FIFTH EDITION

EARLY INTERVENTIONS TO PREVENT AND TREAT DYSTOCIA

EDITED BY
LISA HANSON
EMILY MALLOY
PENNY SIMKIN

WILEY Blackwell

Simkin's Labor Progress Handbook

Early Interventions to Prevent and Treat Dystocia

Fifth Edition

Simkin's Labor Progress Handbook

Early Interventions to Prevent and Treat Dystocia

Fifth Edition

Edited By

Lisa Hanson
Klein Professor and Associate Director, Midwifery Program
Marquette University
College of Nursing
Milwaukee, WI, USA

Emily Malloy
Certified Nurse Midwife
Director of Midwifery Research
Midwifery and Wellness Center
Participating Faculty
Marquette University
College of Nursing
Milwaukee, WI, USA

Penny Simkin
Certified Birth Doula and Certified Childbirth Educator
USA

WILEY Blackwell

This edition first published 2024
© 2024 John Wiley & Sons Ltd

Edition History
Wiley-Blackwell (4e 2017)
Wiley-Blackwell (3e 2011)
Wiley-Blackwell (2e 2005)

Blackwell Science Limited (1e 2000)

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, except as permitted by law. Advice on how to obtain permission to reuse material from this title is available at http://www.wiley.com/go/permissions.

The right of Lisa Hanson, Emily Malloy, and Penny Simkin to be identified as the authors of the editorial material in this work has been asserted in accordance with law.

Registered Offices
John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

For details of our global editorial offices, customer services, and more information about Wiley products visit us at www.wiley.com.

Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

Trademarks: Wiley and the Wiley logo are trademarks or registered trademarks of John Wiley & Sons, Inc. and/or its affiliates in the United States and other countries and may not be used without written permission. All other trademarks are the property of their respective owners. John Wiley & Sons, Inc. is not associated with any product or vendor mentioned in this book.

Limit of Liability/Disclaimer of Warranty
The contents of this work are intended to further general scientific research, understanding, and discussion only and are not intended and should not be relied upon as recommending or promoting scientific method, diagnosis, or treatment by physicians for any particular patient. In view of ongoing research, equipment modifications, changes in governmental regulations, and the constant flow of information relating to the use of medicines, equipment, and devices, the reader is urged to review and evaluate the information provided in the package insert or instructions for each medicine, equipment, or device for, among other things, any changes in the instructions or indication of usage and for added warnings and precautions. While the publisher and authors have used their best efforts in preparing this work, they make no representations or warranties with respect to the accuracy or completeness of the contents of this work and specifically disclaim all warranties, including without limitation any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives, written sales materials or promotional statements for this work. This work is sold with the understanding that the publisher is not engaged in rendering professional services. The advice and strategies contained herein may not be suitable for your situation. You should consult with a specialist where appropriate. The fact that an organization, website, or product is referred to in this work as a citation and/or potential source of further information does not mean that the publisher and authors endorse the information or services the organization, website, or product may provide or recommendations it may make. Further, readers should be aware that websites listed in this work may have changed or disappeared between when this work was written and when it is read. Neither the publisher nor authors shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

Library of Congress Cataloging-in-Publication Data
Names: Hanson, Lisa, 1958- editor. | Malloy, Emily, 1983- editor. | Simkin, Penny, 1938- editor.
Title: Simkin's labor progress handbook : early interventions to prevent and treat dystocia / edited by Lisa Hanson, Professor and Director, Midwifery Program, Marquette University, USA, Emily Malloy, Penny Simkin.
Other titles: Labor progress handbook | Labor progress handbook
Description: Fifth edition. | Hoboken, NJ : John Wiley & Sons, 2024. | Revised edition of: Labor progress handbook / Penny Simkin, Lisa Hanson, Ruth Ancheta. Fourth edition. [2017]. | Includes bibliographical references and index.
Identifiers: LCCN 2023026403 (print) | LCCN 2023026404 (ebook) | ISBN 9781119754466 (paperback) | ISBN 9781119754428 (pdf) | ISBN 9781119754497 (epub)
Subjects: LCSH: Labor (Obstetrics)--Complications--Prevention--Handbooks, manuals, etc. | Birth injuries--Prevention--Handbooks, manuals, etc. | Shoulder dystocia--Prevention--Handbooks, manuals, etc.
Classification: LCC RG701 .S57 2024 (print) | LCC RG701 (ebook) | DDC 618.4--dc23/eng/20230623
LC record available at https://lccn.loc.gov/2023026403
LC ebook record available at https://lccn.loc.gov/2023026404

Cover Image: © RuslanDashinsky/Getty Images
Cover design by Wiley

Set in 9/11pt PlantinStd by Integra Software Services Pvt. Ltd, Pondicherry, India

Dedication

We dedicate this book to childbearing people, their families, and caregivers in the hope that some of the suggestions offered reduce the need for interventions and promote normal physiologic labor and birth. This book is named in honor of Penny Simkin, the original author, a leader innovator, activist, author, childbirth educator and doula.

Contents

List of Contributors xvi
Foreword xviii

Chapter 1: Introduction **1**
Lisa Hanson, PhD, CNM, FACNM, FAAN and Emily Malloy, PhD, CNM

Causes and prevention of labor dystocia: a systematic approach 1
Notes on this book 4
Note from the authors on the use of gender-inclusive language 5
Conclusion 5
References 5

Chapter 2: Respectful Care **7**
Amber Price DNP, CNM, MSN, RN 7

Health system conditions and constraints 8
LGBTQ birth care 9
RMC and pregnant people in larger bodies 9
Shared decision-making 10
Expectations 11
The impact of culture on the birth experience 12
Traumatic births 12
Trauma survivors and prevention of PTSD 13
Trauma-informed care as a universal precaution 15
Obstetric violence 16
Patient rights 17
Consent 17
Maternal mortality 18
References 19

Chapter 3: Normal Labor and Labor Dystocia: General Considerations **22**
Lisa Hanson, PhD, CNM, FACNM, FAAN, Venus Standard, MSN, CNM, LCCE, FACNM, and Penny Simkin, BA, PT, CCE, CD(DONA)

What is normal labor? 22
What is labor dystocia? 26
What is normal labor progress and what practices promote it? 26

Why does labor progress slow or stop? 28
Prostaglandins and hormonal influences on emotions and labor progress 29
Disruptions to the hormonal physiology of labor 30
Hormonal responses and gender 30
“Fight-or-flight” and “tend-and-befriend” responses to distress and fear during labor 31
Optimizing the environment for birth 32
The psycho-emotional state of the pregnant person: wellbeing or distress? 33
Pain versus suffering 33
Assessment of pain and coping 34
Emotional dystocia 34
Psycho-emotional measures to reduce suffering, fear, and anxiety 34
Before labor, what the caregiver can do 34
During labor: tips for caregivers and doulas, especially if meeting the laboring client for the first time in labor 37
Conclusion 38
References 38

Chapter 4: Assessing Progress in Labor 41
Wendy Gordon, DM, MPH, CPM, LM, with contributions by Gail Tully, BS, CPM, and Lisa Hanson, PhD, CNM, FACNM, FAAN

