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TETON STYLE

Jackson Hole News

Wednesday, October 25, 1995

Wilson School custodian charms students with snakes, spiders and self.
See page 3B.

VIEW *from the* HOLE

MARK HUFFMAN

Getting the mule to turn at the sign

A visitor writes to tell us about his confusion in Jackson earlier this year, and in doing so he points out the difference between people now and way back then.

Way back then: You've heard the stories. Came over Teton Pass via horse-drawn wagon; had to chop trees all the way up the Idaho side and down the Wyoming side; used cut logs and horses as anchors on the upslope when descending; everyone walked so that everything they owned, which wasn't much, could be hauled; trip took two weeks and that was two days off the previous record.

Or: Came over from Red Desert, over Union Pass, down the Gros Ventre by the same route the Shoshones and the bison took for centuries. Or: Waded up along the Hoback and the Snake. Or: Over Togwotee's July snowdrifts.

In any case, they struggled, dragged, pushed and pulled, forded raging rivers, ate dust for hundreds of miles, were eaten in turn by swarms of mosquitoes, lost Emmy Lou to the colic-the Indians-a cougar-a Mormon husband, broke down, fell out and nearly crossed over — but never gave up.

Made it.

Arrived where they had set out to go, came from Back East, faced every danger and problem, beat and overcame them, arrived in the promised land, the great West, including — of course — Jackson Hole.

Now: Well, you'd think it would be easy now, what with horses a hobby and internal combustion a birthright, the Indians pretty much pacified, antibiotics mostly working, the route blazed and paved.

But we adjust to the problems we face. The challenge looms larger if it's what we have to overcome. The worst is still the worst.

Not to say that there might not be a problem here, in the letter we received.

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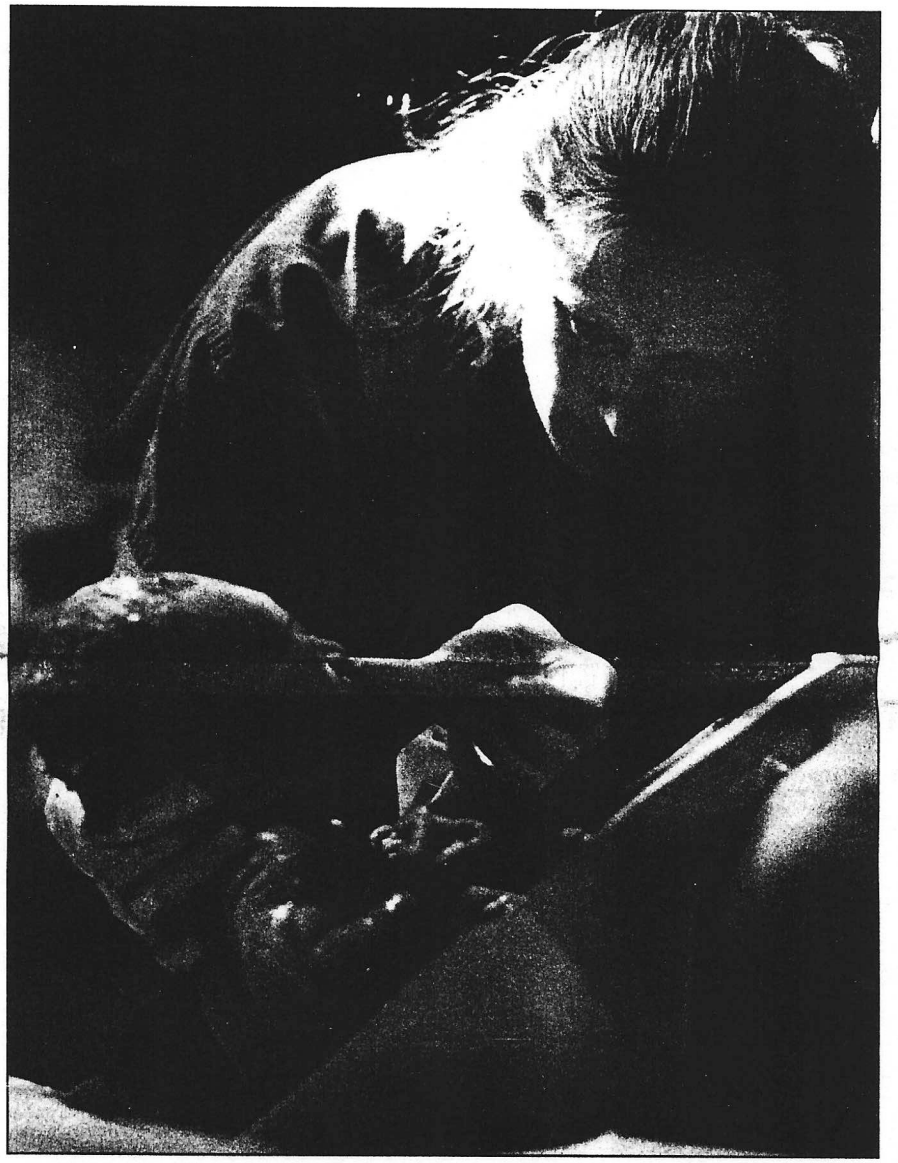

