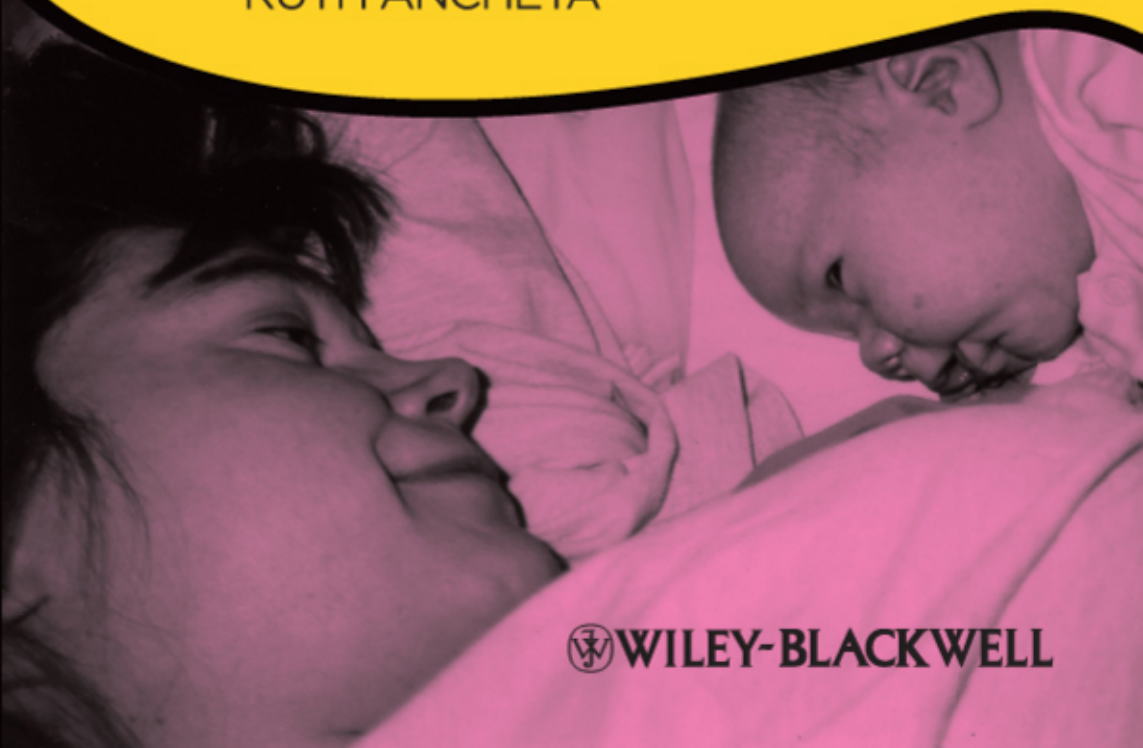
The Labor Progress Handbook

Early Interventions to Prevent and Treat Dystocia

THIRD EDITION

PENNY SIMKIN
RUTH ANCHETA



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Dedication

We dedicate this book to childbearing women and their caregivers in the hope that some of our suggestions will reduce the likelihood of cesarean delivery for dystocia; also to the wise, patient, and observant midwives, nurses, doulas, family doctors, and obstetricians whose actions and writings have inspired and taught us.

Contents

Foreword to the third edition

Writing the foreword to the third edition of a successful book is a simple yet daunting task. Ellen Hodnett and Michael Klein so extolled the merits of the previous editions that there is little left to say. The core of the *Labor Progress Handbook* remains the same: a detailed description of labor as a physiologic process entwined with practical advice on how to help keep it that way. However, the third edition has been updated and newly referenced with some important additions: more practical guidance such as detailed descriptions of massage techniques and a complete analysis of directed versus spontaneous pushing. A beautifully written new chapter on the third and fourth stages of labor dispenses neatly with routine newborn suctioning and early cord clamping and gives a balanced discussion of active versus physiological third stage management. Another describes "intermediate interventions"—manual techniques and relatively low-level interventions to help avoid the need for medical or surgical management when labor is not progressing.