Before labor begins 42
Fetal presentation and position 42
Abdominal contour 42
Location of the point of maximum intensity (PMI) of the fetal heart tones via auscultation 42
Leopold’s maneuvers for identifying fetal presentation and position 46
Abdominal palpation using Leopold’s maneuvers 46
Estimating engagement: The rule of fifths 49
Malposition 53
Other assessments prior to labor 53
Estimating fetal weight 53
Assessing the cervix prior to labor 54
Assessing prelabor 55
Six ways to progress 55
Assessments during labor 55
Visual and verbal assessments 55
Hydration and nourishment 55
Psychology 56
Quality of contractions 56
Vital signs 57
Purple line 58
Assessing the fetus 58
Fetal movements 58
Gestational age 58
Meconium 59
Fetal heart rate (FHR) 59
Internal assessments 67
Vaginal examinations: indications and timing 68

Performing a vaginal examination during labor 68
Assessing the cervix 69
Assessing the presenting part 70
Identifying those fetuses likely to persist in an OP position throughout labor 75
The vagina and bony pelvis 76
Putting it all together 76
Assessing progress in the first stage 76
Features of normal latent phase 76
Features of normal active phase 76
Assessing progress in the second stage 77
Features of normal second stage 77
Conclusion 77
References 77

Chapter 5: Role of Physiologic and Pharmacologic Oxytocin in Labor Progress 82
Elise Erickson, PhD, CNM, FACNM and Nicole Carlson, PhD, CNM, FACNM, FAAN

History of oxytocin discovery and use in human labor 83
Structure and function of oxytocin 83
Oxytocin receptors 83
Oxytocin and spontaneous labor onset and progression 84
Promoting endogenous oxytocin function in spontaneous labor 85
Ethical considerations in oxytocin administration 85
Oxytocin use 86
Oxytocin use during latent phase labor 87
Oxytocin use during active phase labor 87
Oxytocin use during second stage labor 88
Changes in contemporary populations and labor progress 88
Oxytocin dosing 89
High dose/low dose 89
Variation in oxytocin dosing among special populations 89
Higher body mass index 89
Nullipara 90
Maternal age 90
Epidural 91
Problems associated with higher doses or longer oxytocin infusion 91
Postpartum hemorrhage 91
Fetal Intolerance to labor 92
Oxytocin holiday 92
Breastfeeding and beyond 92
New areas of oxytocin research 93
Conclusion 93
References 93

Chapter 6: Prolonged Prelabor and Latent First Stage 101
Ellen L. Tilden, PhD, RN, CNM, FACNM, Jesse Remer, BS, CD(DONA), BDT(DONA), LCCE, FACCE, and Joyce K. Edmonds, PhD, MPH, RN

The onset of labor: key elements of recognition and response 102
Defining labor onset 102

Signs of impending labor 103
Prelabor 103
Prelabor vs labor: the dilemma 103
Delaying latent labor hospital admissions 103
Anticipatory guidance 104
Anticipatory guidance for coping prior in prelabor 105
Sommer's New Year's Eve technique 106
Prolonged prelabor and the latent phase of labor 106
Fetal factors that may prolong early labor 107
Optimal fetal positioning: prenatal features 107
Miles circuit 109
Support measures for pregnant people who are at home in prelabor and the latent phase 110
Some reasons for excessive pain and duration of prelabor or the latent phase 111
Iatrogenic factors 112
Cervical factors 112
Management of cervical stenosis or the "zipper" cervix 112
Other soft tissue (ligaments, muscles, fascia) factors 112
Emotional dystocia 113
Troubleshooting Measures for Painful Prolonged Prelabor or Latent Phase 113
Measures to Alleviate Painful, Non-progressing, Non-dilating Contractions in Prelabor or Latent Phase 114
Synclitism and asynclitism 114
Open knee–chest position 118
Closed knee–chest position 119
Side-lying release 119
When progress in prelabor or latent phase remains inadequate 120
Therapeutic rest 120
Nipple stimulation 120
Membrane sweeping 121
Artificial rupture of membranes in latent labor 121
Can prenatal actions prevent some postdates pregnancies, prolonged prelabors, or early labors? 121
Prenatal preparation of the cervix for dilation 121
References 125

Chapter 7: Prolonged Active Phase **130**
Amy Marowitz, DNP, CNM

What is active labor? Description, definition, diagnosis 131
When is active labor prolonged or arrested? 131
Possible causes of prolonged active labor 132
Treatment of prolonged labor 132
Fetopelvic factors 132
How fetal malpositions and malpresentation delay labor progress 134
Determining fetopelvic relationships 134
Malpositions 134
Malpresentations 134
Use of ultrasound 135
Artificial rupture of the membranes (amniotomy) when there is a fetal malposition or malpresentation 135

Epidural analgesia and malposition or malpresentation 135
Maternal positions and movements for suspected malposition, malpresentation, or any "poor fit" 136
Overview and evidence 136
Positions to encourage optimal fetal positioning 137
Forward-leaning positions 137
Side-lying positions 137
Asymmetrical positions and movements 137
Abdominal lifting 142
"Walcher's" position 142
Flying cowgirl 142
Low technology clinical approaches to alter fetal position 144
Digital or manual rotation of the fetal head 144
Digital rotation 145
Manual rotation 146
Early urge to push, cervical edema, and persistent cervical lip 147
Manual reduction of a persistent cervical lip 148
Reducing swelling of the cervix or anterior lip 148
Disruptions to the hormonal physiology of labor 150
Overview 150
If emotional dystocia is suspected 150
Predisposing factors theorized to contribute to emotional dystocia 151
Possible indicators of emotional dystocia during active labor 151
Measures to help cope with expressed fears 151
Hypocontractile uterine activity 152
Factors that can contribute to contractions of inadequate intensity and/or frequency 152
Immobility 152
Environmental and emotional factors 152
Uterine lactate production in long labors 152
Sodium bicarbonate 153
Calcium carbonate 154
When the cause of inadequate contractions is unknown 154
Breast stimulation 154
Walking and changes in position 154
Acupressure or acupuncture 154
Coping and comfort issues 155
Individual coping styles 155
Simkin's 3 Rs: Relaxation, rhythm, and ritual: The essence of coping during the first stage of labor 156
Hydrotherapy: Warm water immersion or warm shower 156
Comfort measures for back pain 156
Exhaustion 157
Sterile water injections 158
Procedure for subcutaneous sterile water injections 159
Hydration and nutrition 160
Conclusion 160
References 160

Chapter 8: Prevention and Treatment of Prolonged Second Stage of Labor 166
Kathryn Osborne, PhD, CNM, FACNM and Lisa Hanson, PhD, CNM, FACNM, FAAN

