

## Chapter 1

# Introduction

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Labor dystocia, dysfunctional labor, failure to progress, arrest of labor, arrested descent – all these terms refer to slow or no progress in labor, which is one of the most vexing, complex and unpredictable complications of labor. Labor dystocia is the most common medical indication for primary cesarean sections. In countries where rates of vaginal births after previous cesareans (VBAC) are low (for example, in the United States in 2003 the VBAC rate was less than 11%<sup>1</sup>, having dropped from a high of almost 30% in 1996<sup>2</sup>), dystocia also contributes indirectly to the number of repeat cesareans. The American College of Obstetricians and Gynecologists estimates that 60% of all cesareans in the USA are attributable to the diagnosis of dystocia<sup>3</sup>. With a primary cesarean rate of 19.1%, and a total rate of 27.6%<sup>1</sup> (or more than 1 million cesareans) in 2003, it is clear that prevention of dystocia would not only reduce the number of costly and risky obstetric interventions, including cesareans, but it would also spare some women the feelings of discouragement and disappointment that often accompany a prolonged or complicated birth.

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The possible causes of labor dystocia are numerous. Some are intrinsic:

- The *powers* (the uterine contractions)
- The *passage* (size, shape, and joint mobility of the pelvis, and the stretch and resilience of the vaginal canal)
- The *passenger* (size and shape of fetal head, fetal presentation and position)
- The *pain* (and the woman's ability to cope with it)
- The *psyche* (anxiety, emotional state of the woman)

Others are extrinsic:

- *Environment* (the feelings of physical and emotional safety generated by the setting and the people surrounding the woman)
- *Ethno-cultural factors* (the degree of sensitivity and respect for the woman's culture-based needs and preferences)
- *Hospital or caregiver policies* (how flexible, family- or woman-centered, how evidence-based)
- *Psycho-emotional care* (the priority given to non-medical aspects of the childbirth experience)

Please see Michael Klein's Foreword to this edition for his discussion of factors influencing labor progress.

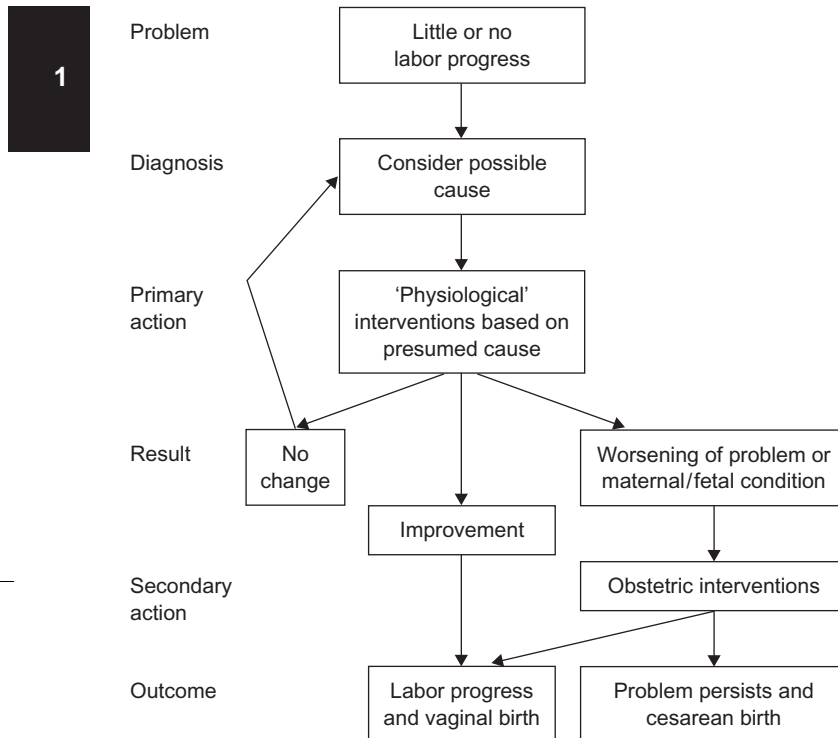
This book focuses on prevention, differential diagnosis, and early interventions to use with dysfunctional labor. The emphasis is on relatively simple and sensible care measures or interventions designed to help maintain normal labor progress and to manage and correct minor complications before they become serious enough to require major interventions. We believe this approach is consistent with worldwide efforts, including those of the World Health Organization, to reserve the use of medical interventions for situations in which they are needed: 'The aim of the care [in normal birth] is to achieve a healthy mother and baby with the least possible level of intervention that is compatible with safety<sup>4</sup>.'

