
Healthy Birth Practice #4: Avoid Interventions Unless They Are Medically Necessary


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ABSTRACT

Maternity care in the United States is intervention intensive. The routine use of intravenous fluids, restrictions on eating and drinking, continuous electronic fetal monitoring, epidural analgesia, and augmentation of labor characterize most U.S. births. The use of episiotomy is far from restrictive. These interventions disturb the normal physiology of labor and birth and restrict women's ability to cope with labor. The result is a cascade of interventions that increase risk, including the risk of cesarean surgery, for women and babies. This article is an updated evidence-based review of the "Lamaze International Care Practices That Promote Normal Birth, Care Practice #4: No Routine Interventions," published in *The Journal of Perinatal Education*, 16(3), 2007.

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Maternity care in the United States is intervention intensive. *Listening to Mothers III* (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013), the most recent national survey of women's pregnancy, birth, and postpartum experiences, reports that for women who gave birth from June 2011 to June 2012, 89% of women experienced electronic fetal monitoring (66% continuously), 62% received intravenous fluids, 79% experienced restrictions on eating, and 60% experienced restrictions on drinking in labor. Sixty-seven percent of women who gave birth vaginally had an epidural in labor, and 31% were given Pitocin to speed up their labors. Twenty percent of women had their membranes artificially ruptured.

Seventeen percent of women had an episiotomy, and 31% had a cesarean. The high use of these interventions reflects a system-wide maternity care philosophy of expecting trouble. There is an increasing body of research that suggests that the routine use of each of these interventions, rather than decreasing the risk of trouble in labor and birth, actually increases complications for both women and their babies.

The purpose of this article is to review the literature related to the evidence base and the outcomes associated with the interventions routinely used in labor and birth in the United States. The findings make the case for the value of maternity care that avoids the use of routine interventions.

NORMAL PHYSIOLOGY OF LABOR AND BIRTH

The physiologic process of labor and birth is largely driven by hormones, and the hormonal orchestration of the process is easily disrupted. Buckley (2014) provides a seminal systematic review of this complex interplay of hormones that prepare the body for birth and then orchestrate the process of labor. In the last weeks of pregnancy, the cervix, under the influences of increasing amounts of oxytocin and prolactin, softens and may begin to efface and dilate. The uterus becomes increasingly sensitive to oxytocin. This preparation is essential for labor to progress optimally.

During labor, increasing amounts of oxytocin increase both the strength and the efficiency of the contractions. The increasingly strong contractions cause increasingly high levels of pain. As women cope with the increasingly painful contractions, increasing amounts of oxytocin are released. If the pain is taken away (for instance, with an epidural), oxytocin levels drop and contractions become fewer and less effective. Most often, oxytocin augmentation is then needed to keep labor moving. If, however, she can manage the increasingly painful contractions, the contractions become more frequent and more effective. At some point, when oxytocin levels are high, endorphins are released. Endorphins produce an intuitive, dreamlike state and pain perception decreases. This makes coping with the contractions easier. Endorphins in labor are sometimes called “nature’s narcotic.” If the woman requires an epidural and oxytocin augmentation, she does not experience this endorphin release because exogenous oxytocin (Pitocin) does not cross the blood–brain barrier.

Catecholamines, the stress hormones, are released if the mother is fearful or if she does not feel safe and protected. Early in labor, high levels of catecholamines can slow or even stop labor. At the end of labor, however, there is a natural surge of catecholamines that facilitates the quick birth of the baby, even in a tired mother. If the natural, physiologic process of labor and birth has not been disrupted, both mother and baby have large amounts of circulating oxytocin and catecholamines at birth. The effect is an alert, eager mother and baby who are ready to greet each other calmly and begin breastfeeding.

Optimal care in childbirth is care that facilitates rather than disrupts the normal physiology. There is substantial research evidence for five birth practices

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that facilitate the physiologic process: letting labor start on its own (so that mother and baby are ready for labor), freedom of movement (to help women cope with pain and to protect the birth canal and the baby during rotation and descent of the baby), labor support (to decrease fear, enhance emotional and physical relaxation, and provide for privacy), spontaneous pushing and birth in upright positions (to facilitate rotation and descent of the baby), and keeping mother and baby together (to facilitate transition of the baby to extrauterine life, breastfeeding, and placental separation; *Cochrane Database of Systematic Reviews*; Goer & Romano, 2012). These findings are summarized in Healthy Birth Practice papers by Amis (2014), Crenshaw (2014), DiFranco and Curl (2014), Green and Hotelling (2014), and Ondeck (2014).

Routine interventions have the potential to interfere with the processes at every point in labor and birth, leading to a cascade of other interventions and ultimately increasing risk for mothers and babies. Because of this, optimal care includes avoiding routine interventions unless there is a clear medical indication—the Healthy Birth Practice #4.

