Supporting Unmedicated Birth

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Disclosure

- The speaker has no financial conflicts of interest and nothing to disclose.

Objectives

- Review the move to increase NTSV births.
- Define physiologic birth.
- Discuss three techniques to assist your patient desiring/requiring unmedicated birth.

The New Labor Curves (the "Zhang" curves)

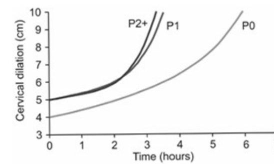

Figure 2.
Average labor curves by parity in singleton, term pregnancies with spontaneous onset of labor, vaginal delivery and normal neonatal outcomes. P0: nulliparas; P1: women of parity 1; P2+: women of parity 2 or higher.

From NICHD Free Public Access Article, published by Zhang J, et al. (2010). Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Obstetrics & Gynecology,116*(6):1281-7

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Partogram for Nulliparous Labor

Figure 3.
The 95th percentiles of cumulative duration of labor from admission among singleton, term nulliparas with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes.

From NICHD Free Public Access Article, published by Zhang J, et al. (2010). Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Obstetrics & Gynecology,116*(6):1281-7

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The Conclusion?

In their consensus statement, *Safe Prevention of the Primary Cesarean Delivery,* ACOG & SMFM state:

- A specific absolute maximum length of time that should be allowed in the second stage of labor has not been identified
- When maternal and fetal conditions permit, allow two hours of pushing in multiparous women and three hours of pushing in nulliparous women prior to diagnosing arrest of labor
- Longer durations may be appropriate on an individual basis (eg, epidural anesthesia, fetal malposition) as long as progress is being documented

Caughey et al., 2014

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Summary of Findings in ACOG and SMFM (2014) *Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery*

- Induction of labor < 41 0/7 weeks gestation generally should be limited to women with maternal and/or fetal indications.
- Induction of labor at ≥ 41 0/7 weeks gestation is recommended to minimize risk of cesarean birth and risk of perinatal morbidity and mortality.
- Cervical ripening should be used for women being induced with an unfavorable cervix.
- Active labor is more accurately defined as beginning at 6 centimeters (cm) cervical dilation.
- Neither active phase labor protraction nor labor arrest should be diagnosed before 6 cm.
- Most women with a prolonged latent phase will eventually begin active phase of labor with expectant management.
- A prolonged latent phase (e.g., > 20 hours in nulliparous women and > 14 hours in multiparous women) should not be an indication for cesarean birth.
- Slow but progressive labor in the first stage should not be an indication for cesarean birth.
- Women with ≥ 6 cm of cervical dilation and ruptured membranes who do not progress after 4 hours of adequate uterine activity, or at least 6 hours of oxytocin administration with inadequate uterine activity and no cervical change, may have active phase arrest in first-stage labor and may need cesarean birth.
- Intrauterine resuscitation measures may be useful in maintaining fetal well-being and thereby avoiding cesarean birth for abnormal or indeterminate fetal status.
- The ideal length of second-stage labor is unknown.
- Diagnosis of arrest of second-stage labor should not be made until at least 2 hours of pushing in multiparous women and at least 3 hours of pushing in nulliparous women (assuming maternal and fetal well-being are maintained).
- Labor epidurals may be associated with longer second-stage labors.
- Operative vaginal birth and manual rotation of the fetal occiput in the context of fetal malposition in second-stage labor may be viable alternatives to cesarean birth.

