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Pushing for Change

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Physiologic management of the second stage of labor has been discussed, studied, and promoted since the early 1980s. However, widespread clinical adoption of this approach has been met with limited success.[1] The directed approach to second-stage pushing is deeply ingrained in nursing practice and continues to be extensively used.

Yet evidence-based practice requires change to a physiologic approach to the expulsive phase of labor, meaning second-stage care that is "in line with nature." The common behaviors that women manifest when cared for using this approach are that they (a) begin pushing at the onset of the urge to bear down, (b) receive support to use their own pattern and technique of bearing down in response to the sensations they experience, (c) use some form of open-glottis bearing down with most contractions, (d) push with variations in strength and duration, (e) push with increasing intensity as the second stage progresses, and (f) use multiple positions to promote progress and comfort. The duration of the second stage is determined by the condition of the mother and fetus rather than arbitrary time limits. Furthermore, women often "breathe" the baby out.

In stark contrast, women managed traditionally begin pushing when the anatomic landmark of complete dilatation is achieved (often necessitating numerous vaginal exams). They are instructed to use prolonged Valsalva bearing down efforts (count to 10) while applying consistently strong intensity to each contraction, are

generally in the lithotomy position or a variation thereof, and are often encouraged to continue to push with strong efforts during contractions as the fetal head emerges.

Laboring down, also referred to as the promotion of passive descent, is recommended as an alternative strategy for the care of laboring women who have epidurals. Using this approach, the fetus descends and is ultimately born without coached maternal pushing. The maternal and fetal outcomes of laboring down (early vs. delayed pushing) have been studied in 10 randomized controlled trials.[2,3] Individual trial outcomes of delayed pushing included fewer fetal heart rate decelerations, improved perineal outcomes, diminished fatigue in primigravidas, and less time spent actively bearing down. Authors of a recent meta-analysis[2] reported that the use of delayed pushing resulted in a 58-minute increase in overall second-stage duration; however, the women who labored down spent less time actively pushing. Although this difference was a consistent finding, it was statistically significant in only 3 of the studies. The researchers also found that with delayed pushing there was a nonsignificant reduction in second-stage cesareans and overall instrumental deliveries but a significant reduction in rotational or midpelvic forceps. No other differences between early versus delayed pushing groups reached statistical significance. Most important, no adverse outcomes were reported with the use of laboring down.

Ironically, the same intrapartum nurse may care for 2 optimally healthy laboring women, 1 with an epidural being managed with the laboring down technique and the other without an epidural being managed by the traditional “count to 10 approach.” There is no clear rationale to support an approach that unnecessarily hastens the second stage for women without an epidural, while women with epidurals are allowed to labor down.

Evidence is mounting that the management of the second stage, particularly pushing, is a modifiable risk factor in long-term perineal outcomes.[4] Valsalva bearing down and supine maternal positions are linked to negative maternal-fetal hemodynamics and outcomes. The adoption of a physiologic, woman-directed approach to bearing down *all laboring women* is long overdue.

One obvious reason for the persistence of traditional second-stage management for women without epidurals is pain. It may be assumed that a shorter second-stage duration leads to diminished maternal discomfort. There is, however, no evidence to support this rationale. In fact, it is this author's experience that physiologic management of healthy laboring women during the expulsive phase of labor leads to the achievement of optimal comfort and coping. Furthermore, comfort measures such as constant support, massage, warm compresses, and lidocaine gel to the perineum can go a long way to diminish discomfort and distress. Women's self-direction and autonomy in labor is critical in their reports of satisfaction with their birth experience. Epidural anesthesia is not desired by all women, yet women with epidurals also need continuous labor support as well as encouragement and support for their physiologic processes.[5]

It is this author's opinion that a major reason that complete adoption of evidence-based second-stage management has not occurred is that the American labor and birth system is centered around “getting the birth attendant to the birth on time.” The nurse is placed in the awkward and challenging role of achieving the perfect timing for the arrival of the birth attendant. Arrival too soon may lead to unnecessary intervention for the woman. Arrival too late incurs the risk of a missed delivery. The result is frequent and unnecessary vaginal examinations as well as early diagnosis of complete dilatation prior to the physiologic landmark of the urge to bear down. Nursing care that assists women to guide their bearing down efforts and time their birth according to their own emotional, spiritual, and physical readiness and sensations is optimal. Therefore, care practices based on arbitrary rules of behavior fashioned to plan for the arrival and readiness of the birth attendant should be altered on the basis of evidence. Change is long overdue.