Labor is a dynamic neurohormonal dance and dramatic physical transition that transforms a woman's body, psyche, and soul. Labor is defined by dynamic and complex processes: psychological phenomena such as privacy and inhibition; the endocrine enigma of pulsatile oxytocin and endorphin surges; even the more tangible physiologic and anatomic changes of Ferguson's reflex and molding of the fetal skull. From a deductive scientific perspective, these remain poorly understood, even in 2011. Where science can no longer inform us, we must rely upon the experience, insight, and art of generations of skilled midwives and labor attendants, and this is where the *Labor Progress Handbook* is so helpful.

The authors demonstrate an excellent understanding of modern evidence-based practice; however, unlike in most medical texts, they are not constrained by the limits of science. Throughout the book, the highest level of evidence is sought and a multitude of current

randomized trials are cited, yet the discussions weave seamlessly from Cochrane reviews and randomized controls trials through formal cohort evidence when available to anecdotal observations and midwifery lore when not. For a phenomenon as complex as labor, the latter are often more informative than the former. A Cochrane review of randomized trials demonstrates the effectiveness of doulas in avoiding analgesia and operative birth. However, to understand why, one is left with observations of the roles of "privacy" and "support" to facilitate "disinhibition" of the "instinctual brain" integral to normal labor and key to avoiding "emotional dystocia." These concepts are neither easily definable nor amenable to reductionist analysis, yet they are understood by any experienced birth attendant.

When I was a young medical student first learning about labor, evidence-based medicine had not yet been born, yet I was lucky enough to have skeptical mentors who had dispensed with routine enemas, shave preps, and episiotomies. Without Cochrane reviews and meta-analyses to distract us, we were taught to unobtrusively observe and support women in normal labor (since most women did not have an epidural). Had it existed then, the *Labor Progress Handbook* would have been a very helpful guide.

In today's obstetric environment, where the majority of laboring women receive epidurals and where information and knowledge have largely replaced wisdom and art, the *Labor Progress Handbook* is that much more important—an invaluable asset to any birth attendant and essential reading for any student of birth—whether nurse, midwife, doctor, or doula.

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Foreword to the second edition

In Canada, where we pride ourselves on having an integrated system of maternity care, where obstetricians, family doctors, nurses, and midwives work collaboratively, a recent national study nevertheless reported that three out of four women receive one or more major interventions in labor. How can this be? Could it be because we have forgotten how to look after women in labor?

The second edition of this thoughtful and practical book will be a gift to the full range of practitioners and trainees from the sister disciplines of obstetrics and gynecology, family practice, midwifery and nursing. It is a skillful blend of classical obstetrical teaching, quoting liberally from conventional textbooks and scientific literature, to "new" information gleaned from the long experience of midwives.

Generations of medical students have learned a huge amount about the pathology of childbirth, with the result that they tend to fear labor and have learned to intervene with the "big guns," like oxytocin augmentation and various forms of expedited birth. We learned as students that childbirth could be reduced to a little plumbing: the "three Ps." And if we regurgitated this in an exam, we received a sure pass.

(1) The *Passage* or pelvis: size, shape, angles.
(2) The *Power* or strength of contractions.
(3) The *Passenger* or fetus, meaning principally the size of fetal head but also position and attitude.