Definitions of the second stage of labor 167
Phases of the second stage of labor 167
The latent phase of the second stage 168
Evidence-based support during the latent phase of second stage labor 169
What if the latent phase of the second stage persists? 169
The active phase of the second stage 169
Physiologic effects of prolonged breath-holding and straining 170
Effects on the birth giver 170
Effects on the fetus 170
Spontaneous expulsive efforts 171
Diffuse pushing 172
Second stage time limits 173
Possible causes and physiologic solutions for second stage dystocia 174
Position changes and other strategies for suspected occiput posterior or persistent occiput transverse fetuses 174
The use of supine positions 174
Why not the supine position? 176
Use of the exaggerated lithotomy position 177
Differentiating between pushing positions and birth positions 178
Knees together pushing 178
Leaning forward while kneeling, standing, or sitting 178
Squatting positions 178
Asymmetrical positions 180
Lateral positions 181
Supported squat or "dangle" positions 181
Other strategies for malposition and back pain 182
Early interventions for suspected persistent asynclitism 183
Positions and movements for persistent asynclitism in second stage 188
Nuchal hand or hands at vertex delivery 190
If cephalopelvic disproportion or macrosomia ("poor fit") is suspected 190
The influence of time on cephalopelvic disproportion 191
Fetal head descent 191
Verbal support of spontaneous bearing-down efforts 192
Guiding the birthing person through crowning of the fetal head 192
Hand skills to protect the perineum 192
Perineal management during second stage 194
Topical anesthetic applied to the perineum 194
Differentiating perineal massage from other interventions 194
Waterbirth 194
Positions for suspected "cephalopelvic disproportion" (CPD) in second stage 197
Shoulder dystocia 197
Precautionary measures 202
Two step delivery of the fetal head 204
Warning signs 204

Shoulder dystocia maneuvers 205
The McRoberts' maneuver 206
Suprapubic pressure 206
Hands and knees position, or the Gaskin maneuver 207
Shrug maneuver 207
Posterior axilla sling traction (PAST) 208
Tully's FlipFLOP pneumonic 208
Somersault maneuver 208
Decreased contraction frequency and intensity 210
If emotional dystocia is suspected 211
The essence of coping during the second stage of labor 211
Signs of emotional distress in second stage 211
Triggers of emotional distress unique to the second stage 211
Conclusion 213
References 213

Chapter 9: Optimal Newborn Transition and Third and Fourth Stage Labor Management 219
Emily Malloy, PhD, CNM, Lisa Hanson, PhD, CNM, FACNM, and Karen Robinson, PhD, CNM, FACNM

Overview of the normal third and fourth stages of labor for unmedicated mother and baby 219
Third stage management: care of the baby 220
Oral and nasopharynx suctioning 220
Delayed clamping and cutting of the umbilical cord 221
Management of delivery of an infant with a tight nuchal cord 222
Third stage management: the placenta 222
Physiologic (expectant) management of the third stage of labor 223
Active management of the third stage of labor 224
The fourth stage of labor 226
Baby-friendly (breastfeeding) practices 227
Supporting microbial health of the infant 228
Routine newborn assessments 229
Conclusion 230
References 230

Chapter 10: Epidural and Other Forms of Neuraxial Analgesia for Labor: Review of Effects, with Emphasis on Preventing Dystocia 235
Sharon Muza, BS, CD/BDT(DONA), LCCE, FACCE, CLE and Robin Elise Weiss, Ph.D., MPH, CLC, LCCE, FACCE, AdvCD/BDT(DONA)

Introduction: analgesia and anesthesia—an integral part of maternity care in many countries 235
Neuraxial (epidural and spinal) analgesia—new terms for old approaches to labor pain? 236
Physiological adjustments that support maternal-fetal wellbeing 237
Multisystem effects of epidural analgesia on labor progress 237
The endocrine system 237
The musculoskeletal system 238
The genitourinary system 239
Can changes in labor management reduce problems of epidural analgesia? 239
Descent vaginal birth 243

Guided physiologic pushing with an epidural 244
Centering the pregnant person during labor 245
Conclusion 246
References 246

Chapter 11: Guide to Positions and Movements **249**
Lisa Hanson, PhD, CNM, FACNM, FAAN and Emily Malloy, PhD, CNM

Maternal positions and how they affect labor 250
Side-lying positions 250
Pure side-lying and semiprone (exaggerated Sims') 250
The "semiprone lunge" 256
Side-lying release 257
Sitting positions 259
Semisitting 259
Sitting upright 261
Sitting, leaning forward with support 262
Standing, leaning forward 263
Kneeling positions 264
Kneeling, leaning forward with support 264
Hands and knees 266
Open knee–chest position 266
Closed knee–chest position 269
Asymmetrical upright (standing, kneeling, sitting) positions 269
Squatting positions 270
Squatting 270
Supported squatting ("dangling") positions 272
Half-squatting, lunging, and swaying 274
Lap squatting 274
Supine positions 277
Supine 277
Sheet "pull-to-push" 278
Exaggerated lithotomy (McRoberts' position) 279
Maternal movements in first and second stages 280
Pelvic rocking (also called pelvic tilt) and other movements of the pelvis 281
Hip sifting 282
Flexion of hips and knees in hands and knees position 283
The lunge 284
Walking or stair climbing 285
Slow dancing 286
Abdominal lifting 288
Abdominal jiggling with a shawl 289
The pelvic press 290
Other rhythmic movements 292
References 293

Chapter 12: Guide to Comfort Measures **294**
Emily Malloy, PhD, CNM and Lisa Hanson, PhD, CNM, FACNM, FAAN

Introduction: the state of the science regarding non-pharmacologic, complementary, and alternative methods to relieve labor pain 295
General guidelines for comfort during a slow labor 295
Non-pharmacologic physical comfort measures 296
Heat 296
Cold 297
Hydrotherapy 299
How to monitor the fetus in or around water 301
Touch and massage 302
How to give simple brief massages for shoulders and back, hands, and feet 302
Acupuncture 307
Acupressure 307
Continuous labor support from a doula, nurse, or midwife 307
How the doula helps 308
What about staff nurses and midwives as labor support providers? 309
Assessing the laboring person's emotional state 310
Techniques and devices to reduce back pain 312
Counterpressure 312
The double hip squeeze 312
The knee press 314
Cook's counterpressure technique No. 1: ischial tuberosities (IT) 315
Cook's counterpressure technique No. 2: perilabial pressure 316
Techniques and devices to reduce back pain 318
Cold and heat 318
Cold and rolling cold 318
Warm compresses 319
Maternal movement and positions 319
Birth ball 320
Transcutaneous electrical nerve stimulation (TENS) 321
Sterile water injections for back labor 323
Procedure for subcutaneous sterile water injections 324
Breathing for relaxation and a sense of mastery 324
Simple breathing rhythms to teach on the spot in labor 325
Bearing-down techniques for the second stage 325
Spontaneous bearing down (pushing) 325
Self-directed pushing 326
Conclusion 326
References 326

Index 329

List of Contributors

Editors:

Lisa Hanson PhD, CNM, FACNM, FAAN
Klein Professor
Associate Director, Midwifery Program
Marquette University, USA
College of Nursing
Milwaukee, WI

Emily Malloy PhD, CNM
Certified Nurse Midwife
Director of Midwifery Research
Midwifery and Wellness Center
Aurora Sinai Medical Center
Participating Faculty
Marquette University, USA
College of Nursing
Milwaukee, WI

