41] Exactly. So with cord clamping, the evidence is pretty clear with both preterm and term babies that leaving the cord unclamped for at least 3 to 5 minutes is beneficial, and clamping it early causes harm in terms of lowering the baby's blood volume and risk of anemia as an infant. So the problem is, there's still a lot of myths out there about delayed cord clamping, particularly among physicians. Some physicians think that leaving the cord unclamped for too long will cause jaundice, and

that the baby will need treatment for jaundice. So they might say, well, you can leave it unclamped for one minute and that's it. We're clamping it after that.

But evidence actually shows you need to wait 3 to 5 minutes for the full benefits. Like 60s is better than 30s, but 60s is still not long enough for the baby to get all of the blood back. So at the time they're born, one third of their blood volume is still circulating in the placenta. So we need that blood to drain back through the cord, back into the baby. That helps with their lungs because now their lungs are working, whereas in utero they were not. So that additional blood volume helps with their perfuse of their lungs with oxygen. So that is another reason why it's important. But there was one Cochrane review years ago that included one unpublished dissertation study that found a higher rate of jaundice requiring phototherapy, but they did not objectively measure the bilirubin levels. And because of that - one unpublished student's study - that's why doctors think that it causes jaundice. But no study since then has shown that. And there's been some really high quality studies, and none of them have found any higher risk of jaundice with delayed cord clamping. So that's a myth that can be busted, but unfortunately it's still circulating out there.

Sarah Trott: [00:31:45] Yeah, I appreciate you explaining the whole purpose in the first place. It sounds like the evidence, all the research is pointing towards just the opposite, that letting the baby regain their full blood back into their bodies.

Dr Rebecca Dekker: [00:32:01] Evidence does support leaving the cord unclamped until it stops pulsating. And so these things are really interesting because this could be just 15 to 20 minutes of your the beginning of your postpartum period, but you're technically still in labor because you're having the placenta and you don't want to start off whatever you can do to lower your risk of postpartum hemorrhage is helpful. And also making sure your baby is born and is able to start life with all of their blood and all of their stem cells and red blood cells is really important. Now babies are resilient. Obviously they can survive without it, but we don't want to put them at a disadvantage if we don't have to.

Sarah Trott: [00:32:58] Yeah, definitely. So what else would you recommend for this immediate recovery period?

Dr Rebecca Dekker: [00:33:05] The other thing I wanted to talk about is skin to skin care. So skin to skin care is important throughout the fourth trimester. But we have the most research on the immediate postpartum period. So with skin to skin care, we know that research overwhelmingly supports it, that babies have benefits as well as parents. So for birthing parents, you're more likely to have a longer duration of breastfeeding, you're more likely to exclusively breastfeed, you have less chest engorgement and pain at three days after birth, you have less anxiety after birth and higher satisfaction.

Dr Rebecca Dekker: [00:33:46] And then for babies, who are held skin to skin immediately after birth, they're more likely to suckle effectively. They are 12 times less likely to cry. So being skin to skin is stabilizing for them emotionally as well as with their heart rate. Their breathing, their oxygen levels, and their blood sugar are more likely to stabilize quickly. So it's kind of a win-win to use skin to skin care. The main problem we have, because you're like, well, that's a no brainer. Everybody should get it. And for the most part, if you have a vaginal birth, you'll be able to get it with no problem.

Dr Rebecca Dekker: [00:34:23] The difficulty is if you have a cesarean there, which in our country is still around 32% of people are giving birth by cesarean. Hospitals are still separating mothers and babies during that immediate postpartum recovery period. And I don't know what you're hearing from your guests. There's not a lot of, like, numbers I can pull on that. But from what I'm hearing, just on the ground talking to people around the United States and Canada, I'm hearing that it's more common that you can get skin to skin immediately after a C-section in a planned cesarean scenario.

But if you're having an unplanned cesarean or an urgent one, it's less likely to happen. So we're still having a big percentage of people who are not getting that immediate skin to skin care. And we need people to advocate for skin to skin care in the operating room, and for babies and parents to recover together after cesarean, instead of separating the baby into the nursery and the mom and to the post surgery area. So that's been a really important thing to advocate for.

Sarah Trott: [00:35:32] Yeah. And skin to skin just feels so lovely. It's so wonderful to hold that baby and be close. I mean, they've never been apart. They've never been apart for their whole existence.

Dr Rebecca Dekker: [00:35:42] All of their instincts and needs and keeping you close - it's part of how we're designed, which is why it feels like such a violation when you're not able to. And I know, I know, there are times where maybe the mom is in the ICU or the baby has to go to the ICU. But most of the time you can recover together. And if you can't, then you should be reunited as soon as possible and have lots of skin to skin and skin to skin continues to be important over the next weeks and months. It definitely helps with feeding and bonding.