Unfortunately, while plumbing is important in childbirth and in life (especially for those of us in advancing years), there is so much more to labor and life. Responding to the complexity and simplicity of labor so well described in this book, some of us have invented

another "seven Ps," and I was pleased to find that many of them have been enumerated by the authors:

(4) The *Person*—the woman: her beliefs, preparation, knowledge, and "capacity" for doing the work of labor and birth.
(5) The *Partner*—how the woman is supported and the partner"s knowledge, beliefs, and preparation for the labor.
(6) The *People*—the "entourage"—others who may be involved in the pregnancy, labor, and birth process, and who are working with the woman. The entourage also have their beliefs, preparation, and knowledge of the process, and this interacts positively or negatively with those of the woman and her partner.
(7) The *Pain*—the influence and experience of pain and the sociocultural beliefs of the woman and her support system and her personal psychological environment. All this influences the woman's capacity for coping with labor and birth. Clearly pain interpretation and pain control impacts the progress of labor.
(8) The *Professionals*—the manner in which all members of the health care team support, inform and collaborate in care and information-sharing with the woman and her partner and support people, significantly influences the woman's response to the labor and birth process.
(9) The *Passion*—the journey of pregnancy, labor and birth, is one that is special and unique for all women. It is crucial for all involved in the care of women to recognize and honor this passion and allow this concept to guide us in our practice as we appreciate and guard the intimacy of this life-changing experience. And we need to control our anxiety and need for perfection so that the woman can fully experience the passion even when the birth is complex and requires considerable help from us.
(10) The *Politics*—You know it's true!

This book focuses on these concepts, while providing concrete information to help us facilitate the natural processes that are ready to be released, if we but give them time.

How refreshing to find a book that teaches how to stay out of trouble, how to prevent dysfunctional labors (and even to do so well before labor occurs) during prenatal care. It is liberating to have information on how to shift a fetus from an unfavorable to a favorable position, rather than waiting pessimistically to see an antenatal fetal

malposition turn into an intrapartum OT or OP. New learners will benefit from the detailed descriptions of asynclitism and how to diagnose and treat it, as well as excellent descriptions of how to diagnose a flexed or extended head.

I have seen Penny teach these techniques in workshops for maternity caregivers, and seen the "Aha!" experience that results in the statement, "I can't wait to try these techniques in my next clinic or labor."

And now the information is available in accessible form to share with trainees and the women themselves. Thus, this book complements and augments the materials conventionally taught to medical students and specialist trainees. It will empower them with information that they can use in the labor suite. It will make them feel useful.

Epidural analgesia: the new reality. Who can argue with good pain relief ? But at what price? And do women know, and have they been taught the full picture? The Cochrane Collaboration clearly demonstrates that it increases the length of the first and second stages of labor, increases the use of instrumentation and leads to excess perineal trauma. And while Cochrane reports no increase in cesarean section, most of us know that to be untrue. When used early and often (not the conditions of the major new trials in Cochrane)[1], epidural analgesia usually requires oxytocin augmentation (which is generally given in low dose regimes). Epidural analgesia clearly increases the frequency of cesarean section.

Therefore, I was particularly impressed with the way that the authors explained the influence of epidural analgesia on the course of labor. In fact, epidural analgesia is now so pervasive that we have forgotten how the entire shape of labor has been altered by its availability and omnipresence. Not to overstate the issue, there are places in North America and elsewhere where the staff either do not know or have forgotten how to look after women who do not have an epidural.

Unfortunately, it is this sad situation that makes it so necessary to describe how epidural analgesia alters labor and what techniques are needed to assist women who have an epidural. The authors have therefore elaborated on this new reality and provided the cautions and tools to assist caregivers do their best to let labor unfold in the presence of an epidural.

This little text, which will fit nicely in a back pocket or "lab coat," provides practical diagrams of normal and abnormal fetal positions

that can be identified well before labor, and more importantly, corrected, so as to lessen the malpositions of labor that unleash the "cascade" of interventions that characterize the experience of so many women having their first babies. It will take much to turn society back from thinking of childbirth as an accident waiting to happen and to help women realize their power and competence, but the authors have given us a tool to help in that process, to help us keep normal birth normal. I am grateful that this book is available and entering its second edition.

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Foreword to the first edition

At last, a book that offers practical advice for nurses and midwives who wish to help to prevent and treat dysfunctional labor! Penny Simkin and Ruth Ancheta have done a superb job of interweaving the clinical wisdom of observant, expert practitioners with the best available research evidence about what helps and does not help women during labor.

