ACOG Consensus Statement: Safe Prevention of the Primary Cesarean Delivery

More Questions than Answers?
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What I’ll cover today...
1. A bit of history
2. Essential components of the guidelines
3. Their impact on diagnoses of “failure to progress,” “fetal intolerance of labor” and indications for induction and c/s
4. The clinical skills that doctors, midwives, and nurses will need in order to follow the new guidelines
5. Potential impact of the guidelines on childbearing women who have come to accept many of the practices now being rejected by ACOG
6. How childbirth education and doula care may contribute to success of the guidelines by helping women understand and cope with the new approach to labor
7. A dose of reality


Historical Perspective

- C/S Rate rose steadily from 1996 to 2009 (32.9%), then slowly dropped to 32.7% in 2010-13
- High cesarean rates did not result in improvement in maternal/ neonatal morbidity or mortality
- Cesarean crisis led ACOG to review many questionable care practices
- ACOG issued many guidelines from 2009 to today, in hopes of reversing the trend.
- Examples...

2009-2013, ACOG issued New Guidelines on -

- Definition of “Term Pregnancy” (2013)
  - Early Term: 37/0 weeks – 38/6
  - Full Term: 39/0 – 40/6
  - Late Term: 41/0 – 41/6
  - Postterm: 42/0 and beyond

- Prevention & Timing of Nonmedically Indicated Early-term Deliveries (2013)
  - Macrosomia NOT an indication
  - < 39 weeks NOT acceptable

- How to Define, Classify, Interpret FHR Tracings* (2009)

Are You Ready for the Tidal Wave?
New statement integrates all these and goes much further

ESSENTIAL COMPONENTS OF THE SWEEPING 2014 ACOG STATEMENT

Studies of normal & abnormal nulliparous labor progress:
Friedman 1955-1965
Zhang 2002-2012
Large differences between the generations.

From Dr. Waldman’s Analysis
• “Friedman Curve is Obsolete”
• Today, more use of anesthesia and augmentation
• Birth and maternal weights have increased
• Different research methods:
  • Friedman plotted 500 individual curves, synthesized them into one curve
  • Consortium for Safe Births (Zhang, et al) collected labor data from 62,000+ low risk labors with a normal perinatal outcome
• Findings: Labor can safely continue for much longer and cesareans can be reduced.

“Perils of New Labor Management Guidelines” – Cohen & Friedman, AJOG, 2014
• Analytical methods differed; Friedman’s more valid*
• Friedman never said that 4 cm = active labor
• 2 different math models were used; that’s why curves are different (not because labors are different
• Following ACOG Guidelines could put M & B at risk—
  • Excessive contractions, pressure & head compression, infection, long term morbidity
• Model of labor progress should be tested before accepted
“Perils of New Labor Management Guidelines” – Cohen & Friedman, AJOG, 2014
- Friedman advocates clinical evaluation for reasons for slow labor (pelvimetry, malposition, inadequate contractions, descent, other). Some conditions do not benefit from more time.
- However, clinical assessment and manual skills are not well taught or widely used any more.
- Friedman implies that ACOG is using only the clock to manage labor.

Besides Labor Progress, ACOG’s Other Essential Components
- Improve diagnosis of presentation and position with U-S
- Improve manual skills (breech version, rotation of fetus).
- If macrosomia is suspected:
  - No induction
  - No planned cesarean unless EFW is ≥5000 grams (>11 lbs) without diabetes; 4500 g (9 lbs) w diabetes
  - No elective induction before 41 weeks*
  - Induction after 41 weeks is advised to reduce c/s and perinatal mortality and morbidity*
  - Increase use of fetal scalp stimulation and amnioinfusion
  - Increase skills and use of vacuum and forceps
  - Increase women’s access to continuous labor support

In Summary, Roles of Calendar & Clock Have Changed!

In ironic management of “Indeterminate” Fetal Heart Rate Tracings
- Most cesareans for fetal causes are in this category – “indeterminate”
- Confirm fetal intolerance with--
  - Fetal scalp stimulation!
- Education needed for caregivers and nurses*

Potential Impact of Guidelines on Nurses’ Role
- Longer occupancy of labor beds (staffing problems?)
- Longer duration of epidurals, Pitocin, & duration-related side effects
  - Fever, FHR concerns, malposition, hypotension, uterine hypotonia
  - Oversee equipment
- Need for skills to support woman
  - Patience, psychological support, non-pharmacological measures for comfort and progress
  - Reduce side effects of epidural
  - Assess for correctible causes for indeterminate FHR patterns* and use intrauterine resuscitation
- Nurses’ role with amnioinfusion, fetal scalp stimulation?
- Adjustment to caregivers’ views of the guidelines

Replaced by patience & support
Key Concepts

Time and Patience are Allies of the Woman!
But we have to convince her!