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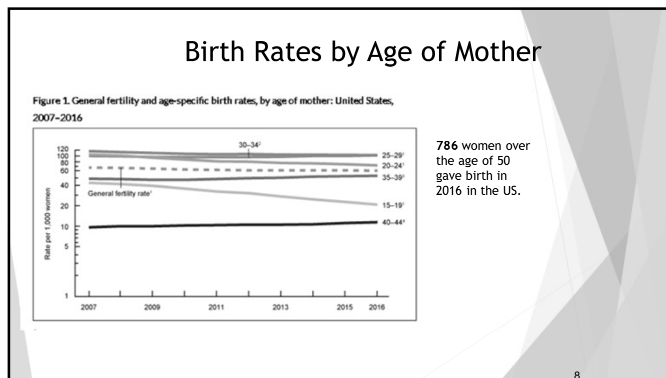
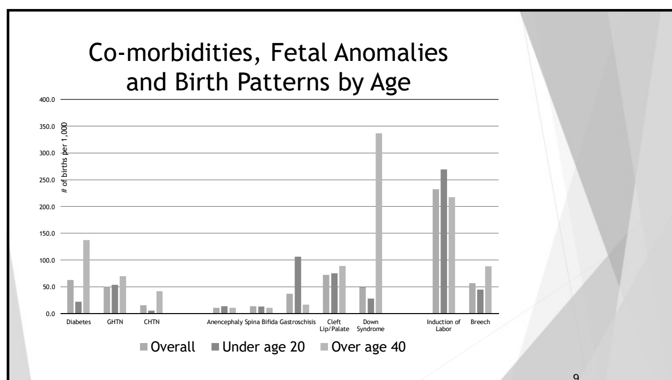
From Simpson, MCN, July/Aug 2014





Google Search: Supporting Unmedicated Birth

- 549,000 hits
- Most consumer websites
- Encourage use of doulas, birth plans, movement, "careful selection" of place of birth

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So what can NURSES do?

- Use Your AWHONN Tools
- Promote Physiologic Birth
- Use the New Labor Curves
- Encourage Your Patient to Move
- Utilize Available Methods to Enhance the Labor Process

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Simpson and Lyndon (2016): Labor Nurses' Views of Their Influence on Cesarean Birth

Two focus groups were held (n = 15 and n = 9). Nurses overwhelmingly agreed nursing care can influence mode of birth. They described multiple strategies routinely used to help a woman avoid a cesarean, which were categorized into three main themes: support, advocacy, and interactions with physicians. Support was emotional, informational, and physical. Advocacy involved advocating for women and helping women advocate for themselves. Nurses tried to focus on positive aspects of labor progress when communicating with physicians. Descriptions of interactions with some physicians implied less than optimal teamwork and lack of collaboration.

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Use your AWHONN tools

- Go the Full 40 Campaign
- Perinatal Orientation and Education Program (POEP 4) Module III: The Process of Labor and Birth
- Webinars, such as "*Is Six the New Four: Assessing, Defining and Promoting Progress in Labor*" webinar
- Journal articles in JOGNN and Nursing for Women's Health, as well as other perinatal Journals

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Promote normal physiologic labor and birth

"*A normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus*. This birth is more likely to be safe and healthy because there is no unnecessary intervention that disrupts normal physiologic processes."

American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives, 2012

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Normal Physiologic Childbirth

- Spontaneous onset and progression of labor
- Biological and psychological conditions that promote effective labor
- Vaginal birth of the infant and placenta
- Results in physiological blood loss
- Facilitates optimal newborn transition through skin-to-skin contact and keeping the mother and infant together during the postpartum period
- Supports early initiation of breastfeeding

American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives, 2012

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Factors Disrupting Normal Physiologic Childbirth

- Induction of labor
- Augmentation of labor
- Unsupportive environments
  - bright lights, cold room, lack of privacy,
  - multiple providers, lack of supportive companions,
  - time constraints, including those driven by institutional policy and/or staffing

American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives, 2012

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More Disruptive Factors

- Nutritional deprivation, e.g., no food or drink
- Opiates, regional analgesia, or general anesthesia
- Episiotomy
- Operative vaginal (vacuum, forceps) or Cesarean birth
- Immediate cord clamping;
- Separation of mother and infant, and/or
- Any situation in which the mother feels threatened or unsupported

American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives, 2012

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Six Physiologic Principles of Movement in Labor

1. Promote spinal flexion
2. Promote an increase in the uterospinal (pelvic) drive angle
3. Facilitate stronger expulsive forces
4. Promote a "good fit"
5. Increase pelvic diameters
6. Facilitate occiput posterior rotation

Fenwick & Simpkin, 1987; Zwelling, 2010

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Promote spinal flexion

- **The problem**: natural spinal lordosis (an "S" curve) occurs by the end of pregnancy which is made worse by supine or semi-reclining positions. In these positions the pelvis is tilted back and the baby has more trouble engaging, flexing and descending.
- **The solution**: encourage women to move into a "C" curve position during contractions by rounding the back and leaning slightly forward, when standing. When the side-lying, encourage a position that promotes the "C" curve rather than allowing the back to arch.