The suggestions in this book are based on the following premises:

- Progress may slow or stop for any of a number of reasons at any time in labor – pre-labor, early labor, active labor, or during the second or third stage.
- The timing of the delay is an important consideration when establishing cause and selecting interventions.

- Sometimes several causal factors may occur at one time.
- Caregivers and others are often able to enhance or maintain labor progress with simple non-surgical, non-pharmacological physical and psychological interventions. Such interventions have the following advantages:
  - compared to most obstetric interventions for dystocia, they carry less risk of harm or undesirable side effects to mother or baby
  - they treat the woman as the key to the solution, not the key to the problem
  - they build or strengthen the cooperation between the woman, her support people (loved ones, doula), and caregivers
  - they reduce the need for riskier, costlier, more complex interventions
  - they may increase the woman's emotional satisfaction with her experience of birth
- The choice of solutions depends on the causal factors, if known, but trial and error is sometimes necessary when the cause is unclear. The greatest drawbacks are that the woman may not want to try these interventions, they sometimes take time, or they may not correct the problem.
- Time is usually an ally, not an enemy. With time, many problems in labor progress are resolved. In the absence of clear medical or psychological contraindications, patience, reassurance and low or no risk interventions may constitute the most appropriate course of management.
- The caregiver may use the following in determining the cause of the problem(s):
  - *objective observations*: woman's vital signs; fetal heart rate patterns; fetal presentation, position and size; cervical assessments; assessments of contraction strength, frequency, and duration; membrane status; and time
  - *subjective observations*: woman's affect, description of pain, level of fatigue
  - *direct questions* of the woman and *collaboration* with her in decisions regarding treatment:
    - 'What was going through your mind during that contraction?'
    - 'Please describe your pain.'
    - 'Why do you think labor has slowed down?'
    - 'Which options for treatment do you prefer?'

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**Chart 1.1** Care Plan for the Problem, 'Little or No Labor Progress'.

- Once the probable cause and the woman's perceptions and views are determined, appropriate primary interventions are instituted and labor progress is further observed. The problem may be solved with no further interventions.
- If the primary interventions are medically contraindicated or if they are unsuccessful, then obstetrical interventions are instituted under the guidance of the doctor or midwife.

Chart 1.1 illustrates the approach described in this book. Other similar flowcharts appear throughout this book to illustrate the

application of this approach to a variety of causes of dysfunctional labor.

Many of the interventions described in this book are derived from the medical, midwifery, nursing, and childbirth education literature. Others come from the psychology, sociology, and anthropology literature. We have provided references for these, when available. Some suggestions have come from the extensive experience of nurses, midwives, doctors, and doulas (labor support providers). Many are applications of physical therapy principles and practices. Some items fall into the category of 'shared wisdom', where the original sources are unknown. We apologize if we neglect to mention the originator of an idea that has become widespread enough to fall into this category. Finally, some ideas originated with one or both of the authors who have used them successfully in their work with laboring women.

With today's emphasis on evidence-based practice, many rather entrenched maternity care customs are falling out of favor because they have been proven ineffective or harmful. Such routine practices as enemas, pubic shaving, continuous electronic fetal monitoring without access to fetal scalp blood sampling, the use of maternal supine and lithotomy positions in the second stage of labor, and routine episiotomy are some examples of forms of care that became widespread before they were scientifically evaluated. Then, once well-controlled trials of safety and effectiveness had been performed and the results combined in meta-analyses, these common practices were found to be ineffective and to increase risks<sup>5</sup>.