WHAT DO WOMEN THINK AND KNOW? HOW AND WHAT DO THEY LEARN?

Some Findings From LtM III

Childbearing women seek knowledge from --
In order of frequency . . .
1. Their care providers
2. Experienced mothers
3. Childbirth classes (of varying quality, length, and purpose)
4. Pregnancy and childbirth websites
5. Books were not on the list 😊

Some Important Findings:

Most women trust their caregivers.
• Yet, caregivers often give inaccurate incomplete info.
• Women usually follow caregiver’s recommendation
• But they feel they made their own decisions
• Generally, they were poorly informed

Listening to Mothers III found . . .
Most pregnant women poorly informed, when asked:*
1. Safest gestational age to deliver a healthy baby
2. Cesarean complications, such as--
   a. Likelihood of placenta problems in future pregnancies
   b. Likelihood of breathing problems in newborn
3. Whether induction for “big baby” makes sense

Even though they wanted knowledge, most were poorly informed!
Providers’ misinformation led to less safe choices

Big baby (Macrosomia)—
- 32% of women were told near term the baby might be large.
- 62% discussed induction.
- 49% discussed C/S.
- Most women felt the final decision on induction (80%) and C/S (62%) was their own.
- In the end, their decisions were usually what the doctor suggested (80% and 72%).

Common beliefs of many birthing women, loved ones (& doctors)

As interventions have become common, many women now believe . . .
- Planned elective inductions and cesareans are safe if done >37 wks
- Induction for a big baby improves outcomes, prevents c-s and injury
- Long labors cause harm and should be avoided.

Common beliefs of many childbearing women, their loved ones & doctors

- Cesareans, planned & unplanned, are as safe as vaginal birth
- Forceps, vacuum extraction are more dangerous than CD
- Cesarean births of twins, breech babies are safer
- Fetal distress can be identified by EFM, and a CD often saves a baby from brain damage
- The safety, predictability, convenience, and absence of labor pain of CD appeals

The Catch 22 for promoters of normal birth

- While educators, doulas, and many nurses applaud these guidelines, the women may not.
- The guidelines require more effort and participation from women than today’s “usual care.”

Childbirth Education and Doula Care are crucial to the success of these guidelines

When women understand why and how to avoid a c-s, and are assisted along the way, odds of success improve.
Concepts in teaching

Teaching to avoid induction
Rather than starting from a risk-benefit perspective.

- Begin with how labor normally begins.
- The baby starts labor when he/she is ready to thrive outside the uterus.
- When the fetal lungs mature and produce surfactant, that starts the process.
- Under normal circumstances (89-90% of the time), the fetus continues to benefit from time in the womb.
- Does the parent realize that her baby may not be quite ready to be born if induced when nothing is wrong?
- Then cover risks and benefits and alternatives.

Concepts in teaching

Techniques for comfort and progress
- Many (most?) teachers shortchange their students in this area.
  - If people haven’t done it in class, they are unlikely to recall or do it in labor.
  - If necessary, start a class or two with rehearsal of labor techniques.
  - A doula is invaluable in helping apply the techniques in labor, but
    - Doulas love it if clients already know how to do them.

Concepts in teaching

Outcomes of Non-pharmacologic Methods of Labor Pain Management vs Usual Care

<table>
<thead>
<tr>
<th>Mechanism &amp; Methods</th>
<th>Obstetric interventions</th>
<th>Maternal outcomes</th>
<th>Fatal/newborn outcomes</th>
</tr>
</thead>
</table>
| **Gate Control** (non-painful stimulation of pain site) | -22% fewer epidurals  
-25% less use of oxytocin  
-64% fewer c/s (w. ambulation) | -9% lower pain scores  
-Much lower anxiety scores | - No differences between groups |
| **Diffuse Noxious Inhibitory Control (DNIC)** | -62% fewer epidurals  
-Much lower pain scores | - No differences between groups |
| **Biofeedback** |  |  |  |
| **TENS (hi-intens, low freq)** |  |  |  |
| **Other** |  |  |  |

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| **Higher centers of CNS control (CNSC)** | -18% less use of epidural  
-25% less use of oxytocin  
-40% fewer cesareans | -10% lower pain scores  
-30% less excess bleeding  
-70% more positive birth experiences  
-72% less anxiety in 1st stage  
-25% less anxiety in 2nd stage  
-28% fewer Apgars <7 at 5 min  
-11% less resuscitation |
| **Beck & Drolet外面** |  |  |  |
| **Continuous support** |  |  |  |

*Continuous support, with its tailored approaches, was the most effective in reducing obstetric interventions.
Practical Applications to Support New Guidelines

What is Labor Dystocia?
- Prolonged Labor
- Failure to progress
- Uterine inertia
- Cephalo-pelvic disproportion
- Arrest of labor
- Persistent malposition
- Approx. 60 other terms!