And the partner can do skin to skin too. There is research on that. The skin to skin with the person who just gave birth is going to be the most effective, because there's actually research showing that the temperature of the breast that the baby, the side of the chest that the baby is on, that your temperature rises to keep the baby at the perfect temperature. And that does not happen as well with the partners, but it still helps with bonding and keeping the baby warm. But it's like we're our own incubators for babies.

Sarah Trott: [00:36:53] Yeah. That's so fascinating. Our bodies know what they're doing. Trusting our bodies and trusting our process is a huge part of it, because it is possible to sort of overthink some of this stuff because there is so much out there. But I think focusing on, as you're saying, the evidence based pieces as well as trusting your instincts and trusting your body is just a huge thing as a parent. It starts at birth.

Dr Rebecca Dekker: [00:37:15] Our instincts, the evidence, the physiology, it all lines up to show that skin and skin care is really beneficial and it's beneficial for everybody, not just one side of the party. So we talked about bleeding earlier and skin to skin increases your oxytocin levels, which will help the uterus clamp down again to prevent excess blood loss. oxytocin, when it's released naturally in your brain, helps relieve pain. It is the love hormone. It's all of these things associated with bonding. So it's important to get it if you can and to find out what is your hospital's practice if you're

having a hospital birth. do they do skin to skin in the operating room. Do they allow, parents and babies to recover together or do they separate you temporarily. And that might play into your decision as to which hospital you choose. Because again a lot of the things that happen in birth impact your fourth trimester.

Sarah Trott: [00:38:19] Yeah. And know your rights advocate for yourself. And sometimes doctors or the hospital may just state things as fact, as if you don't have a choice. But you'd be surprised how much choice you actually do have as the parent. It doesn't hurt to ask and to say no, I really do prefer this. This is what I want to happen. And don't be afraid to make that request or make it clear in your documentation or your discussions with the care team beforehand.

Dr Rebecca Dekker: [00:38:48] Yeah, advocacy can happen in the moment. It can also happen before you give birth. And I think one of the problems with whenever you are having a cesarean or an epidural for pain management is you can't get up and go get your baby, right. You are sort of at the mercy of the people who are taking care of you, because you cannot literally move or walk. And that's what happened to me with my first birth.

My baby was in the nursery. I could not go down the hall and knock on the door and ask for my baby. I could put my call light on and they could keep saying, oh, we're not ready or we're not ready. But if I had known in advance that they were routinely separating babies from their moms, I would have rethought a lot of things and I could have prepared for that. But you don't know what you don't know. So that's why your listeners are educating themselves now so that they can hopefully improve things for the better down the line.

Sarah Trott: [00:39:44] Yeah, certainly. Well, I appreciate all of this information. And I want to invite you to direct us towards things that you think would be useful resources of your own or kind of other third party resources even that you recommend for parents to look into.

Dr Rebecca Dekker: [00:40:02] Yeah, I want to echo what doctor Amanda Williams said when she came on your podcast and talked about the state of postpartum maternal health, and it wouldn't be evidence based if I didn't talk about the research on warning signs. Because the data from the CDC are showing that two thirds of all maternal deaths occur in the first six weeks after birth, and 84% of these have been shown to be preventable. And half of all pregnancy related deaths are occurring between days seven and day 365. So we know that the evidence shows that the most common causes of maternal mortality postpartum, which again make up most of the maternal deaths, are postpartum preeclampsia, heart failure bleeding.

So you can have a late postpartum hemorrhage, not just an early one. Infections due to mental health issues and blood clots, intimate partner violence and stroke. And so knowing the warning signs of that is important. You should call 911 if your blood pressure is over 160 systolic or 110 diastolic, if you're short of breath, if you're seeing spots having seizures. Those are all reasons to call 911. you should call your doctor right away if your blood pressure is over 140 systolic or 90 diastolic. If you have a severe headache. Vision changes, stomach pain, chest pain, severe nausea and vomiting, swelling of your hands or face. Thoughts of harming yourself or harming your baby. Dizziness. Fainting soaking through your pad in an hour, having a fever, having flu like symptoms, having overwhelming fatigue or signs of postpartum depression or anxiety or rage. Those are all reasons to call your doctor right away.

Dr Rebecca Dekker: [00:42:00] And all of the guidelines say now that you should always report in very strong words that you were recently pregnant. Just because you're not pregnant anymore, people might not think of you as a pregnant person. They just think of you as a regular person. And, well, most regular women in their 30s are not having heart attacks, right? So you're not going to think about cardiovascular issues, you're just going to dismiss it. So it's really important to say that you were recently pregnant.