Penny Simkin BA, PT, CCE, CD(DONA)
Certified Birth Doula and Certified Childbirth Educator, USA

Contributing Authors:

Nicole Carlson PhD, CNM, FACNM, FAAN
Associate Professor
Nell Hodgson Woodruff School of Nursing
Emory University Atlanta, Georgia, USA

Joyce K. Edmonds, PhD, MPH, RN
Senior Research Scientist
Ariadne Labs
Harvard T.H. Chan School of Public Health
Boston, MA, USA

Elise Erickson PhD, CNM, FACNM
Assistant Professor
The University of Arizona AZ, USA
College of Nursing: Advanced Nursing Practice & Science
College of Pharmacy: Pharmacy Practice & Science
College of Medicine: Department of Obstetrics & Gynecology

Wendy Gordon, DM, MPH, CPM, LM
Chair & Associate Professor
Department of Midwifery
Bastyr University
WA, USA

Amy Marowitz, DNP, CNM
Associate Professor
Department of Midwifery and Women's Health
Frontier Nursing University
Kentucky, USA

Sharon Muza, BS, CD/BDT(DONA), LCCE, FACCE, CLE
Seattle Area Certified Birth Doula and Lamaze Certified Childbirth Educator

Kathryn Osborne PhD, CNM, FACNM
Associate Professor
Department of Women, Children and Family Nursing
College of Nursing
Rush University
Chicago, USA

Amber Price DNP, CNM, RN
President
Sentara Williamsburg Regional Medical Center
Williamsburg, VA, USA

Jesse Remer, BS, CD(DONA), BDT(DONA), LCCE, FACCE
Founder, Mother Tree International

Karen Robinson, PhD, CNM, FACNM
Interim Assistant Dean of Graduate Programs
Associate Professor
Marquette University College of Nursing

Venus Standard MSN, CNM, LCCE, FACNM
Director, DEI Education and Community Engagement
Director and Co-Principal Investigator of LEADoula program
University of North Carolina School of Medicine
Columbia, USA
Department of Family Medicine
Women's Health - Maternal and Child Health

Ellen L. Tilden, PhD, RN, CNM, FACNM, FAAN
Associate Professor
Oregon Health and Science University Portland, Oregon, USA
School of Nursing, Nurse-Midwifery Department
School of Medicine, OBGYN Department
Center M Co-Founder and CSO

Gail Tully, BS, CPM
Spinning Babies®

Robin Elise Weiss, Ph.D., MPH, CLC, LCCE, FACCE, AdvCD/BDT(DONA)
DONA International

Foreword

Writing a Forward to the 5th edition of Simkin Penny's *Labor Progress Handbook* brings to mind many of Penny's workshops that I attended either as an attendee or rarely a co-teacher. Penny's genius is her ability to present in a way that is accessible and pertinent to childbirth educators, doulas, family doctors, midwives, maternity nurses, and obstetricians. The Simkin's Labor Progress Hanbook evokes memories of Penny's workshops, where a mélange of maternity professionals of all kinds working, together on the floor and on birthing balls, or squeezing each other's pelvises or squatting in the correct position, with heels down or incorrect, heels up—demonstrating how the former opens the pelvic floor while the latter does not. What a collaborative scene!

How did Penny do it, when the normally separate but obviously related disciplines rarely learn together? Penny's understated and matter-of-fact, just-get-on-with-it approach engaged participants in an uplifting experience—an exercise based on her long-acquired knowledge as a physiotherapist applying her understanding of anatomy to birthing. No wonder Penny's workshops were always full. The Simkin's Labor Progress Handbook is deeply reflective of this experience, and the collaboration of the many birth disciplines is reflected in the authorship.

Penny was one of the founders of the doula movement, who, along with Marshall Klaus, Phyllis Klaus, John Kennel, and Annie Kennedy, embraced this new collaborator, and worked to bring doulas into the mainstream—fully appreciating how difficult that was going to be.[1] That doulas were part of the workshops made a statement that doulas could add their knowledge, as demonstrated in the Simkin's Labor Progress Handbook, to that of the other birth providers, even while the doula's allegiance and responsibility was to the laboring person only–and not the hospital or other institution.[2]

Reading Simkin's Labor Progress Handbook, one comes to the realization that it fits into the knowledge gap between a dry obstetrical textbook, cold evidence from a randomized controlled trial (with all its issues of generalizability)[3] and the bedside or floor side of real laboring persons and their supporters. Reading Simkin's Labor Progress Handbook is like being in one of Penny's workshops, navigating between evidence coming from multiple conventional sources and the lived experience of the multidisciplinary participants–respectfully appreciating the practice lives of all. I am especially excited to see so many midwifery scientists and doula clinical experts carry on the legacy of Penny's book and renaming it in her honor.

As in the introductory chapter, I too grappled with the narrow perspective of the three Ps, and in appreciation of Penny's many contributions, I offer my version of the three Ps:

The 3 Ps Expanded**

1. **Power** – strength, length, duration of contractions
2. **Passage** – the pelvis; shape, size, angles
3. **Passenger** – the baby; size, position, and attitude.

These are the commonly recognized "P's," to which we add nine more to consider:

4. **Person** – the laboring person's beliefs, preparation, knowledge, and "capacity" for doing the work of labor and birth

5. **Partner** – how the laboring person is supported and their knowledge, beliefs and preparation for the labor is integrated
6. **People** – the "entourage" – others who may be involved in the birth process and their beliefs, preparation, and knowledge of the process
7. **Pain** – the *laboring person's* past experiences of pain and the experience of pain in psychological and cultural terms: beliefs, environment, on the laboring person's capacity for coping with labor and birth.
8. **Pain** – *OURS*: how we professionals think of pain and manage it—seeking to abolish it or use it; how we professionals time the pain management tools at our disposal to minimize further interventions
9. **Professionals** –the manner in which all members of the healthcare team support, inform, and collaborate in care and information-sharing with the woman and her partner.
10. **Passion** – the *Laboring Person's*. The experienced journey of pregnancy, labor, and birth is one that is special and unique to each participant. It is crucial for all parties involved in the care to be recognized and honored, and that this principle guide us in our practice.
11. **Passsion** – *OURS*. The passion toward maternity care that drives us
    a) But for the woman and her supports, we need to recognize the importance of intimacy in this life-changing experience.
    b) We need to control our anxiety and need for perfection so that the laboring person can fully experience the passion – even when the birth is complex and requires considerable help from us.
12. **Politics** – enough said **–** You know it's true!