Failure to Wait!!!

THE PROBLEM

Little or no labor progress

Causes of Slow Labor/Dystocia
1. Cervical
   - Unripe, scarred, rigid, or tense
2. Emotional
   - Distress, fear, exhaustion, suffering
3. Fetal
   - Malposition, large deflexed head

Causes of Labor Dystocia (cont.)
4. Iatrogenic
   - Misdiagnosis of active labor, elective induction, drugs, disturbance
5. Pelvic
   - Malformation, non-gynecoid shape, small dimensions
6. Uterine
   - Inadequate inefficient contractions, lactic acidosis

Dystocia Prevention
General Principles
- The mother is not the problem
- The mother is key to the solution
- The fetus and mother work together to achieve the birth
**Dystocia Prevention**

**General Principles**

- Do nothing to cause dystocia:
  - Induction for big baby or convenience
  - Withholding food and drink in labor
  - Restricting or coercing a woman to bed or to one position

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**Prolonged Pre/early Labor**

- Emotional dystocia
  - Stress response (fear, anxiety from past or present)
  - Increased catecholamines reduce blood supply to uterus & placenta
  - Slows ctx and O2 to fetus
  - Dystocia and nonreassuring or “indeterminate” FHT

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**Prolonged Pre/early Labor**

- Iatrogenic dystocia – misdiagnosis of labor or active labor
- Inappropriate intervention
Pain and Suffering

• Labor pain—an unpleasant physical sensation in abdomen or back, associated with contractions
• Suffering—an emotional response; being overwhelmed, worried, alone, helpless, afraid
• Labor pain does not mean suffering if she:
  — Understands that it is a normal side effect of contractions
  — Knows how to work with it
  — Has reassurance, guidance, and companionship
  — Has access to medications when needed

If she can cope, she is not suffering

Assessing the Woman's Ability to Cope with Labor Pain

<table>
<thead>
<tr>
<th>When Pain is Intense</th>
<th>Woman's Coping Response</th>
<th>Woman's Distress Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>MW/RN/Doula: &quot;What was going through your mind during that contraction?&quot;</td>
<td>Focus on calm, constructive activity, or positive or neutral thoughts</td>
<td>Focus on fatigue, pain, time, worry, self-doubt, inability to continue</td>
</tr>
<tr>
<td>MW/RN/Doula observes woman's response to contractions.</td>
<td>Rhythmic behavior during, relaxing between contractions</td>
<td>Tense, anxious, crying out, pleading, no rhythm</td>
</tr>
</tbody>
</table>

Prolonged Pre/early Labor

• Cervical dystocia
  • Scarred cervix
  • Posterior, firm, uneffaced cervix

Solutions for Prolonged Early Labor

• If cervical dystocia is suspected --
  • Support and validation
  • Education and explanation
  • Massage cervix to dilate?

Fetal dystocia

• Position (asynclitism, brow, hand by face)
  • Frequent, painful contractions
  • “Coupling” with little progress

Solutions for Prolonged Early Labor

• If fetal dystocia is suspected use
  • Open knee-chest position
  • Abdominal lifting, stroking
  • Walking, crawling, stair climbing

Help babies find their way!
Open Knee-Chest Using Couch. Woman said this was quite comfortable!

Open Knee–chest position.

Prolonged Active Labor with or w/o excessive pain

- Iatrogenic dystocia
- Immobility in bed, drugs?
- Misdiagnosis of active labor
- Fetal dystocia
- OP, asynclitism, back pain

Prolonged Active Phase

- Time, wait for 6 cm
- Increased activity:
  - Change positions
  - Walk/lunge
  - Nipple stimulation
  - OP/asynclitism/deflexed head

- Bath/shower
- EFM or frequent auscultation
- Let meds wear off
- Emotional support
- Hydration

Fetal intolerance

Maternal pain/exhaustion

Epidural or IV narcotics, rest and time

Active Labor Progress

Cesarean Section

Prolonged Active Labor with or w/o excessive pain

- Uterine dystocia
  - Less pain, ctx space out, become irregular or “couple”
- Emotional dystocia
  - Excessive pain, maternal distress, exhaustion
- Pelvic dystocia
Rupture of Membranes?
• Makes fast labors faster
• Makes slow labors slower
• If malposition exists
• A gamble worth taking in active labor if progress has stalled?

Epidurals are associated with slow progress, increased malpositions

Is it the epidural or the management that causes these problems?
Can better supportive care lower cesarean rates, other problems?