Moments after delivering him, midwife Kathy Watkins clears Teague Manley's nose of mucous.

A Special Delivery

In the dimly lit birthing room at St. John's, Mariam Manley was in the early stages of labor.

She had been carrying her son low for weeks, and the pressure on her cervix was painful. Nurse-midwife Kathy Watkins had given her Seconal so she could sleep and conserve her energy for the birth.

Mariam had slept, but now she was up and ready for the birth to be over. She told Kathy as much.

"I feel like I know my body well, and Kathy respects that," Mariam said.

Her contractions eight minutes apart, Mariam was relaxed, sitting quietly in a rocking chair. Her husband, Steve, was stretched out on the bed. It was almost midnight.

Watkins considers it her job as a midwife to listen to the mother. Resting on a reserve bed, she began deliberating strategies for accelerating the labor.

Mariam and Steve had their first child, Anna Lise, with Watkins. Anna Lise, now 21 months, is a lively child, who has been heavily involved in her mother's pregnancy.

For Mariam, who is pursuing her doctorate in social psychology, the midwife birthing option was closely examined.

"I'm an educated person, as is my husband, and this was carefully researched, and it was a very informed choice," she said.

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Steve Manley coaches his wife, Mariam, through a painful contraction while nurse-midwife Kathy Watkins monitors the baby's heartbeat.

A weary Kathy Watkins rests on a cot in the darkened birthing room as Manley's labor continues into the night.

A Specia Deliver

Continued from cover

Both Mariam and her husband are thoroughly satisfied with the care they have received from Watkins. Strong-minded, Mariam appreciates that Watkins listens to her and knows her.

"She knows exactly what stage I'm at, and she does that without having to examine me when I'm nine centimeters dilated," she said. "That would be painful."

Watkins took a reading with a fetal heart monitor, which measures the mother's contractions and blood pressure and the fetal heart rate.

Midwives don't believe in continual fetal monitoring during labor. A midwife's approach is more "low tech" than a doctor's and, on average, their techniques elicit shorter labors.

Accelerating the labor

Watkins agreed it was time to wake the baby and accelerate the labor. She pressed a fetal acoustic stimulator to Mariam's belly, a kind of alarm clock for the baby.

To quicken the labor even more, Mariam decided to pace the hospital hallways with Steve.

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NEWS PHOTOS / MARY GERTY

Alone in the night, Miriam and Steve walk laps of hospital corridors as labor proceeds.

Steve Manley gets his first look at his newborn son while pediatricians Jim Little and Lisa Ridgeway examine the infant.

A Special Delivery

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"Let's go do some laps," she said, gripping his hand.

Earlier, Mariam had had a snack of cereal and apple juice. Because midwives allow mothers to eat during labor, there is no need to hook them up to an IV. This allows for much more mobility.

"Ice cubes are all [doctors provide] at a [traditional] birth," Watkins said. "When doctors used to give mothers general anesthetic for C-sections, it was felt the woman would asphyxiate if she had food."

But the rate of cesarean sections is very low for midwives — in fact, during Kathy's tenure at St. John's, the cesarean-section rate has dropped by 40 percent. Even doctors rarely use general anesthesia for cesarean sections any more.

When Mariam and Steve returned, the baby still was not very active. Since it would be Mariam's second child, Watkins decided to use another technique: poking a hole in the amniotic sack.

"The bag of water washes over the cervix and intensifies the contractions," Watkins said. "We don't do it routinely unless there's an indication or the mother wants to get on with it.

"In this case, there will be a better outcome, because of the willingness of the mother."

The procedure is a simple one, and Mariam began to move into the later stages of labor, her contractions coming more often. They also became more painful.

