The Winds of Change: The American College of Obstetricians and Gynecologists Recommends Limiting Interventions in Labor and Birth

Judith Lothian, PhD, RN, FAAN

ABSTRACT

The American College of Obstetricians and Gynecologists (ACOG) recent committee opinion, “Approaches to Limit Intervention During Labor and Birth,” reflects a shift in thinking that holds promise for sweeping changes in maternity care. This editorial puts the document in the context of the history of evidence-based maternity care and highlights the approaches suggested by ACOG including the use of intermittent auscultation, no routine amniotomy, or intravenous, delayed hospital admission, and freedom of movement throughout labor and birth. “Approaches to Limit Intervention During Labor and Birth” signals winds of change in maternity care.

Judith Lothian
Associate Editor

The Journal of Perinatal Education, 26(4), 167–171, <http://dx.doi.org/10.1891/1058-1243.26.4.167>

Keywords: labor and birth, labor interventions, cesarean

The American College of Obstetricians and Gynecologists (ACOG) latest committee opinion, “Approaches to Limit Intervention During Labor and Birth,” more than anything in the last decades, suggests winds of change in maternity care (ACOG Committee on Obstetric Practice, 2017). There appears to be a fundamental shift in thinking that holds promise for sweeping changes in routine intrapartum maternity care. After decades of research supporting the importance of not interfering in the natural processes of labor and birth and the risks associated with doing so, ACOG has provided evidence-based guidelines for providers that encourage limiting interventions for low-risk women. A look at the history of evidence-based childbirth,

or the lack of it, helps make the case for the importance of this latest committee opinion from ACOG.

Famously, in 1979, Archie Cochrane presented obstetrics with the wooden spoon for being the least evidence-based specialty in medicine. In the next decade, researchers took up the challenge and got to work. Chalmers, Enkin, and Kierse summarized the research findings of that decade in *Effective Care in Pregnancy and Childbirth* (1989) and made recommendations for practice based on the evidence.

“Approaches to Limit Intervention During Labor and Birth,” more than anything in the last decades, suggests winds of change in maternity care (ACOG Committee on Obstetric Practice, 2017).

We invite readers to respond to the contents of this journal issue or share comments on other topics related to natural, safe, and healthy birth. Responses will be published as a letter to the editor. Please send comments to Wendy Budin, Editor-in-Chief (wendy.budin@rutgers.edu).

It was a major contribution to the literature and added to our understanding of the processes of labor and birth and the risks of interfering in that process without clear indications. Despite a lack of evidence to support the value of routine intervention and increasing evidence of their risk, routine interventions in labor and birth continued to increase. In response to the escalating use of interventions, in 1996, the World Health Organization (WHO) Technical Work Group published *Care in Normal Birth*. The document presents evidence-based guidelines related to interventions. The guiding principle was that there should be a valid reason to intervene with the natural process of labor and birth. The WHO evidence-based guidelines included no routine interventions, including labor induction, augmentation, and early amniotomy. The document noted the evidence basis for eating and drinking in labor and labor support. The document encouraged the use of nonpharmacological methods to enhance coping such as massage, relaxation, music, patterned breathing, and verbal coaching. Based on best evidence, they recommended the use of intermittent auscultation rather than electronic fetal monitoring, position change and movement and avoiding the supine position throughout labor, pushing with the urge and with no time limits as long as mother and baby are doing well, and keeping mother and baby together.

The evidence-based care practices outlined in *Care in Normal Birth* (WHO Technical Work Group, 1996) became the framework for Lamaze International’s Six Safe, Healthy Birth Practices in 2004 (updated in 2017 and 2014) and continue to provide the foundation for Lamaze childbirth education. Professional and advocacy organizations, including the American College of Nurse-Midwives (ACNM), the Association of Women’s Health, Obstetric and Neonatal Nursing (AWHONN), DONA International, Childbirth Connection, and Lamaze, over the past decades have focused attention on the importance of evidence-based maternity care including the overuse of interventions in labor and birth.

“Approaches to Limit Intervention During Labor and Birth” (ACOG Committee on Obstetric Practice, 2017) acknowledges the role that routine interventions play in disrupting the process of normal, physiologic labor and the risks of disrupting that process, including the increased risk of cesarean.

Despite these efforts, maternity care in the United States continues to be intervention-intensive. In 2013, 50% of American women had their labor induced, 93% experienced continuous electronic fetal monitoring, 60% did not move freely in labor, 76% had an intravenous infusion during labor, 68% gave birth on their backs, and 50% of women were separated from their babies after the birth (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014). More alarming has been a continued rise in the maternal mortality rate and the continued high (32%) cesarean rate (Martin, Hamilton, & Osterman, 2016). The high cesarean rate and its connection with the rising maternal mortality rate was the impetus for ACOG and the Society for Maternal-Fetal Medicine to collaborate on “Safe Prevention of the Primary Cesarean Delivery” (2014).

