Safe Prevention of the Primary Cesarean Delivery: ACOG and SMFM Change the Game

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ABSTRACT

Safe Prevention of the Primary Cesarean Delivery, a joint statement of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, changes the rules of maternity care management. The statement reviews the research and uses the findings to make practice recommendations. This article discusses the major recommendations and their importance in decreasing risk and increasing safety for mothers and babies. The articles in the current issue of the journal are also reviewed.

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In March 2014, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine issued a joint Obstetric Care Consensus statement. It was published concurrently in *Obstetrics and Gynecology*, the Green Journal (American College of Obstetricians and Gynecologists [ACOG], 2014). This statement is a game changer.

The alarming and sustained increase in the cesarean rate in the United States has not improved either maternal or neonatal outcomes. In fact, data suggest that there is increased maternal mortality and morbidity associated with cesarean delivery. The statement describes the myriad of complications associated with cesarean and the increased risks associated with cesarean for mother and baby. The authors suggest that potentially modifiable factors such as patient preferences and practice variation among hospitals, systems, and health-care providers are likely to contribute to the escalating cesarean rates. There is a need to prevent overuse of cesarean, particularly the primary cesarean.

The most common reasons for cesarean include labor dystocia, abnormal or indeterminate fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. The authors revisited the definition of labor dystocia in light of the fact that labor progresses at a rate that is slower than what we had thought previously. They also reviewed research related to interpretation of fetal heart rate patterns and access to nonmedical interventions during labor that may reduce cesarean rates. External cephalic version for breech presentation and a trial of labor

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@nyu.edu).

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These guidelines change the rules of the labor management game.

for women with twin gestations when the first twin is in a cephalic presentation can lower the cesarean rate. The authors analyzed the research using a rubric that rated the quality of the available evidence. The result is a set of guidelines that have the potential to substantially decrease the cesarean rate. These guidelines change the rules of the labor management game.

These are some of the recommended guidelines:

- The Consortium on Safe Labor data rather than the Friedman standards should inform labor management (Zhang et al., 2010). Slow but progressive labor in the first stage of labor should not be an indication for cesarean. With a few exceptions, prolonged late phase (greater than 20 hr in a first time mother and greater than 14 hr in multiparous women) should not be an indication for cesarean. As long as mother and baby are doing well, cervical dilation of 6 cm should be the threshold for the active phase of labor. *Active phase arrest* is defined as women at or beyond 6 cm dilation with ruptured membranes who fail to progress despite 4 hr of adequate uterine activity or at least 6 hr of oxytocin administration with inadequate uterine activity and no cervical change.
- Adverse neonatal outcomes have not been associated with the duration of the second stage of labor. The absolute risks of adverse fetal and neonatal outcomes of increasing second stage duration appear to be, at worst, low and incremental. Therefore, at least 2 hr of pushing in a multiparous woman and at least 3 hr of pushing in a first-time mother should be allowed. An additional hour of pushing is expected with the use of an epidural, as there is progress. Interestingly, there is no discussion of position change during second stage, including the upright position, to facilitate rotation and descent of the baby. Also, the authors note that second stage starts at full dilation rather than when the mother has spontaneous bearing down efforts. Spontaneous bearing down, according to the Cochrane database, is considered the start of second stage. Using this definition might also decrease the incidence of cesarean.
- Instrument delivery can reduce the need for cesarean. The authors note concern that many obstetric residents do not feel competent to do a forceps delivery.
- Recurrent variable decelerations appear to be physiologic response to repetitive compressions of the umbilical cord and are not pathologic. There is an in-depth discussion of fetal heart rate patterns and interventions other than cesarean to deal with this clinically. Amnioinfusion for variable fetal heart rate decelerations may safely reduce the rate of cesarean delivery.
- Neither chorioamnionitis nor its duration should be an indication for cesarean.
- Induction of labor can increase the risk of cesarean. Before 41 0/7 weeks, induction should not be done unless there are maternal or fetal indications. Cervical ripening with induction can decrease the risk of cesarean. Only 24 hours after oxytocin and ruptured membranes should an induction be considered a failure.
- Ultrasound done late in pregnancy is associated with an increase in cesareans with no evidence of neonatal benefit. Macrosomia is not an indication for cesarean.
- Continuous labor support, including support provided by doulas, is one of the most effective ways to decrease the cesarean rate. The authors note that this resource is probably underused.
- Before a vaginal breech birth is considered, women need to be informed that there is an increased risk of perinatal or neonatal mortality and morbidity and provide informed consent for the procedure.
- Perinatal outcomes for twin gestations in which the first twin is in cephalic presentation are not improved by cesarean delivery (even if the second twin is a noncephalic presentation).