Dr Rebecca Dekker: [00:42:27] And another tip I have before I go is about mental health. So there's a lot of research on identifying postpartum depression and anxiety. And one of the most well researched tools is called the Edinburgh Postnatal Depression

Scale. I don't know if you've heard of that. Sometimes it's abbreviated as EPDS and it's free online. There's apps and websites where you can take it, or you can just find a PDF, copy and print it off.

So my final tip for anyone who's listening is if they want evidence based information, is to go ahead and print off six copies of the Edinburgh Postnatal Depression Scale. Give one to yourself, one to your birth partner if you have one, and go ahead and fill it out right now while you're pregnant. And that gives you a baseline. And then set a calendar reminder. Or put a sticky note on your fridge. And then you and your partner should both take that survey again at six weeks postpartum, and then save another copy for if you need it. And then there's usually instructions on the document of like if you score a certain level, contact your provider right away. So I think that's like a really evidence based tool that a lot of people don't realize that they can use.

And it kind of gives sometimes it's hard when you're postpartum and you're kind of in the fog, I should say, of sleep deprivation, taking care of a baby, taking care of yourself, recovering from such a huge life event. And this is a great way to just like, pause and assess how you're doing. And then it gives you a data point to talk with your healthcare provider about.

Sarah Trott: [00:44:15] Yeah, for sure. I love that recommendation. So we'll include links to that in the show notes. So anyone who's interested in trying that out themselves can just find it right away. So thank you. And I'd love to know more about the courses that you have available. You can definitely take a moment to share more about that if you like.

Dr Rebecca Dekker: [00:44:37] Yeah so if people want to learn more, I talk a lot about birth trauma in my book. Babies Are Not Pizzas: They're Born, Not Delivered, which you can get at any online bookseller. And I think that's important, especially for your listeners who've had a first trauma, traumatic birth to kind of process what happened to them. And so there's some good information in there. and it's basically a story about what happened to me and what I learned about the evidence on everything. So if you're interested in birth trauma or preventing traumatic births, go ahead and check that out.

Dr Rebecca Dekker: [00:45:09] And then you can go to the Evidence Based Birth website. And we have two articles that are related to what I talked about today. So we have an article all about the evidence on the third stage. So that's at https://evidencebasedbirth.com/evidence-on-pitocin-during-the-third-stage-of-labor/. And then we also have an article on skin to skin care after a cesarean with tips for how to advocate for yourself. And that's at https://evidencebasedbirth.com/the-evidence-for-skin-to-skin-care-after-a-cesarean/. And so I hope those are helpful. And then we do have childbirth classes through Evidence Based Birth that EBB instructors are teaching around the world. And we focus a lot on advocacy. And we also have a section on postpartum care and our childbirth class, because of course that's super important. But I just think it's really interesting and powerful to know that your birth can impact your postpartum and to in your immediate postpartum recovery. And so as you're preparing for the fourth trimester, just remember it's like it's all connected. It's all part of the whole.

Sarah Trott: [00:46:14] Thank you. I appreciate you also mentioning some of the other episodes with Kimberly Seals Allers and the Irth app. We'll put a link to that app as well in the show notes and also to the Amanda Williams episode. And just to mention a bit about what she said, she said, if you're preparing for your postpartum recovery, you need three things. She recommended a breast pump, a blood pressure cuff, and getting a doula. Those are just a few things that she recommended specifically.

Dr Rebecca Dekker: [00:46:46] Yeah, there's definitely a lot of research coming out about home monitoring of blood pressure, which as I used to work in cardiovascular nursing, that was just every heart patient had a blood pressure cuff, you know. But I think it's really important that if you're pregnant, you get one as well.

Sarah Trott: [00:47:03] Well, wonderful. Thank you again for all of the information. such a rich conversation. I appreciate you coming on the show.

Dr Rebecca Dekker: [00:47:11] Thank you for having me, Sarah.

Sarah Trott: You can also subscribe to this podcast in order to hear more from us. **Click here for iTunes and click here for Spotify**. Thank you for listening everyone and I hope you'll join us next time on the Fourth Trimester. The theme music on this podcast was created by Sean Trott. Hear more at https://soundcloud.com/seantrott. Special thanks to my true loves: my husband Ben, daughter Penelope, and baby girl Evelyn. Don't forget to share the Fourth Trimester Podcast with any new and expecting parents. I'm Sarah Trott. Goodbye for now.