

Women in Labor who Push without the "Urge" May Experience More Complications - An in-depth review of the literature reveals stro



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Washington, DC-2/26/2002-An in-depth review of the literature reveals strong support for redefining the second stage of labor and decreasing the duration of time pregnant women are instructed to push. In fact, letting the body make gradual changes in the early phase of second stage labor, may actually shorten the pushing phase and reduce the incidence of physiological stress in the mother, acidosis in the neonate, instrument deliveries and damage to maternal perineal structures, says Ohio State University School of Nursing Professor **Joyce Roberts, CNM, PhD**. The results of the literature review and a call for more research is reported in this month's *Journal of Midwifery & Women's Health*.

The second stage of labor, by definition, begins when the cervix is completely thinned out (effaced) and open (dilated). It is at this point, when the door leaving the uterus is open as wide as possible, that women in the US are typically given active verbal and physical encouragement to help move the baby through the birth canal (vagina) by pushing and pushing hard with every contraction. Instructions on how to push, frequently result in repetitive and prolonged periods of time when the mother-to-be is holding her breath. There is evidence that the duration of active pushing is associated with a build up of lactic acid in the fetus (acidosis), due to maternal exhaustion and insufficient oxygen.

There is also good evidence that most women have a spontaneous, almost uncontrollable, urge to push. With the increased utilization of epidural anesthesia and the resultant loss of all sensation associated with delivery, most women and many health care professionals have no knowledge of this variation in labor. Furthermore, if routine pushing is the norm, it is likely that many nurses and doctors have never thought to ask the woman if she feels like pushing. There does appear to be an optimal anatomic relationship between the baby and the mother when pushing will achieve its desired results. The lack of urge to push is most likely due to the position of the unborn baby, i.e. how far the baby's head has traveled down the birth canal and/or the angle assumed by the head as it travels through the canal. Therefore, unless the mother has the urge to push or it is determined that the head is well engaged in the pelvis, interventions that promote pushing may do more harm than good.

"There have been numerous European investigators who have examined the progression of second stage labor in phases and these data provide a strong impetus to reconceptualize the second stage entirely," says Roberts, the paper's author. "The idea is not to prolong labor so much as to let that first phase transpire without intervention, then to maximize the overall effect of pushing once the active phase of the second stage of labor begins."

Though this concept is not uncommon in Europe where there have been numerous reports about less active pushing, it is a novelty in the United States. Frequently cited obstetric textbooks provide little guidance as to the existence of distinct phases during the second stage of labor, thus physicians have no reason to consider altering their management. One possible explanation is the relatively low number of midwife attended births in the US (approximately 10%) in comparison to the number in other industrialized countries. To clarify safe parameters for the second stage of labor, including length of each phase, positions that facilitate progress and prevent trauma, and appropriate instructions for pushing, additional research is needed.

The complete study is available in the latest edition of the *Journal of Midwifery & Women's Health*. Journalist can receive a complimentary copy at <http://www.midwife.org/jmwh>. For more information, or to reach Joyce Roberts, contact Eric A. Dyson at 202-728-9876, email edyson@acnm.org, or visit www.midwife.org.

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