**MCK: Borrowed, stolen and modified from too many people to mention

Michael C Klein CM, MD, FCFP CCFP FAAP (neonatal-perinatal)
Emeritus Professor
Family Practice & Pediatrics
University of British Columbia
Senior Scientist Emeritus
BC Children's Hospital Research Institute, Vancouver
Recipient The Order of Canada
mklein@mail.ubc.ca
www.michaelcklein.ca
Author Dissident Doctor—catching babies and challenging the medical status quo.
2018. Douglas and McIntyre. ISBN 978–1–77162–192–2

REFERENCES

1. Eftekhary S, Klein, MC, Xu, S. (2010) The life of a Canadian doula: Successes, confusion, and conflict. *Journal of Obstetrics and Gynaecology Canada* 32(7), 642–649.
2. Amram N, Klein, MC, Mok, H, Simkin, P, Lindstrom, K, Grant, J. (2014) How birth doulas help clients adapt to changes in circumstances, clinical care, and client preferences during labor. *The Journal of Perinatal Education* 23(2), 96–103.
3. Klein MC. (2023) Homage to Dr. Murray Enkin and the complexity of evidence-based medicine. *Birth* 50(2), 255–257. doi: 10.1111/birt.12723.

Chapter 1

Introduction

Lisa Hanson, PhD, CNM, FACNM, FAAN and Emily Malloy, PhD, CNM

Causes and prevention of labor dystocia: a systematic approach, 1
Notes on this book, 4
Note from the authors on the use of gender-inclusive language, 5
Conclusion, 5
References, 5

CAUSES AND PREVENTION OF LABOR DYSTOCIA: A SYSTEMATIC APPROACH

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.[1] Some have suggested that the use of the term "dystocia" be abandoned in favor of more precise definitions since one clear explanation is lacking.[1] The modern course of labor is very different than in the past, and optimal strategies to reduce unnecessary interventions while providing interventions when needed and appropriate are still under investigation.[2] Dystocia also contributes indirectly to the number of repeat cesareans, especially in countries where rates of vaginal births after previous cesareans (VBAC) are low. Thus, preventing primary cesareans for dystocia decreases the total number of cesareans. The prevention of dystocia also reduces the need for many other costly, time-intensive, and possibly risky interventions, and spares the laboring person from discouragement and disappointment that often accompany a prolonged or complicated birth.[3]

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

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

Others are *extrinsic*:

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

The focus of Simkin's Labor Progress Handbook is on prevention, differential diagnosis, and early interventions to use to prevent labor dystocia. We emphasize relatively simple care measures and low technology approaches

Simkin's Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia, Fifth Edition. Edited by Lisa Hanson, Emily Malloy, and Penny Simkin.
© 2024 John Wiley & Sons Ltd. Published 2024 by John Wiley & Sons Ltd.

designed to help maintain normal labor progress, and to manage and correct minor deviations before they become serious enough to require technologic 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 [birth parent] and baby with the least possible level of intervention that is compatible with safety."[4]

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

- The timing of dystocia is an important consideration when establishing cause and selecting interventions.
- Sometimes several causal factors can occur simultaneously.
- Clinicians and caregivers 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 laboring person or fetus;
  - The laboring persons is autonomous with the right to accept or refuse interventions. These suggestions treat the laboring person as the key to the solution, not part of the problem;
  - They build or strengthen the cooperation between the laboring person, their support people (loved ones, doula), and their clinicians;
  - they reduce the need for riskier, costlier, more complex interventions;
  - They may increase the person's emotional satisfaction with their 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 laboring person may not want to try some interventions; they may take time; and/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 medical or psychological contraindications, patience, reassurance, and low- or no-risk interventions may constitute the most appropriate course of management.
- The clinician may use the following to determine the cause of the problem(s):
  - Objective data: 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 data: person's affect, description of pain, level of fatigue, ability to cope using self-calming techniques:
  - Essential components:
    - Attentive listening
    - Informed consent and refusal
    - Shared decision-making with the laboring person

Chart 1.1 illustrates the step-by-step approach followed in this book—from detection of little or no labor progress through graduating levels of interventions (from simple to complex) to correct the problem.

If the primary physiologic interventions are contraindicated or if they are unsuccessful, then secondary—relatively low-technology—interventions are used, and only if those are unsuccessful are tertiary, high-technology obstetrical interventions instituted under the guidance of the physician or midwife. Other similar flow charts appear throughout this book showing how to apply this approach to a variety of specific causes of dysfunctional labor.

Many of the interventions described here are derived from the medical, midwifery, nursing, and childbirth education literature. Some of the strategies described in this book lend themselves to randomized controlled trials, others do not. Others come from the psychology, sociology, and anthropology literature. Suggestions also come from the extensive wisdom and experience of nurses, midwives, physicians, and doulas and other labor support providers. Many are applications of physical therapy principles and practices. The fields of therapeutic massage and chiropractic provide methods to assess and correct soft tissue tension and imbalance that can impair labor progress. We have provided references for these, when available. Some items fall into the category of "shared wisdom," where the original sources are unknown.

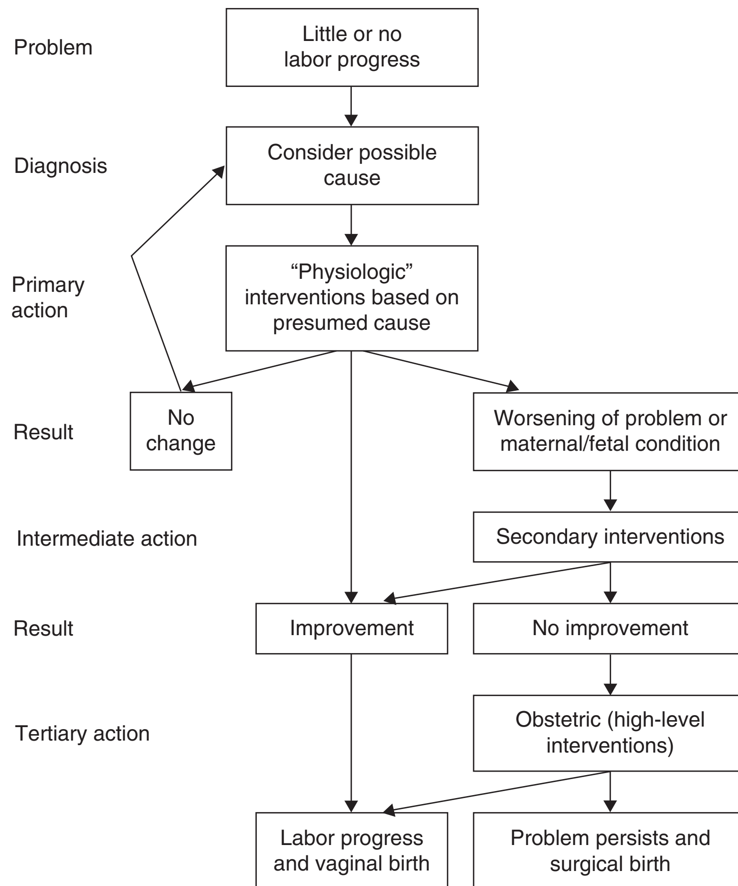

Chart 1.1. Care plan for the problem of "little or no labor progress."