“Safe Prevention of the Primary Cesarean Delivery” was a game changer (Lothian, 2014). The recommendations in several areas opened the door to a more patient, less hands-on approach to labor and birth. The most important changes that were identified as having the potential to decrease the cesarean rate included the following:

- Active labor is defined as 6-cm dilation with the acknowledgment that labor can take a long time.
- Pushing can take several hours especially with an epidural in place.
- Labor support, especially the support of a doula, can reduce the cesarean rate.
- A more realistic interpretation of changes in fetal heart rate picked up with electronic fetal monitoring (EFM)
- Reconsideration of the need for cesarean for breech and for twin births in some instances
- No inductions before 41 completed weeks of pregnancy
- Macrosomia identified in late ultrasound is not an indication for cesarean.

Since the publication of “Safe Prevention of the Primary Cesarean Delivery,” there has been a small but significant decrease in the cesarean rate (Martin et al., 2016), although this decrease might be because of practice changes predating “Safe Prevention of the Primary Cesarean Delivery.”

“Approaches to Limit Intervention During Labor and Birth” (ACOG Committee on Obstetric Practice, 2017) acknowledges the role that routine interventions play in disrupting the process of normal, physiologic labor and the risks of disrupting that process, including the increased risk of cesarean.

“Approaches to Limit Intervention During Labor and Birth,” coming on the heels of “Safe Prevention of the Primary Cesarean Delivery,” signals what can only be thought of as winds of change in maternity care.

These are the critical points in the document. The recommendations refer to women who are low risk, in spontaneous labor with a singleton, full-term pregnancy:

- Labor can be managed individually including engaging in shared decision making related to admission to the hospital even in the case of premature rupture of the membranes. If admission is delayed, it is important for women to have support, encouragement, and a variety of non-pharmacological ways to cope with contractions at home.
- Expectant management of premature rupture of the membranes is recommended.
- Active labor starts around 6 cm. Patience is encouraged related to the length of labor.
- Continuous emotional and physical support is important throughout labor. This is in addition to nursing care.
- As long as labor is progressing, amniotomy is not needed.
- Intermittent auscultation is preferred. ACNM and AWHONN guidelines for auscultation are recommended.
- Women are encouraged to move and change position throughout labor including second stage.
- A wide variety of nonpharmacological ways of coping with contractions should be available and used based on women’s preferences.
- Routine intravenous is not required. Women should be encouraged to drink during labor. They do not recommend eating.
- Pushing is most effective when women do what they want related to positioning and breath holding. The supine position should be avoided.

Interestingly, the evidence-based approaches to limit interventions suggested by ACOG are similar to those identified by Chalmers et al. in 1989 and the WHO Technical Work Group in 1996. Now, of course, there is even more evidence to support the limitation of routine interventions in labor and birth. We applaud ACOG for its commitment to reducing nonmedically indicated interventions and providing women with the resources they need, such as freedom of movement and the availability of

We are hoping that maternity care providers and hospital administrators are swept along by the winds of change that “Approaches to Limit Intervention During Labor and Birth” signal.

nonpharmacological pain relief, to cope effectively with labor and birth. We are hoping that maternity care providers and hospital administrators are swept along by the winds of change that “Approaches to Limit Intervention During Labor and Birth” signal. Winds can of course become gale force. There may be storms ahead as providers and hospitals make the changes that ACOG recommends. The result will be safer births for mothers and babies.

Childbirth educators are in a powerful position to advance ACOG’s recommendations. In fact, “Approaches to Limit Intervention During Labor and Birth” is an important resource for women as they develop their birth plans and engage in shared decision making with their care provider. It is also an important resource for childbirth educators, supporting what we do to help women have the safest, healthiest birth.

It is 38 years since Archie Cochrane gave the wooden spoon to obstetrics as the least evidence-based specialty in medicine, 28 years since the publication of *Effective Care in Pregnancy and Childbirth*, and 21 years since the publication of the WHO’s *Care in Normal Birth*. Could the winds of change that “Approaches to Limit Intervention During Labor and Birth” signal finally result in evidence-based childbirth?

IN THIS ISSUE

In this issue’s Celebrate Birth! column, Katherine Moen (Kate) shares that she wanted an unmedicated birth. She planned a hospital birth with a midwife. During her pregnancy, she hired a doula and she and her husband, Corey, attended both natural childbirth classes and a natural comfort measures class. Despite having an intense labor, Kate was able to relax between contractions, and with the support of her husband and doula, she managed to cope with increasingly difficult contractions. Her commitment and hard work during labor, and the emotional and physical support she received, helped her achieve the unmedicated birth she wanted. Kate and her husband welcomed their daughter, Clara Mae, into the world after 10.5 hours of labor.