ROUTINE INTERVENTIONS

Restrictions on Eating and Drinking

Listening to Mothers III reported that 79% of women were restricted from eating, and 60% were restricted from drinking in labor. Restrictions on eating and drinking in labor were based on the observations of Mendelson in the 1940s. Mendelson observed that during general anesthesia, there was an increased risk of vomiting and aspiration of stomach contents into the lungs, leading to severe lung disease or death.

Obstetric anesthesia has changed dramatically since the 1940s. General anesthesia is rarely

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used, there is greater use of regional anesthesia, and unlike in Mendelson's time, the airway is protected during general anesthesia, reducing any risk of aspiration. It is also important to know that the stomach is never empty, and fasting doesn't ensure less acidic stomach contents, so restricting intake does not achieve the intended result of an empty stomach. Given these advances, it seems logical that there is no longer a need to restrict eating and drinking in labor. In addition, fasting in labor is unpleasant, makes it more difficult for women to meet the demands of labor, and may cause longer and more painful labors (Singata, Tranmer, & Gyte, 2013).

Singata et al. (2013) conducted the Cochrane review of eating and drinking in labor. The review looked at studies of any restriction of fluids and food in labor compared with being able to eat and drink. Five studies involving 3,130 women were reviewed. Most studies had looked at specific foods being recommended, although one study let women choose what they wished to eat and drink. There were neither benefits nor harms associated with restricting eating and drinking in labor for woman at low risk for needing anesthesia. There were no studies identified that looked at women who were at high risk for needing anesthesia. Based on the findings, the Cochrane recommendation is that women should be free to eat or drink what they want in labor. Goer and Romano's (2012) review of the research literature arrived at the same conclusion.

The World Health Organization (1996) and the American College of Nurse-Midwives (2008) recommend that women eat and drink in labor. Yet despite the evidence, the American Society of Anesthesia (2007) and the American College of Obstetricians and Gynecologists (ACOG; 2009a) continue to recommend that oral intake for low-risk women be restricted to clear fluids.

Intravenous Fluids

Dawood, Dowswell, and Quenby (2013) conducted a Cochrane review of the effect of intravenous fluids on length of labor. They note as background that there is almost no risk of aspiration when general anesthesia is administered today, and because there is no clear evidence of harm associated with oral intake during labor, the practice should be abandoned and rather than routine administration of intravenous fluids, they should only be administered for clinical reasons or if the women become ketotic. They note also the potential maternal and neonatal

morbidity that may arise from the unnecessary administration of intravenous fluids, including large weight loss of infants whose mothers received intravenous fluids in labor (Chantry, Nommsen-Rivers, Peerson, Cohen, & Dewey, 2011). The findings of the systematic review did not provide evidence that intravenous fluid use affected length of labor, and it did not provide evidence to recommend the routine use of intravenous fluid in labor.

Goer and Romano's (2012) review includes studies suggesting that intravenous fluids in labor can cause symptomatic fluid overload, which can decrease uterine contractility. There is also evidence that intravenous fluid that contains glucose, unless given slowly, can cause hyperglycemia in the mother and fetus and hypoglycemia in the newborn (Goer & Romano, 2012). There is also some evidence that breast edema caused by excessive fluids in labor can affect breastfeeding.

There is no evidence base for the routine use of intravenous fluids in labor, and there appears to be some risk associated with the practice. In spite of the evidence, *Listening to Mothers III* (Declercq et al., 2013) reported that 62% of women had intravenous fluids in labor.

Electronic Fetal Monitoring

Electronic fetal monitoring (EFM) was introduced in the 1970s and was touted as a way to decrease cerebral palsy and perinatal mortality. Although there was no research to support its value, it quickly became a standard of practice. Before that time, the fetal heart rate was assessed using intermittent auscultation with a stethoscope. Today, intermittent auscultation is most often done using Doppler ultrasound. *Listening to Mothers III* reported that 89% of women had the fetal heart rate assessed with EFM and 66% of women had continuous EFM. Only 11% of women had the fetal heart rate monitored with intermittent auscultation (Declercq et al., 2013).

Randomized controlled trials dating from the late 1970s have consistently found no difference in infant outcomes but increased maternal morbidity related to an increase in cesarean surgery in the EFM group compared to intermittent auscultation. Most recently, Alfirevic, Devane, and Gyte (2013) conducted a systematic review of 13 randomized controlled trials, comparing neonatal and maternal outcomes in women who had continuous EFM or intermittent auscultation during labor. The trials

included 37,715 women. There was no difference in perinatal mortality or cerebral palsy rates, but women who were monitored continuously with EFM were more likely to have a cesarean surgery or instrumental vaginal birth. Neonatal seizures were less in the infants exposed to high doses of oxytocin in the EFM groups compared to infants exposed to high doses of oxytocin in the intermittent auscultation groups.

