Preventing Primary Cesareans: Implications for Laboring Women, Their Partners, Nurses, Educators, and Doulas

Penny Simkin, PT

New evidence-based guidelines for Safe Prevention of the Primary Cesarean Delivery call for extensive modifications of many long-standing obstetric practices that have collectively contributed to large increases in cesarean rates and worsening outcomes (1). The document also calls for the resurrection of some skills and beneficial practices (such as external cephalic version and manual rotation of the fetal head) that have largely fallen out of favor. The most dramatic and revolutionary change, however, is the revision of long-held norms of labor progress that have guided obstetric management for many decades. The conclusion of recent extensive studies (2) of labor progress of tens of thousands of women who had normal healthy outcomes might be summed up in this catchy slogan: “6 is the new 4” (or “six centimeters is the new four centimeters”) (3). In other words, the threshold for the active phase, which until now had been defined as 4 centimeters may be as late as 6 centimeters (as it normally can require up to 6 hours to progress from 4 to 6 centimeters). Labor management should include a greater tolerance of longer labors and avoidance of a cesarean delivery for arrest of labor until there has been no cervical change for several hours, even with augmentation. The guidelines also recommend allowing nulliparas to push for 3 hours, and multiparas for 2 hours (plus another hour if an epidural is in place) before diagnosing second stage arrest.

Many other “sacred cows” of obstetrics are challenged in this document, including current approaches to management of elective induction of labor, abnormal or indeterminate fetal heart rate tracings, fetal malpresentation and malposition, multiple gestation, suspected fetal macrosomia, and others (1).

Such sweeping reforms will likely encounter resistance or may create a backlash among some clinicians. In a field where time limits and fear of litigation too often rule, all the players, including physicians, hospital administrators, nursing staff, third party payers, and risk managers, will have to make adjustments. As exciting and promising as these recommendations are, implementation will not only require buy-in from providers, but also from the childbearing public. Expectant parents will need quality education and support to address their fears and enhance their willingness to embrace longer labors. Ironically, as obstetricians steadily increased their use of cesarean delivery over the past two generations, women at first resisted (4, 5). They had to be convinced that this surgery was benign and safe. In an effort to reassure or convince women that a cesarean made sense, obstetric care providers emphasized the risks associated with labor and vaginal birth to both baby and mother. This emphasis is sometimes cynically referred to as “playing the dead baby card.” Even when those risks were not supported by scientific evidence or best practice models, the suggestions of harm were very powerful, especially when coming from the expert.

But now all that is changing! Updated “best practice” models call for a reversal of management to include practices that were previously thought to be dangerous. Clinicians and expectant parents must now be persuaded that widespread use of cesareans or measures to speed early labor are no longer believed to be

Penny Simkin is a Senior Faculty in the Simkin Center for Allied Birth Vocations at Bastyr University, Kenmore, WA, USA.

Address correspondence to Penny Simkin, Simkin Center for Allied Birth Vocations at Bastyr University, Kenmore, Washington; 1100 23rd Ave. East, Seattle, WA 98112, USA.

© 2014 Wiley Periodicals, Inc.
in the best interests of either mother or baby. To cooperate wholeheartedly with the new style of labor management, laboring women and their support teams must understand the advantages of patience and the normalcy of slow progress to 6 centimeters. They need to know the reasons that cesareans are undesirable when a safe vaginal birth is possible. Otherwise, they might interpret a lack of hasty, aggressive management as poor care or neglect. Attention must also be paid to the emotional stress that comes with experiencing a slowly progressing labor.

What about other stakeholders? What about nurses, whose jobs require them to maintain the policies and care plans of the physicians and midwives (some of whom may embrace the new guidelines while others will not)? When labors are allowed to progress much more slowly, nurses’ roles will change. For more hours than they are accustomed to, they will need to oversee the equipment, watch for side effects of epidurals and synthetic oxytocin, deal with indeterminate fetal heart rate tracings, and encourage and reassure tired and discouraged mothers. Nurses will need education and some new skills to assess and correct potential problems. Nursing staffs may also be spread thinner than they are today, since labor beds may be occupied for longer periods, leading to crowding and inadequate staffing on the maternity floor.

As a childbirth educator and doula, I am thrilled with these guidelines, and I humbly suggest that the educators’ and doulas’ roles should be elevated in this new paradigm to be sure that birthing women or couples understand, appreciate, and are able to work with the challenges posed by the guidelines. Childbearing women in the United States are often poorly informed about the best childbirth practices. For example, the Listening to Mothers III survey of women’s childbearing experiences discovered a surprising lack of knowledge among more than half their respondents on key topics, such as fetal macrosomia, safe timing for birth, and possible adverse effects of cesareans (6). Only about 60 percent of nulliparas participated in childbirth education classes, and many of the classes were brief and focused on what to expect in the hospital, and not on how to help themselves during labor or make informed choices. Instead, women relied primarily on their care providers for information, and almost always followed their recommendations, even when the recommendations were not based on the best practices (6).

More thorough childbirth classes, usually provided by independent educators or agencies (i.e., not affiliated with a hospital or practitioner group), include 10–20 hours of class. The intention is to prepare women and their partners with knowledge and tools to participate competently, confidently, and constructively in their own labors and in decisions related to them and their baby’s care. If hospitals wish to adopt the American College of Obstetrics and Gynecology guidelines for lower cesarean rates, they will need their clients to participate actively as equals in their own care. Once they have the knowledge and tools, women may wish to self-manage labor pain and postpone (or even avoid) the epidural, and thus reduce its duration-related side effects (such as maternal fever, fluid overload, prolonged second stage, and possibly, persistent fetal malposition).

An expanded role for childbirth education will require other approaches than the typical classes offered today to thoroughly prepare more expectant parents. For example, Centering Pregnancy or other similar approaches combine group prenatal care with prenatal education (7). This model is adaptable to the needs of a variety of ethnic and socioeconomic groups, and because the education takes place during prenatal care, it is convenient for busy mothers or those with limited transportation. Online childbirth education courses may suit some women, especially if there exists the opportunity for interaction with the teacher. If childbirth education is to be valued as a way to improve women’s satisfaction and participation in birth, effective culturally sensitive models must be developed to make it accessible and acceptable to all women.

The authors of the consensus statement point out that continuous labor support in the form of a trained doula reduces cesarean deliveries. The doula is the intrapartum guide who helps the laboring woman or couple to implement what they learned prenatally. The doula assists with nonmedical methods to relieve pain and promote labor progress. She provides emotional support, hands-on comfort, encouragement, fear reduction, and assistance in getting information for decision-making. She also assists women to labor effectively even with an epidural in place (8). With the longer labors to be expected from implementation of the new guidelines, it is essential that each woman be accompanied by people who never leave her side and provide confidence, patience, and practical methods to work with the challenges of labor.

In conclusion, these guidelines are only the beginning, albeit a momentous first step, in improving maternity care. Whether and when these recommendations will be widely accepted and implemented by the majority of practicing obstetricians is, of course, unknown, and could take years (9). Fortunately, we have in our midst a model of care—the midwifery model—that embodies many of these recommendations. We know from midwifery outcomes and from scientific evidence that these recommendations are sound. To be successfully implemented, all stakeholders must have the desire, commitment, skills, and patience to lower the primary cesarean rate. It will take more than convincing
obstetricians of the value of a new approach, though that is absolutely critical. Everyone else involved in maternity care must also be on board. By harnessing all of the resources available and enlisting all of the people who care deeply about the well-being of parents and future generations, success is possible.

References