Where possible, we will base our suggestions on such scientific evidence and will cite appropriate references. However, numerous simple and apparently risk-free practices have never been scientifically studied. Some of these are based on an understanding of the emotional and physiological processes taking place during childbirth. Others are applications of anatomy, kinesiology, and body mechanics to enhance the relationships between such separate but interdependent forces as pelvic shape, maternal posture, fetal position and station, uterine activity, and the force of gravity. Still others are based on a recognition of the importance of each laboring woman's personal and cultural values.

Some of the strategies suggested in this book will lend themselves well to randomized controlled trials, while others may not. Perhaps readers will gather ideas for scientific study as they read this book and apply its suggestions.

## **SOME IMPORTANT DIFFERENCES IN MATERNITY CARE BETWEEN THE UNITED STATES, THE UNITED KINGDOM, AND CANADA**

This book is being published simultaneously in North America and the United Kingdom, where the approaches to maternity care are quite different from one another. It may surprise the reader to discover some of those differences, and it may also be interesting to learn that practices that are considered essential for safety in one country are considered ineffective or archaic in another. We hope that one effect of our book will be to encourage a willingness to reconsider practices that are either entrenched or avoided in one's own workplace.

Table 1.1 compares some basic features of maternity care between the United States, Canada, and the United Kingdom. Because of such differences in maternity care as those listed in Table 1.1, the willingness to introduce new practices and the power to do so will vary among caregivers in different countries. We hope our readers will begin to utilize the simplest, most innocuous measures immediately, and to educate themselves and change policies where necessary.

### **NOTES ON THIS BOOK**

This book is directed toward midwives, nurses, and doctors who want to support and enhance the physiological process of labor, with the objective of avoiding complex, costly, more risky interventions. It will also be helpful for students in obstetrics, midwifery, and maternity nursing, for childbirth educators who can teach many of these techniques to expectant parents, and for doulas (trained labor support providers). The chapters are arranged chronologically according to the phases and stages of labor.

Because a particular maternal position or movement is useful for the same problem during more than one phase of labor, we have included illustrations of these positions in more than one chapter. This will allow the reader to find position ideas at a glance when working with a laboring woman. Complete descriptions of all the positions, movements, and other measures can be found in the Toolkit, Chapters 7 and 8.

The term 'caregiver' is used to refer to any of the people mentioned above who are providing care and support for the woman in labor.

**Table 1.1** Comparison of maternity care in the United States, Canada, and the United Kingdom.

Feature	United States	Canada	United Kingdom
Primary maternity caregivers	Obstetricians for approximately 90% of women; midwives and family physicians for 10%. Maternity nurses provide most of the care during labor in the hospital, with the obstetrician managing any problems and the delivery.	Family physicians, with obstetricians and autonomous midwives now increasing in numbers. As in the USA, nurses provide most in-hospital care.	Mostly midwives, some general practitioners, with obstetricians caring for women with complications. There are no maternity nurses. Midwives provide all intrapartum care and conduct most deliveries.
Autonomy and independence of caregiver	Great variation in preferred routines among independent physicians. Nursing care varies according to the orders of each physician. Insurance providers and health maintenance organizations now increasingly limit those physicians' practices that are not cost effective.	Government limits payment for some interventions, and regulates numbers of doctors and hospitals, giving doctors less autonomy than in the USA.	Midwives have little autonomy, and practice according to the policies of their institutions. Those policies are established by authorities in maternity care and by the government.
Participation by childbearing women in decision-making	'Informed consent' is the law, though most women (except assertive women with strong opinions) expect the obstetrician to make decisions and most obstetricians prefer that style of practice. Most midwives and family physicians share decision making with the woman.	Similar to the USA.	'Informed choice' and 'woman-centered care' are now standards of care, and extensive efforts are being made by government and childbirth activists to ensure that women are well informed for their role as partners in decision making.