Zwelling, 2010

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Promote an Increase in the Uterospinal (Pelvic) Drive Angle

- **The problem**: when the woman is semi-reclining or supine, baby is parallel to the spine and contractions force the baby toward the symphysis and anterior, smaller half of the pelvic inlet.
- **The solution**: leaning forward in an upright position will help the woman's back assume a "C" curve. Then the uterus/baby can fall forward and contractions will drive the baby toward the larger, posterior half of the inlet and facilitate the baby flexing, rotating and descending.

Zwelling, 2010

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Facilitate Stronger Expulsive Forces

- Upright positions will increase gravity and pelvic diameters—ctx will strengthen
- Standing, walking, "slow dancing," sitting in a rocking chair, or the birth ball
- In bed, encourage the "throne position"—a woman sits completely upright with knees flexed

Zwelling, 2010

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Promote a "good fit"

- When the woman keeps moving, her pelvis moves to help the baby find the good fit. Rocking movements will help the baby flex, rotate, and descend.
- When a woman has an epidural help her change position every 30 to 45 minutes. Rotate from right side-lying to "C" curve, to throne to left side-lying.

Zwelling, 2010

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Increase Pelvic Diameters

- Sitting on a firm surface puts pressure on the ischial tuberosities resulting in lateral movement of the innominate bones of the pelvis. Transverse pelvic diameter can increase up to 30% more.
- Leaning forward in the "C" curve increases mobility of the sacrum and coccyx.
- Use of the peanut ball between the knees when side-lying widens the pelvic diameter.

Zwelling, 2010

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Facilitate Occiput Posterior (OP) Rotation

- For a suspected OP baby have woman lie on same side as baby's occiput.
- Side-lying lunge (top leg lunges and can be placed on a stirrup)
- Move bed to full upright and woman kneels, facing and leaning over head of bed; or try knee-chest or on all fours—try pelvic rocking in these positions.

Zwelling, 2010

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Encourage women to move throughout labor – Labor Lounge?

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Utilize available methods to enhance the labor process

- Continuous labor support
- Relaxation
- Breathing
- Visualization
- Showering/bathing
- Aromatherapy
- Labor dancing
- Intermittent auscultation
- Accupressure
- Medication (including nitrous)

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What do nurses think they can do to safely prevent primary Cesarean section? (An informal survey)

- Encouraging the mother to move
- Labor support to decrease early epidural
- Turning every 30-45 minutes
- Let labor progress at the rate it happens

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- Use peanut balls
- Laboring down
- Identification of the malpositioned baby and exercises and positioning to encourage rotation
- Appropriate induction with favorable Bishops score and dating
- No AROM until indicated (late)

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- "Use Pitocin only to mimic normal labor, less is more."
- Work nights!
- "Do all the paperwork for section to ward off evil spirits!"
- Wear the AWHONN button "Stay calm and wait for labor!"
- Use water – shower or tub!
- A rocking chair paired with a low footstool
- Prenatal education!

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"Unnecessary interventions lead to more interventions."

Perinatal RN's response to informal survey about nurses' role in Cesarean prevention

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"I also think a big key is setting the expectations before admission. The whole toolkit concept is critical. You know the saying "When all you have is a hammer, the whole world looks like a nail". So you should bring the whole toolkit to the patient, but only pull out what she needs. So, don't expect an elective induction. Don't expect to get your epidural, lay down, and have a baby. Don't expect to deliver with the dolphins, either. Do expect to trust your team. Do expect your doctor and your nurse to act with your safety foremost in mind. Yes, Plan A is the vaginal delivery. Plan B is the Cesarean. Know what criteria are used to call Plan B, and know who gets to make the call."

Perinatal RN's response to informal survey about nurses' role in Cesarean prevention

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What do you think?