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These guidelines offer great promise in lowering the cesarean rate and making labor and birth safer for mothers and babies. They also suggest an emerging respect for and understanding of women's ability to give birth and a more hands-off approach to the management of labor. Women will be allowed to have longer labors. Obstetricians will need to be patient because nature guides the process of birth. Hospitals will have to plan for longer stays in labor and delivery. And women will need to have more confidence in their ability to give birth.

The prize will be safer birth and healthier mothers and babies.

The authors rightly note that changing local cultures and obstetricians' attitudes about labor management will be challenging. They also note that tort reform will be necessary if practice is to change. It's interesting to consider whether standards of practice based on best evidence (as these guidelines are) rather than on fear of malpractice might make tort reform more likely.

What is noticeably missing in the consensus statement is a discussion of electronic fetal monitoring and its impact on the primary cesarean rate in spite of the fact that the research is clear that the routine use of continuous electronic fetal monitoring increases the risk of cesarean with no benefit for the baby. Goer and Romano (2012) provide an excellent review of the research related to electronic fetal monitoring and suggest possible reasons for its entrenchment in U.S. maternity care.

Also missing is a discussion of maternity versus obstetric care. Interestingly, the maternity care practices encouraged reflect standard midwifery care. The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine are to be applauded for their careful research and willingness to make recommendations for labor management based on best evidence. These guidelines provide direction for health-care providers and women and will make a difference in not just the cesarean rate but women's experiences.

Not surprisingly, the guidelines are consistent with Lamaze Healthy Birth Practices. This statement provides an additional, powerful resource for childbirth educators, nurses, doulas, and women as we all push for the safest, healthiest birth for babies and mothers.

IN THIS ISSUE

In this issue, we are delighted to continue the practice of advancing the Lamaze International mission to promote, support, and protect natural, safe, and healthy birth by sharing birth stories. Jessica and Samuel Boro share the story of the birth of their daughter, Elizabeth Belle. With the physical and emotional support of her husband and doula, this mother was able to cope with a long labor and have the natural birth she wanted. Her husband describes how important the doula was for him.

In this issue's feature article, "Birth, Bath, and Beyond: The Science and Safety of Water Immersion During Labor and Birth," Barbara Harper discusses the recent objections to birth in water, which were voiced by both The American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists. She rebuts these concerns by describing the growing body of evidence that reports on the safety and efficacy of labor and birth in water. Harper critically reviews the literature on water birth and thoughtfully explains newborn physiology and the protective mechanisms that prevent babies from breathing during a birth in water.

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In addition to our feature article in this issue, we present four original research studies on topics ranging from breastfeeding knowledge and attitudes, and decision making for the use of epidural analgesia, to perinatal bereavement, and new mothers' thoughts on what triggers labor.

Although it is well-known that promoting breastfeeding worldwide is an important health concern, lack of breastfeeding knowledge is often noted among health-care professionals. In her article "Breastfeeding Attitudes and Knowledge in BSN Candidates," Aurora C. Vandewark describes a study designed to explore the relationship between breastfeeding knowledge and attitudes in undergraduate nursing students at the beginning and end of their clinical education. Although attitude scores did not differ significantly between groups, total knowledge scores between groups differed modestly. Respondents reported that nursing education effectively teaches breastfeeding and that breastfeeding advocacy through patient education is a crucial nursing role.

Holly Bianca Goldberg and Allison Shorten provide a thematic analysis that carefully examines the nature of differences in perceptions of decision making between patients and providers about use of epidural analgesia during labor. Results revealed patients attempted to place themselves in an informed role in decision making and sought respect for their decisions. Some providers demonstrated paternalism and a tendency to steer patients in the

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direction of their own preferences. Nurses observed various pressures on decision making, reinforcing the importance of patients being supported to make an informed choice. Differences in perceptions suggest need for improvement in communication and shared decision-making practices related to epidural analgesia use in labor.

In a sensitively written article by Patricia Moyle Wright, Diane M. Shea, and Robin Gallagher entitled "From Seed to Tree: Developing Community Support for Perinatally Bereaved Monthers," these authors discuss the development of a pregnancy loss support group, which included a community assessment, launching a pilot program, and providing training for facilitators. Other practical considerations will also be reviewed, such as finding a location for the group and securing funding for advertising.

Although we don't really know exactly what triggers labor to begin, Marit L. Bovbjerg, Kelly R. Evenson, Chyrise Bradley, and John M. Thorp, Jr. ask women who experienced spontaneous labor the question "What started your labor?" and report on responses from mothers who participated in the third Pregnancy, Infection, and Nutrition (PIN3) Study. Of the women who reported a specific labor trigger, physical activity (usually walking), clinician-mediated trigger, natural phenomenon, sexual activity, ingesting something, an emotional trigger, and maternal illness were mentioned. Discussion of potential risks associated with "old wives' tale" ways to induce labor may be warranted as women approach term.

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