During her labor with her daughter, Anna Lise, Mariam found the most comfortable position was squatting in the shower, as Steve ran warm water from the detachable shower head over her belly.

But no two births are the same.

"He's so low that frankly the minute contractions hit, I felt like pushing," Mariam said. "If I squatted, I wouldn't be able to resist."

Dilated at only six centimeters, Mariam wasn't ready to push yet. She decided to stand and lean over the bed instead.

According to the Midwives Alliance of Wyoming, a doctor spends an average of four to five hours with a woman for obstetrical care, whereas a midwife spends an average of 50 to 60 hours. That type of involvement allowed Watkins to let Mariam decide such things.

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A Special Delivery

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Calling in the doctors

"Mariam gets weepy with contractions," Watkins said. "Steve will help her, because they are very much partners in this."

Mariam had her forehead pressed to the bed when Watkins decided to call in Dr. Roger Brecheen for possible assistance.

"The baby may have had a narcotic effect from the Seconal, but everything else is normal," she said on the phone.

Watkins also called pediatricians Lisa Ridgway and Jim Little to examine the newborn. It was just past 4 a.m.

All three doctors showed up in less than 10 minutes and immediately receded into the background. Steve was on the phone in another room giving progress reports when Mariam called out.

"Where's Steve?" He quickly returned to rub Mariam's back and breathe with her.

Now in a fetal position on her side in bed, Mariam decided she wanted a warm washcloth on her belly. As a nurse applied one, Watkins coaxed Mariam into drinking some juice.

"Can I have drugs?" Mariam asked, with some urgency.

Watkins quietly declined. "When you spend that much time with the mothers, you can get them to cooperate with anything you say," she explained. "They know your voice, they know you."

She then gently had Mariam lift her leg, with Steve's assistance. She used a couple of pillows to keep Mariam's legs separated.

At 4:19 a.m., there were two minutes between Mariam's contractions.

"I want to push," she said loudly.

"Okay, breathe through this one and then give a little push," Watkins said.

The top of the baby's head appeared as Mariam pushed through the next contraction.

"One more, one more, go ahead and stop, relax," Kathy said, mopping up some of the water and blood.

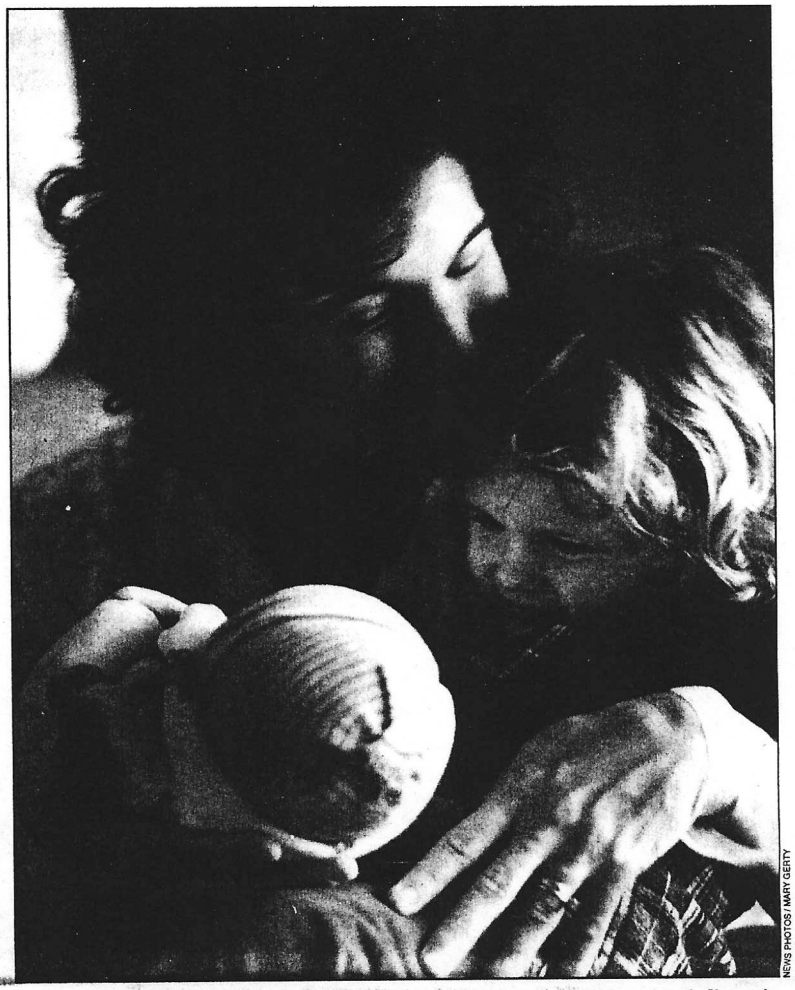
She filled a hypodermic needle with anesthetic in case Mariam required an incision to enlarge the vaginal opening. With most doctors, the surgical operation, called an episiotomy, is the rule, but not with midwives.