In this issue’s continuing education module, Bear and Mellor present Part 2 of a two-part series

The content of all The Journal of Perinatal Education (JPE) issues published since October 1998 is available on the journal’s website (<http://www.ingentaconnect.com/content/springer/jpe>). Lamaze International members can access the site and download free copies of JPE articles by logging on at the “Members Only” link on the Lamaze website (<http://www.lamaze.org>).

on kangaroo mother care (KMC). This article, “Kangaroo Mother Care 2: Potential Beneficial Impacts on Brain Development in Premature Infants,” the authors describe KMC as placing the newborn infant into prolonged skin-to-skin contact with the mother as soon as possible after birth, exclusive breastfeeding, early discharge from the health facility, and careful follow-up at home. Evidence supports the practice of KMC as an aid to mitigating some detrimental features of prematurity. This article explores impairments in brain development of premature infants because of the ex utero environment and some of the negative neurobehavioral, psychosocial, sociocultural, and economic implications.

The authors point out that evidence favoring the use of KMC in stable preterm infants is very strong, although barriers to implementation of KMC persist. Apart from infant infirmity, the basis of its variable use by parents, health-care professional, and/or institutions may be unfounded.

In a follow-up article, Kukla and Ludington-Hoe discuss the “Value of Specialty Certification as a Kangaroo Caregiver.” These authors note that despite the documented benefits of kangaroo care (KC) only 50% of newborns and mothers in U.S. hospitals receive KC because of lack of knowledge and skill competency. Because nurses can increase knowledge and skill competency through a certification course, the value of certification as a kangaroo caregiver and administrative incentives for certification as a kangaroo caregiver were evaluated in 71 neonatal intensive care and maternal-newborn unit nurses who completed an electronic questionnaire and the Perceived Value of Certification Tool. Findings indicated that nurses highly valued their KC certification, agreeing with 17 of 18 positive value statements. KC certification increased salary for a few, but institution-based incentives for KC certification are still limited, and recognition of KC certification is needed.

Canadian authors Fakhraei and Lennox Terrion provide finding from their study that explored the informational and emotional support needs of primipara women. Their focus was on supportive communication. The objective of this study was to explore first-time mothers’ experiences of labor and birth. Three hundred primipara women completed self-report questionnaires. Qualitative analysis of one open-ended question about the women’s experience revealed nine themes that emerged from

the data. Eight themes reflected informational and emotional support needs, whereas the final theme reflected instrumental support needs. The authors concluded that informational and emotional supports are important factors of supportive communication and influence the birthing experience of primipara women.

Pilkington and Rominov discuss how they unobtrusively obtained insights into fathers’ worries during pregnancy by analyzing the content of posts on the Internet forum Reddit. The majority of worries related to infant well-being (50.8%), particularly the potential for perinatal loss (23.0%). Concerns relating to partner well-being and the couple relationship were also common, comprising 17.0% of posts. Several posts related to individual factors, such as apprehension about the father role (16.3%). Finally, situational factors, such as work–family conflict, accounted for 15.9% of posts. These findings contribute to the growing literature on fathers’ experiences of pregnancy and can inform the development of father-inclusive perinatal education.

Finally, in this issue, Beck shares the results of a qualitative secondary data analysis designed to identify the metaphors women used to describe their experiences of the anniversary of their traumatic births. The existing data set that was reanalyzed was from a phenomenological study of the anniversary of birth trauma. Metaphor identification procedure was the method used to identify eight different metaphors from the women’s descriptions that provided a rich source of insight into their yearly struggles. These metaphors characterized the anniversary of traumatic birth as a great pretender, a lottery, a trigger, a clock watcher, a giant rubber band, a guilt trip, a sea of sadness, and bottled up anger.

REFERENCES

- American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2017). Committee Opinion No. 687: Approaches to limit intervention during labor and birth. *Obstetrics and Gynecology*, 129(2), e20–e28.
- American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. (2014). Obstetric Care Consensus No. 1: Safe prevention of the primary cesarean delivery. *Obstetrics and Gynecology*, 123(3), 693–711.
- Chalmers, I., Enkin, M., & Kierse, J. (Eds.). (1989). *Effective care in pregnancy and childbirth: Volume 1—Pregnancy*. Oxford, United Kingdom: Oxford University Press.

- Declercq, E., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2014). Major survey findings of Listening to Mothers (SM) III: Pregnancy and birth: Report of the third national U.S. survey of women's childbearing experiences. *The Journal of Perinatal Education*, 23(1), 9–16.
- Lothian, J. (2014). Safe prevention of the primary cesarean delivery: ACOG and SMFM change the game. *The Journal of Perinatal Education*, 23(3), 115–118.
- Martin, J. A., Hamilton, B. E., & Osterman, M. J. K. (2016). *Births in the United States, 2015* (NCHS Data Brief No. 258). Hyattsville, MD: National Center for Health Statistics.
- World Health Organization Technical Work Group. (1996). *Care in normal birth: A practical guide*. Geneva, Switzerland: Author. Retrieved from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM_96_24_/en/

JUDITH LOTHIAN is the associate editor of *The Journal of Perinatal Education*. She is also a professor of nursing at Seton Hall University. She is a fellow in the American College of Childbirth Educators and the American Academy of Nursing and is chair of the Lamaze International Certification Council.