The following 9 steps can help make a real change in moving toward evidence-based second-stage labor care for women with and without epidurals.

1. Assist laboring women to avoid the supine position in first-stage labor in order to maximize maternal and fetal well-being. Use pillows, wedges, and position changes to promote comfort as well as progress.
2. Remain physically present with women during late first-stage labor, providing support and comfort measures while observing for signs of the spontaneous onset of the expulsive phase.
3. Await the physiologic sign, involuntary maternal bearing down, to indicate that the expulsive phase of labor has begun instead of directing the woman to push upon the diagnosis of second-stage onset made by the caregiver's determination of the anatomic landmark of complete dilatation.
4. Honor the resting phase of the second stage. Rest can be achieved even in women without epidurals if they are supported in following their own instinctual need for rest prior to the onset of the phase of active bearing down.
5. Encourage the birth attendant to arrive at the birth setting early in order to honor the woman's process rather than an arbitrarily predetermined time frame. Birth settings where providers remain present should be marketed and promoted to women who seek consumer-centered healthcare environments.
6. Support the onset and continuation of physiologic bearing down efforts according to the woman's responses to her contractions and the descent and position of the fetus rather than arbitrary rules or a prescribed pattern of Valsalva pushing. Women's spontaneous efforts will occur multiple times per contraction and will vary in intensity between contractions. Furthermore, the efforts will most often be accompanied by the release of air (open-glottis)[6] and other maternal sounds.
7. Avoid the lithotomy position for pushing and birth. If the woman is positioned in the supine position, ensure that her back is elevated at least 30 degrees in order to avoid the negative hemodynamic consequences.
8. Generously use words of support and encouragement to replace a pattern of directed care.[7]
9. Once crowning is achieved, continue to encourage birth of the head between contractions, by breathing the baby out, in order to minimize perineal trauma.

Laboring down is a successful approach and its tenets can be applied to women who labor without epidurals. When nurses assist and support women to identify and respond to their own unique patterns of bearing down in self-selected nonlithotomy positions, then optimal fetal, maternal, and neonatal outcomes result. Nurses are central to the achievement of evidence-based, woman-centered second-stage labor care. Real change is possible.

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REFERENCES

1. Niesen KM, Quirk AG. The process for initiating nursing practice changes in the intrapartum: findings from a multisite research utilization project. *J Obstet Gynecol Neonatal Nurs*. 1997;26:709–717.
2. Roberts C, Torvaldsen S, Cameron CA, Olive E. Delayed versus early pushing in women with epidural analgesia: a systematic review and meta-analysis. *Br J Obstet Gynaecol*. 2004;111:1333–13340.
3. Simpson KR, James DC. Effects of immediate versus delayed pushing during second-stage labor on fetal well-being. *Nurs Res*. 2005;54:149–157.

4. Schaffer JI, Bloom SL, Casey BM, McIntire DD, Nihira MA, Leveno KJ. A randomized control trial of the effects of coached vs uncoached maternal pushing during the second-stage of labor on postpartum pelvic floor structure and function. *Am J Obstet Gynecol*. 2005;192:1692–1696.
5. Simpkin P. Emotional support for the woman with an epidural. *Int J Childbirth Ed*. 2003;18(3):4–7.
6. Roberts J. A new understanding of the second stage of labor: implications for nursing care. *J Obstet Gynecol Neonatal Nurs*. 2003;32(6):794–801.
7. Sampselle CM, Miller JM, Luecha Y, Fischer K, Rosten L. Provider support of spontaneous pushing during the second-stage of labor. *J Obstet Gynecol Neonatal Nurs*. 2005;34:695–702.

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