I wish this book had been available a long time ago. In the early 1970s when I was a novice labor and delivery nurse, I observed a common but puzzling problem. In those days we subjected women to an admission routine that included a variety of very unpleasant procedures. (Thankfully the worst of these procedures—perineal shaves, enemas, and rectal exams—have since been recognized as useless or harmful and have been eliminated from common practice.) Part of the admission routine involved assessment of the quality and strength of contractions. When I inquired about the contractions, I was often told, "My contractions were frequent and strong at home, but they seem to have gotten a lot weaker and further apart since I arrived."

I would reply, "Do not worry, this happens a lot. After we finish the admission procedures and you are settled in here, your labor will probably get going again."

Why did I say this? I believed it. I had observed it often and had overheard experienced colleagues reassure their patients in this way.

At some intuitive level I felt the decrease in labor intensity was caused by the woman's reaction to the stress of the hospital admission routine. But at the time almost nothing had been written about the role of stress hormones on uterine function, nor about the relationships between maternal anxiety, environmental influences, stress hormones, and labor complications. And the randomized controlled trials showing the substantial benefits of labor support had not even been conducted yet[1].

What about the instances in which labor did not return spontaneously to the strong, regular pattern that had been occurring prior to admission? Our repertoire of nursing interventions was limited primarily to advising the woman either to ambulate or to rest and wait. (Currently, in some settings the options may be even fewer, with ambulation restricted by the routine use of electronic fetal monitors.)

These women frequently ended up with a cascade of medical interventions—IV oxytocin, amniotomy, epidural analgesia, and forceps or cesarean delivery.

I now believe that there is much more I could have done to prevent or treat the problem of dysfunctional labor. Penny Simkin and Ruth Ancheta have described how "emotional dystocia" and stressful environmental influences may lead to complications, and they offer simple but potentially powerful nursing measures to ameliorate these problems. They have also persuaded me that many instances of dystocia or prolonged labor may be caused by subtle malpositions of the fetal head, potentially correctable with simple positioning techniques.

I can only imagine how much more effective I would have been if this book had been available when I was a labor and delivery nurse.

As a researcher, I am inspired to study these simple but potentially very powerful labor support techniques. Dystocia or dysfunctional labor is the most common reason for primary cesarean delivery. Given the high rates of cesarean delivery in North America and the United Kingdom, and the limitations and risks of medical treatments for dystocia, it seems long overdue that nurses and midwives take an active role in preventing and treating this common clinical problem. This book contains a wealth of information about and practical suggestions for preventing and correcting dysfunctional labor. It should be required reading for all who care for women in labor, and a reference text in every labor and birthing unit.

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The Labor Progress Handbook

Early Interventions to Prevent and Treat Dystocia

Third Edition

Chapter 1

Introduction

Penny Simkin, BA, PT, CCE, CD(DONA),
and Ruth Ancheta, BA, ICCE, CD(DONA)

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. Dystocia also contributes indirectly to the number of repeat cesareans, especially in countries where rates of vaginal births after previous cesareans (VBAC) are low. In fact, The American College of Obstetricians and Gynecologists (ACOG) estimates that 60% of all cesareans (primary and repeat) in the United States are attributable to the diagnosis of dystocia.[1] Thus, reducing the need for cesareans for dystocia is a strategic way to reduce the overall cesarean rate. Prevention of dystocia also reduces the need for many other costly and risky corrective obstetric

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Edited by Penny Simkin, Ruth Ancheta

measures and spares numerous women from the discouragement and disappointment that often accompany a prolonged or complicated birth.

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)
- *Ethnocultural* 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)
- *Psychoemotional care* (the priority given to nonmedical aspects of the childbirth experience)

Please see Michael Klein's Foreword to the second edition (page xviii) for his discussion of factors influencing labor progress.

The Labor Progress Handbook focuses on prevention, differential diagnosis, and early interventions to use with dysfunctional labor (dystocia). 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."[2]