During the past half-century, extensive scientific evaluation of numerous entrenched medical customs, policies, and practices, intended to improve birth outcomes, has determined that many are ineffective or even harmful. Routine practices, such as enemas, pubic shaving, routine continuous electronic fetal monitoring, maternal supine and lithotomy positions in the second stage of labor, routine episiotomy, immediate clamping of the umbilical cord, routine suctioning of the newborn's airway after birth, and separation of the newborn from parent/s are examples of care practices that became widespread before they were scientifically evaluated. Scientific study now shows that these common practices were not only ineffective, they increased the risks for the birthing person and neonate.[5]

Other valid considerations, such as the laboring person's needs, preferences, and values, also play a large role in the selection of approaches to their care. Our paradigm is one of respectful maternity care, although we recognize that throughout history and around the world, laboring people have been subject to racism, sexism, gender discrimination, disrespect, and other abusive and harmful behaviors. It is our expectation that laboring people are treated using a respectful maternity care and human rights model.

Racism and white supremacy are pervasive in obstetric care. Scholars have identified that many of the people identified as early founders of obstetrics and gynecology learned their skills through experimentation, coercion, and abuse of black, brown, and poor birthing people.[6] Therefore, in this book, we will avoid using the names of

those early experimenters in favor of descriptive terminology, for example, left side lying, or runner's lunge for the position formerly called by a gynecologist's name. Additionally, for one hundred years, nurses, midwives, and physicians were taught a system of pelvic classification with the aim of predicting difficult births that was overtly racist, and based only on pseudoscience.[7] Therefore, in this book, we recognize that humans and pelvises are dynamic, and there is not one perfect pelvis. Rather, our goal is to help birthing people and birth workers take advantage of the mobility of the pelvis. The interventions and positions shown throughout this book are offered to provide many options in one place, rather than a "one size fits all" approach.

Maternity care practices, providers, and outcomes differ around the world. Many counties have recognized the importance of improving maternal and neonatal care, although progress has been slow.[8,9] During the past decade, increasing evidence has pointed to the importance of midwives to improve outcomes. In 2014 the *Lancet* published a series on midwifery in four papers.[10–13] The goal of the series was to correct misunderstandings about the midwifery profession. An important conclusion of the series was that better utilization of midwives could prevent a significant portion of perinatal morbidity, including stillbirth. Many countries are working toward a goal of strengthening their midwifery workforce and increasing access to midwifery care to decrease maternal morbidity and mortality.[14] Midwifery care is associated with more spontaneous vaginal birth, less preterm birth, less epidural use, less episiotomy use, fewer instrumental births.[15] Currently, we must find the balance between intervention and non-intervention. There is a time and place for both, but around the world more labor interventions are occurring without an improvement in outcomes for pregnant and birthing people and their newborns.

Depending on healthcare setting, midwifery training and availability, the World Health Organization makes a recommendation for Midwifery Led Continuity of Care models (MLCC).[16] MLCC involves care by a midwife or team of midwives during the antenatal, intrapartum, and postpartum period.[16] MLCC does not exclude other caregivers from providing care, but rather starts most pregnant people with the midwifery model, and those who need care by other professionals are referred based on their specific needs or conditions. While high-risk pregnant people benefit from the care of an obstetrician, low-risk pregnant people generally benefit from less invasive approaches to care provided by a midwife or family/general physician. Midwifery care is rooted in evidence-based care—a combination of research evidence, clinical experience, and the needs and wishes of the pregnant, laboring, or birthing person.[17]

May 5 is the International Day of the Midwife; in 2021 the theme of the day was "follow the data and invest in midwives."[14] Midwifery care varies widely by country. In the UK midwives and general practice providers deliver 80% of maternity care while in the United States midwives deliver approximately 10% of maternity care.[18,19] In some countries, such as Germany and Japan, there are many more midwives than obstetricians.[20] Many countries are working to increase their midwifery workforce, such as India, which has developed the Nurse Practitioner in Midwifery credential and Mexico which started an Initiative to Promote Professional Midwifery in 2015.[21,22]

The intention of this book is to be widely applicable in many different settings and to many different clinicians and support people, including nurses, midwives, physicians, doulas, and others. The differences in clinicians and their differing approaches to childbirth are reflected in the varying rates of interventions and cesarean births when labor is considered low risk. We hope that this book will offer tools for use in many different settings and situations.

NOTES ON THIS BOOK

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

NOTE FROM THE AUTHORS ON THE USE OF GENDER-INCLUSIVE LANGUAGE

We acknowledge that pregnant and birthing people may or may not identify with the gendered terms woman/women/she/her/hers. Therefore, in this edition we include the use of gender-inclusive language and use the terms pregnant, laboring, or birthing person. This is to avoid making assumptions about those who give birth. There remain references to women and/or mothers when citing scientific literature where participants described themselves as female or the researchers identified the person as a woman or mother.

CONCLUSION

The fifth edition of this book is named to honor Penny Simkin, the original author of this book. She is a world-famous doula, childbirth educator, and author of numerous articles and books. Simkin's Labor Progress Handbook welcomes many new chapter authors and contributors who are expert midwifery clinicians, doulas, childbirth educators and/or scientists. This book focuses on prevention of labor dystocia, and a stepwise progression of interventions aimed at using the least invasive approaches that will result in safe delivery. To our knowledge, this is the first book that compiles labor progress strategies that can be used by a variety of clinicians and support people in a variety of locations. Most of the strategies described can be used for births occurring in hospitals, at home, and in free-standing birth centers.

Knowledge of appropriate early interventions may spare pregnant people from long, discouraging, or exhausting labors, reduce the need for major interventions, and contribute to safer and more satisfying outcomes. The laboring person may not even recognize the intervention done for them, but they will appreciate and always remember your attentiveness, expertise, respect, and support as they brought their child into the world. This will contribute so much to their satisfaction and positive long-term memories of their childbirths.[23] We wish you much success and fulfilment in your important work.

REFERENCES

1. Neal JL, Ryan SL, Lowe NK, Schorn MN, Buxton M, Holley SL, Wilson-Liverman AM. (2015) Labor dystocia: Uses of related nomenclature. *Journal of Midwifery & Women's Health* 60(5), 485–498.
2. Myers ER, Sanders GD, Coeytaux RR, McElligott KA, Moorman PG, Hicklin K, Grotegut C, Villers M, Goode A, Campbell H, Befus D, McBroom AJ, Davis JK, Lallinger K, Fortman R, Kosinski A. (2020) *Labor Dystocia*. Agency for Healthcare Research and Quality (US).
3. (2019 Feb) ACOG Committee Opinion No. 766: Approaches to Limit Intervention During Labor and Birth. *Obstetrics and Gynecology* 133(2), e164–e173. doi: 10.1097/AOG.0000000000003074. PMID: 30575638.N.
4. World Health Organization. (1996) *Care in Normal Birth: A Practical Guide*. Geneva: WHO. Chapter 1. Available from: http://apps.who.int/iris/bitstream/10665/63167/1/WHO_FRH_MSM_96.24.pdf
5. Block J. (2007) *Pushed: The Painful Truth about Childbirth and Modern Maternity Care*. Cambridge, MA: Da Capo Lifelong.
6. Cooper Owens D. (2017) *Medical Bondage. Race, Gender, and the Origins of American Gynecology*. Athens, GA: University of Georgia Press. ISBN-10: 9780820351353.
7. VanSickle C, Liese KL, Rutherford JN. (2022) Textbook typologies: Challenging the myth of the perfect obstetric pelvis. *Anatomical Record (Hoboken, N.J.: 2007)* 305(4), 952–967. doi: 10.1002/ar.24880
8. Kennedy HP, Cheyney, M, Dahlen, HG, Downe, S, Foureur, MJ, Homer, C, Jefford, E, McFadden, A, Michel-Schuldt, M, Sandall, J, Soltani, H, Speciale, AM, Stevens, J, Vedam, S, Renfrew, MJ. (2018) Asking different questions: A call to action for research to improve the quality of care for every woman, every child. *Birth (Berkeley, Calif.)* 45(3), 222–231. doi: 10.1111/birt.12361
9. Kennedy HP, Balaam MC, Dahlen H, Declercq E, de Jonge A, Downe S, Ellwood D, Homer C, Sandall J, Vedam S, Wolfe I. (2020) The role of midwifery and other international insights for maternity care in the United States: An analysis of four countries. *Birth (Berkeley, Calif.)* 47(4), 332–345. doi: 10.1111/birt.12504
10. Homer CS, Friberg, IK, Dias, MA, ten Hoope-Bender, P, Sandall, J, Speciale, AM, Bartlett, LA (2014) The projected effect of scaling up midwifery. *Lancet (London, England)* 384(9948), 1146–1157. doi: 10.1016/S0140-6736(14)60790-X