Guiding Principle for Supportive Care

• Treat her as much as possible like a woman who does not have an epidural
  • Keep her moving
  • Keep her cool
  • Keep her company
  • Keep her from pushing too early (passive descent)
  • Keep her pushing for 5 to 6 sec at a time, with several breaths between
  • Keep her skin to skin with her baby

Prolonged 2nd Stage

• Iatrogenic dystocia
  • Misdiagnosis:
    • Complete dilation
    • Urge to push
    • Both?
  • Restriction of movement, position
  • Prolonged maximal directed pushing with or without urge

Iatrogenic dystocia
Fetal Dystocia/ Malposition
Emotional dystocia

PROLONGED SECOND STAGE
Long-term Impact of Prolonged Val Salva in Supine Position

• Lacerations?
• Pelvic floor relaxation?
• Cystocele? rectocele? Prolapsed uterus?
• Urinary, flatal, fecal incontinence?
• These problems are blamed on vaginal birth itself, but management for speed is more responsible

-- Roberts, Hansen, JMWH 52(3):2007


Pushing and Pelvic Floor Damage

• RCT: n = 128 nullips (67 “coached” pushing; 61 “uncoached”)
• Average age 21 yrs; 94% Hispanic; average birthweight 7¼ lbs.
• At 3 mos. P-P, testing showed...


Pushing & Pelvic Floor Damage (cont.)

• “Pelvic floor injury is less likely to follow... if women are allowed to push in the manner that feels most natural & comfortable to them.”
• “Conversely, the conventional style of coached pushing... is more likely to cause pelvic floor injuries.”
• “Coached pushing is a modifiable practice.”
**Solutions - Prolonged 2nd Stage**

- No pushing without urge
- Change positions every 20 to 30 minutes
- Spontaneous self-directed bearing down
  - A note about open-glottis pushing

**Solutions - Prolonged 2nd Stage**

- Hot compresses to perineum
- Toilet sitting for privacy and to encourage pelvic floor release
  - “Purple” pushing as a last resort

**Solutions - Prolonged 2nd Stage**

- Positions:
  - Squatting
  - Lap squatting
  - Sidelying
  - Hands and knees (with forward and back movement)
  - Semi-sitting
Solutions - Prolonged 2nd Stage

- Positions:
  - Dangle
  - Exaggerated Sims (semi-prone)
  - McRoberts
  - Hands and knees version of McRoberts, ala Susan Steffes, PT,

Dangle with Partner Support
Primary Interventions to Minimize Side Effects of Epidural in 2nd Stage

1. Delay pushing 1–2 hours until baby’s head is visible or mother feels urge to push
2. Help mother push effectively
3. Change position
4. Be patient (ACOG Guidelines)

1. Why Delay Pushing with Epidural?
   • Reduction in –
     --Forceps or vacuum extractor deliveries
     --Episiotomies
     --Cesarean deliveries
   • Policies on delayed pushing vary among hospitals
   • Patience with longer 2nd Stage

2. How to Help the Mother Push
   • When head is visible or she feels urge to push, she may not push well due to lack of sensation
   • Watch the contraction monitor tracing. As contraction builds:
     --Guide her when (use EFM) and how long (5-6 sec) to push
     --Better for mother & baby than constant pushing
     --Give feedback: Note increase in contraction pressure while she pushes and tell her, “You added 50 points to the pressure! Great!”

Use the EFM tracing to
   • guide bearing down efforts
   • give incentive and “biofeedback”
   • “I did it!”
Why Change Positions During Pushing?

• Changing positions causes changes in pelvic shape & effects of gravity
  — Both effects help baby find the “path of least resistance” through the birth canal
• Some or all of these may be possible, depending on density of epidural:
  — Side-lying on right or left side
  — Semi-reclining
  — Pull-to-push

Be cautious with these positions

“Pull-to-Push” (Correct)

The Guidelines call for continuous labor support, “such as a doula.”

• Doulas can assist women through longer and more demanding labors, and can be valuable allies with the maternity care team
• How do doulas support women with epidurals to keep birth as normal as possible?
  As much as possible, doulas treat them as if they do not have an epidural.
How doulas care for women with an epidural like women without one.

• Keep her moving, but let her rest if exhausted
• Keep her cool
• Never leave her alone, even if resting
• Provide help, emotional support & encouragement
• Help her mimic spontaneous pushing

A dose of reality

Even though almost every one of today’s common procedures causes more harm than good,
And even though ACOG has provided an evidence-based statement outlining proven ways to safely reduce cesareans,
It will take years before most obstetricians will accept these changes in their care

Conclusions

• This ACOG statement calls for sweeping reforms in obstetric management to reduce cesareans
• This model of care closely resembles the MIDWIFERY MODEL!
• Many lost skills and abandoned practices are being revived, and many current practices are being revised
• The changes may catch the public by surprise since they have been counseled for years that the present ways are best
• Nurses’ roles will change as inductions, augmentation, and cesareans decline.
• Childbirth educators and doulas can contribute in making these changes successful.

THANK YOU!