Mariam didn't need one, which will make her postnatal recovery quicker and easier.

During the next contraction, the baby's head emerged.

"Don't push," Watkins said. She suctioned out the baby's nose and mouth, one hand under his head.

On her back, with one arm around Steve, Mariam moaned as the next contraction hit.



NEWS PHOTOS / MARY GERTY

Anna Lise Manley is captivated by her new brother. Her mother, Miriam, is a believer in midwifery who asked Watkins to handle both her pregnancies.

Teague's birth

"Let him come out," Watkins called. "Aaauwwww," she said as the baby slid out.

It was 4:33 a.m.

"He's got hair and he's got a weenie," Steve cried. "There's our son, there he is."

Watkins placed Teague on his mother's leg and clamped the umbilical cord. She handed Steve the clippers to cut the cord, as Mariam stroked Teague's head with her finger. "He's very big," she said.

The pediatricians cleaned and wrapped the baby, as Watkins eased the umbilical cord and placenta from Mariam. Steve was beaming over Teague in the warmer. "He looks like your dad," he said to Miriam.

The newborn was wide awake, so Watkins brought him over to Mariam. It was the beginning of many hours of postnatal care she will provide the mother.

Watkins smiled at a successful night on the job, and gave Mariam a hug.

"At every birth, I try to make it a real honest-to-God celebration," Watkins said, "like it's the first baby I've delivered."

What is a midwife?

A midwife is an individual who provides obstetric care to women but is not a doctor. Many midwives deliver babies, often in the home.

Midwifery is a birthing option for women who want a more natural delivery than what is traditionally provided by an obstetrician or family practitioner.

A nurse for over a decade now, Kathy Watkins became certified with the American College of Nurse-Midwives several years ago.

Kathy Watkins

Watkins attended school in Salt Lake City for two years to study prenatal and postnatal care, labor and birth. Her certification allows her to practice midwifery in Wyoming, and she has been at St. John's Hospital for two years.

At school, nurse-midwives experience about 80 births, while registered nurses may not experience any. That experience pays off.

"Practices of certified nurse-midwives in a laboring environment contribute to shorter labors, less surgical interventions, and better outcomes of babies," Watkins said.

Midwives without formal training are called "lay midwives." In Wyoming, lay midwives can deliver babies, but they cannot provide obstetric care.

Since comprehensive care for women is what midwifery is about, this effectively obstructs lay midwives from practicing in Wyoming. Pauline McIntosh, a lay midwife in Jackson, is currently moving her practice to Victor, Idaho.

The number of practicing lay midwives in Wyoming is decreasing, but certified nurse-midwifery is growing, with three practitioners.

Most nurse-midwives practice at a hospital or birth center. Birth centers are places where healthy women can receive obstetrical care and deliver their babies, with low-tech assistance from nurse-midwives.

With no birth center in Jackson, Watkins made her move into the hospital so she would have access to the technology it provides if necessary. She also practices with Dr. Roger Brecheen, her husband, who assists during complicated pregnancies.

While lay midwives are relatively inexpensive with no hospital fee, Watkins charges as much as an obstetrician. "But you get two for the price of one," she said.

Many midwives, especially lay midwives, will only work with low-risk candidates. Some of their success rates are stunning. For instance, in New Mexico, one of a handful of states that licenses lay midwives, no infants delivered by its 120 midwives died in 1987. That's not just because the women were low risk, Watkins said.

"Research that has been statistically adjusted for that factor demonstrates that the success rate is deviated in spite of the fact that midwives take on low-risk cases," she said.

For Watkins, who has overcome a lot of prejudice to break into the medical community, the optimal situation would be to work at a birth center.

"My dream is to open a birth center here," she said. "I want to minimize the health care cost, satisfy patients' desires, and derive career satisfaction," she said.