11. Renfrew MJ, McFadden, A, Bastos, MH, Campbell, J, Channon, AA, Cheung, NF, Silva, DR, Downe, S, Kennedy, HP, Malata, A, McCormick, F, Wick, L, Declercq, E. (2014) Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *Lancet (London, England)* 384(9948), 1129–1145. doi: 10.1016/S0140-6736(14)60789-3
12. ten Hoope-Bender P, de Bernis, L, Campbell, J, Downe, S, Fauveau, V, Fogstad, H, Homer, CS, Kennedy, HP, Matthews, Z, McFadden, A, Renfrew, MJ, Van Lerberghe, W. (2014) Improvement of maternal and newborn health through midwifery. *Lancet (London, England)* 384(9949), 1226–1235. doi: 10.1016/S0140-6736(14)60930-2
13. Van Lerberghe W, Matthews Z, Achadi E, Ancona C, Campbell J, Channon A, de Bernis L, De Brouwere V, Fauveau V, Fogstad H, Koblinsky M, Liljestrand J, Mechbal A, Murray SF, Rathavay T, Rehr H, Richard F, ten Hoope-Bender P, Turkmani S. (2014) Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality. *Lancet (London, England)* 384(9949), 1215–1225. doi: 10.1016/S0140-6736(14)60919-3
14. International Confederation of Midwives (ICM). (2021) Follow the data: Invest in midwives. Retrieved from https://www.internationalmidwives.org/icm-events/international-day-of-the-midwife-2021.html
15. Sandall J, Soltani H, Gates S, Shennan A, Devane D. (2015) Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane Database of Systematic Reviews* (9), CD004667. doi: 10.1002/14651858.CD004667.pub4
16. WHO. (2018) *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.
17. Pape TM. (2003) Evidence-based nursing practice: To infinity and beyond. *The Journal of Continuing Education in Nursing* 34, 154–161.
18. American College of Nurse Midwives. (2021). Evidence base practice definition. Retrieved from: https://www.midwife.org/Evidence-based-Practice-Definition. (accessed October 9, 2021).
19. American College of Nurse Midwives. (2019). Fact Sheet: Essential facts about midwives. (accessed October 9, 2021).
20. Dekker R. (2021) EBB 175: The evidence on midwifery care. *Evidence Based Birth Evidence that Empowers*. Retrieved from: https://evidencebasedbirth.com/evidence-on-midwives
21. Akins L, Keith-Brown K, Rees M, Sesia P, Blanco G, Coronel D, Cuellar G, Hernandez R, Yang C. (2019). Strengthening midwifery in Mexico: Evaluation of progress 2015–2018. Retrieved from: https://www.macfound.org/media/files/strengthening_midwifery_in_mexico_three-year_progress_report_revised_7_junio2019.pdf
22. Lalchandi K. (2021). India's investment in midwives: A step in the right direction to achieving universal health coverage. Retrieved from: https://www.jhpiego.org/story/indias-investment-in-midwives-a-step-in-the-right-direction-to-achieving-universal-health-coverage-for-all-by-2030
23. Simkin P. (1992) Just another day in a woman's life? Part 11: Nature and consistency of women's long-term memories of their first birth experiences. *Birth* 19(2), 64–81. doi: 10.1111/j.1523-536X.1992.tb00382.x

Chapter 2
Respectful Care

Amber Price, DNP, CNM, RN

Health system conditions and constraints, 8
LGBTQ birth care, 9
RMC and pregnant people in larger bodies, 9
Shared decision-making, 10
Expectations, 11
The impact of culture on the birth experience, 12
Traumatic births, 12
Trauma survivors and prevention of PTSD, 13
Trauma-informed care as a universal precaution, 15
Obstetric violence, 16
Patient rights, 17
Consent, 17
Maternal mortality, 18
References, 19

Almost everywhere on the planet, people seek out others for assistance during the birth process. Rarely does birth happen in complete isolation, unless it is by choice or necessity. In years past, birth took place inside the home, visible and audible to all. When people lived in small communities, they relied on others in their communities to assist them. Few people had babies who had not been present at the births of siblings, grandmothers, neighbors, or friends. Demystifying birth having seen it left people prepared, with memories of the sounds and work of labor and birth, and of others successfully completing the journey.[1] Attending birth fosters belief in the ability of the body to give birth, grows confidence, and normalizes the event. We are now in a time in history where people about to give birth have rarely witnessed it. Those who witnessed a birth on television likely saw a medicalized birth, in a hospital, with technology as a central feature.[1] How a person witnesses birth shapes their belief of it. Every culture has its beliefs and rituals around birth, and while it is shrouded in mystery in some cases, it is a universal equalizer.

In most cultures, the societal norm is to present to a health care provider for confirmation of pregnancy as soon as possible.[1] In some cultures, there are a lot of different birth attendants from which to choose. Rarely do pregnant people choose a provider based on attributes like approximation of their communication style, shared cultural or personal beliefs, or the ability to foster confidence and autonomy. Pregnant people may assume that the person who managed their contraception is going to be great at managing their pregnancy. It is very difficult for people to change providers during pregnancy, or they may not have an option to change, and therefore may end up giving birth with someone who does not understand their culture, read their body language well, communicate in a way that makes sense or feels comforting and respectful, or honor their wishes. It is sometimes easier for people to tell themselves that it will be okay, that a safe outcome is all that matters. A "healthy mom and baby" is often repeated by caregivers as the goal of pregnancy, but that is a very low bar to set. The experience of birth can contribute to a person's physical and emotional wellbeing for life.

Simkin's Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia, Fifth Edition. Edited by Lisa Hanson, Emily Malloy, and Penny Simkin.
© 2024 John Wiley & Sons Ltd. Published 2024 by John Wiley & Sons Ltd.