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<p>Continuity of caregiver throughout the childbearing year</p>	<p>Not considered cost effective, feasible, or desirable by policy-makers in health care. Rarely available except for out of hospital births, though to many women it is a highly desirable option. Some assertive women try to obtain continuity of care through birth plans and doulas, and by verbalizing their concerns to each professional involved in their care.</p>	<p>Small group practices of family physicians or midwives are available in many parts of Canada. Continuity of caregiver during pregnancy and post partum is more likely than in the USA, although maternity nurses provide most care in labor.</p>	<p>Considered a very important feature of woman-centered care, programs ensuring continuity of caregiver are beginning to replace the old system of different midwives for pre- and postnatal and intrapartum care.</p>
<p>Influence of scientific evidence on maternity practices</p>	<p>Highly variable, but customs, peer practices, opinions, and prior experience of the practitioner and fear of litigation are more powerful influences. Some medical, nursing, and midwifery schools now teach and follow principles of evidence-based practice.</p>	<p>Leaders in obstetrics, family medicine, midwifery, and nursing are actively engaged in scientific evaluation of numerous unproved clinical practices. The national professional societies of midwives, family physicians, obstetricians, and nurses promote evidence-based practice.</p>	<p>Same as Canada, except that midwives are also actively involved in research. There is widespread acceptance of a scientific approach to maternity care, where possible.</p>
<p>Influence of fear of malpractice litigation on maternity practices</p>	<p>The likelihood of doctors being sued for malpractice is high, and malpractice insurance premiums are extremely expensive, which has driven up the costs of maternity care. In addition, insurers advise on how to reduce the likelihood of lawsuits. Such advice is not based on science, safety or effectiveness, but on risks of being sued.</p>	<p>Trends similar to the USA, although to a much lesser degree. Fear of litigation has less impact on care than scientific findings, costs, customs and other factors.</p>	<p>Similar to Canada.</p>



## CHANGES IN THIS SECOND EDITION

Besides updating the information, suggestions, illustrations, and references throughout this edition, we have asked Suzy Myers, Licensed Midwife in Washington State, USA, to provide a new chapter on 'Assessing Progress in Labor'. She offers scientific evidence and lessons learned empirically over 25 years of attending births in free-standing birth centers and at home, along with many years of teaching midwives at Seattle Midwifery School. Her chapter offers techniques and practical tips that are not taught in many schools of medicine, midwifery, and nursing. For beginners, this chapter will serve as a text. For experienced professionals, this chapter will provide some useful additions to their already considerable repertoire. The innovative concept of 'belly mapping', developed by a Minnesota midwife and artist, Gail Tully, is also presented in this chapter, as a fully integrated approach to determine fetal position. This model uses clues gleaned from the clinical skills of the caregiver and the woman's observations of her fetus' movements. Gail Tully supplied the content and drawings for the 'belly mapping' segment of the chapter.

### Material on epidurals

In acknowledgement of the widespread use of epidural analgesia, we address the needs of readers who work extensively with women who have epidurals and are unable to use many of the measures shown in this book. Labors with epidural analgesia are frequently accompanied by slow progress and the use of synthetic oxytocin. For this reason, to help readers quickly identify those measures that can be used with women with epidurals to correct fetal malpositions and to aid progress, we have prepared a special 'Epidural Index' to indicate locations of illustrations and text that are useful for women with epidurals.

## CONCLUSION

The current emphasis in obstetrics is to find better ways to treat dystocia once it occurs. Little emphasis is placed on prevention, which is the focus of this book.

To our knowledge, this is the first book that compiles labor progress strategies that can be used by a variety of caregivers in a variety

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of locations. Most of the strategies described can be used for births occurring in hospitals, at home, and in free-standing birth centers.

We hope this book will make your work more effective and more rewarding. Your knowledge of appropriate early interventions may spare many women from long, discouraging, or exhausting labors, reduce the need for major interventions, and contribute to safer and more satisfying outcomes. The women may not recognize specific things you have done for them, but they will appreciate and always remember your attentiveness, expertise, and support, which contribute so much to satisfaction<sup>6</sup> and positive long-term memories of their childbirths<sup>7</sup>.

We wish you much success and fulfillment in your important work.

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