Childbearing is a rite of passage in every nation, but it is also universally a time of intense vulnerability. Many people report fear in early pregnancy and seek out immediate medical care for reassurance and guidance. It is this same fear, however, that makes pregnant people uniquely vulnerable to coercion. The cultural and social norms surrounding birth are vastly different around the globe, and stories of beautiful, empowered, and safe birth intermingle with stories of abuse and despair. Examples of giving birth on the floor and having to clean your own space afterward, and of being beaten and scolded by birth attendants, come from nations where unequal treatment in daily life mimics this reality.[2] In other nations, abuse is more subtle, but just as harmful, and can result in trauma even without visible bruises. The culture and belief of the individual giving birth tends to determine the experience. In cultures where gender imbalances are the norm, this imbalance will be amplified in the birth space. All ills in society, from racism to gender inequality and abuse, are amplified in birth settings.

Human rights are fundamental entitlements due to all people. Every culture on earth reports violations of these rights during pregnancy and birth.[2] The term *Respectful Maternity Care* (RMC) is an umbrella term that engulfs a wide range of issues commonly encountered in the birth space. The categories of disrespectful and abusive care during childbirth include[2,3]:

- Physical abuse
- Non-consented clinical care
- Non-confidential care
- Non-dignified care
- Abandonment and detention in healthcare facilities
- Sexual abuse
- Verbal abuse
- Stigma and discrimination
- Failure to meet professional standards of care
- Poor rapport between women and providers

HEALTH SYSTEM CONDITIONS AND CONSTRAINTS

> "*There is no circumstance where abuse, coercion, or a violation of your rights is acceptable. Every person has the right to self determination, in a safe, respectful, and supportive birth environment, free from harm. We strongly condemn any and all physical and verbal abuse of birthing persons and demand an immediate cessation of the antiquated harmful obstetric practices of years past. This includes intervention by force, coercion, or legal threat.*"[4]

Examples of violations of the principles of Respectful Maternity Care can be found in our daily lives. Most births are completely normal and uncomplicated. However, there are numerous examples of birth being portrayed as humorous, normalizing screaming and bodily harm. In movies, birthing people are almost always screaming, and birth is usually an emergency, because that keeps viewers on the edge of their seats. Many people therefore go into their birth experience expecting it to be traumatic, and have a great fear of birth, which is referred to as *tokophobia*.[5] Making light of suffering, exhaustion, and injury is not something we see portrayed in any other aspect of healthcare. If these are your only exposures to birth, it primes you to be afraid, and fear is the worst possible deterrent to self-advocacy.

While healthcare systems should strive to be safe spaces for birthing families, and minimize instances where crucial conversations are necessary, it is common for pregnant people to be challenged on birthing wishes that go counter to the culture of the clinician, birth setting, or the local region.[6] Memories of birth last a lifetime and are widely shared. A birth story may inspire fear or confidence in a birthing community, firmly rooting cultural norms and birth practices in a region.

Among the populations most vulnerable to disrespectful care are prisoners, people of color, LGBTQ people, obese people, and people with addiction issues or mental health conditions. While disrespect and abuse may happen to anyone, those who are more vulnerable to it have likely had prior negative experiences with healthcare providers, are less likely to seek care, and are uncomfortable in a medical setting.

LGBTQ BIRTH CARE

The sex a person is assigned at birth may not correspond to the individual's personal identity. "Sexual orientation"—loosely defined as who someone is attracted to sexually—and gender identity may define people's life and birth experiences. Choosing to love someone who is not of an opposite sex is still taboo in some cultures and can be intensely triggering to some people. "Gender identity" reflects a deeply felt and experienced sense of one's own gender. A person's gender identity is typically consistent with the sex assigned to them at birth. "Gender expression" refers to the way in which an individual outwardly chooses to presents their gender. Expressions of gender may be expressed through dress, body language, and other enhancers/modifications that may include make-up and hair choices that do not conform to the sex assigned at birth. According to the World Health Organization, "heteronormativity" is defined as the assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities. Among both individuals and institutions, this can lead to invisibility and stigmatization of other sexualities and gender identities. Often included in this concept is a level of gender normativity and gender roles, the assumption that individuals *should* identify as men and women, and be masculine men and feminine women. In some cultures, the stigma of being non-normative to the culture is so strong that people experience significant discrimination and abuse at the hands of society and healthcare providers. Gender identity is not static and limited to male/female identities, but rather exists on a spectrum.[7]

Birthing people who do not identify as women struggle with a world where birth has traditionally been the "realm of the woman." Most images of pregnancy in media and literature feature traditional female-identifying persons and language. The pregnant person is almost exclusively referred to as "she," and is usually featured with breasts. Birth terminology is sex-specific, and often excludes people who do not identify as female. Even the terminology of Maternity care, identifying a pregnant person as "mother," may not feel accurate to the person. This trigger-language is everywhere for people who do not identify as female, and can cause significant distress and a feeling of being "other" during an intensely vulnerable time that should be exciting and enjoyable.

When a person or couple does not conform to the cultural norm attributed to childbearing people, there may be situations where Respectful Care is compromised. Sometimes this is done without malice or intent, such as when someone refers to the baby's parents as "mother and father," though sometimes the intent is to chastise and harm due to an intense personal reaction from the provider rooted in their own beliefs about sex and gender identity. For people who encounter a system where they are likely to be marginalized or encounter abuse, it is important to find a provider who respects personal wishes, and to communicate expectations about sex/gender specific language for themselves, their partner, and their baby. The birth experience itself may trigger intense feelings, and predispose the gender non-normative birthing person to trauma. It is important to process the birth experience with a trusted person who is privy to the specific circumstances and identity within a few weeks of the birth. When caring for someone who identifies as LGBTQ+, it is important to ask how they want to be addressed, what the important things are for you to remember and share with the rest of the team, and how they envisioned their birth. Making assumptions about who receives the baby at birth, culture-specific parenting and sex terminology (i.e., "it's a girl," "she," "mother") may not only be offensive and upsetting to the birthing person, but may lead to a trauma response. Not using the word "woman" has been a hotly debated issue in women's healthcare, where the perception is that women are erased from birth by eliminating this gendered term. However, the word "woman" is perfectly fine and appropriate to use with anyone who identifies as such. The care we must take is to follow *The Platinum Rule*—to do unto others as they would have done unto themselves, rather than *The Golden Rule*, which assumes we should care for others the way we wish to be cared for ourselves[8]. This principle extends to the language people prefer us to use.

RMC AND PREGNANT PEOPLE IN LARGER BODIES

The World Health Organization estimates that 52% of the world's people have a BMI over 25. During pregnancy, 73% of pregnant people gain more weight than recommended.[9] People in a large body face significant bias in society, but particularly in the healthcare setting, where weight is quickly blamed for all health problems and risks. Equipment is designed for people of average weight. Monitors used to listen to baby hearts rely on ultrasound technology, which does not penetrate adipose tissue well. Beds have weight limits, as do MRI machines, OR tables, and CT scans. Gowns are rarely big enough to comfortably fit a person in a larger body. Blood pressure cuffs, fetal