In their review, Goer and Romano (2012) also identify the increased likelihood of cesarean surgery and instrumental vaginal birth with the use of continuous EFM and its failure to reduce the incidence of cerebral palsy. In addition, the review identified that the admission test strip (routine use of continuous EFM for a limited time) increases interventions without improving neonatal outcomes.

EFM disrupts normal physiology of labor by restricting movement and potentially interfering with appropriate labor support as providers and family watch the monitor. It certainly limits women's access to comfort measures such as showers, tubs, and birth balls and that ultimately can increase the chance that they will need an epidural and a further cascade of interventions.

The increased cesarean rate is probably in part because of problems with interpretation. ACOG and the Society for Maternal-Fetal Medicine (SMFM; 2014), in *Safe Prevention of the Primary Cesarean Delivery*, note that recurrent variable decelerations appear to be a physiologic response to repetitive compressions of the umbilical cord and are not pathologic. This is a marked change in medical thinking. The article provides an in-depth discussion of fetal heart rate patterns and interventions other than cesarean to deal with this clinically. What they fail to do is identify the use of intermittent auscultation rather than EFM for low-risk women as the preferred standard of care.

In the meantime, there is continued discussion in the literature that expresses concern with the failure of obstetricians to abandon the routine use of EFM. Sartwelle (2012) in the *Journal of Legal Medicine* had this to say about EFM:

Despite its ubiquity and acceptance in daily clinical obstetrical practice, there are and always have been some important, esoteric EFM secrets: its scientific foundation is feeble; inter-observer/intra-observer reliability is poor; the false-positive prediction of fetal distress rate is greater than 99%; it has substantially

increased the cesarean section rate with attendant mortality and morbidity; and it failed completely in its initial stated promise—reducing by half the incidence of cerebral palsy (CP), mental retardation (MR), and perinatal mortality. Any other medical procedure with such an abysmal pedigree would have gone the way of bleeding by medieval barbers. (p. 313)

Obstetricians continue to be concerned with litigation if they do not use EFM, but Lent (1999) in the *Stanford Law Review* demonstrates that rather than protecting obstetricians from litigation, having the permanent EFM record may increase risk because of problems with interpretation. She goes on to note that the large body of literature that supports the use of intermittent auscultation rather than EFM should compel the courts to at the very least look on intermittent auscultation as equally acceptable.

ACOG's (2009b) latest practice bulletin on fetal monitoring notes that given that the available data show no benefit of EFM over intermittent auscultation, either option is acceptable in patients without complications. The Association of Women's Health, Obstetric, and Neonatal Nursing (2008) recommends intermittent auscultation rather than continuous EFM for healthy women with no complications. Despite these recommendations, and despite the clear compelling evidence that EFM has no clear benefits and increases risk for women, EFM remains a standard of care.

Optimal care should include intermittent auscultation for low-risk women. Admission test strips should not be done. If there is a medical indication for EFM, telemetry should be used to permit mobility.

Epidurals

Epidural analgesia provides excellent pain relief, but it disrupts labor physiology in several ways. Without pain, oxytocin levels drop dramatically, and women require intravenous oxytocin (Pitocin). Pitocin does not pass the blood-brain barrier; therefore, women with epidurals do not get an endorphin release. Relaxation of the pelvic muscles makes rotation and descent of the baby more difficult. As a result, there is increased risk for several unintended complications.

Anim-Somuah, Smyth, and Jones (2011) reviewed 38 randomized controlled studies involving 9,658 women. Of these studies, 33 compared epidural analgesia with opiates, and the remaining 5 studies compared epidural analgesia with no

analgesia. Epidurals relieved labor pain better than other types of pain medication but led to more use of instruments to assist with the birth. Cesarean surgery rates did not differ overall, although there were more cesareans for fetal distress in the epidural group. There were no effects of the epidural on the baby soon after birth. Women who used epidurals were more likely to have a longer birth (second stage of labor), needed their labor contractions stimulated with oxytocin, experienced very low blood pressure, were unable to move for a time after the birth (motor blockage), had problems with fluid retention, and experienced intrapartum fever.

Goer and Romano's (2012) systematic review of the research also found that epidural analgesia decreased the likelihood of a spontaneous vaginal birth. In addition, they found that early epidural administration appears to increase the risk of persistent malposition of the baby, and this could increase cesarean and instrumental vaginal birth. Epidurals also increased the risk of maternal fever which has both direct and indirect consequences, including separation of mother and baby and admission of the baby to the neonatal intensive care nursery for evaluation. Epidurals also increase the risk of early breastfeeding problems. "Fentanyl appears to be the culprit" (Goer & Romano, 2012, p. 286). Delaying pushing appears to decrease the instrumental vaginal birth rates, although they continue to remain high, and delayed pushing appears to have no effect on the cesarean rate. Upright positioning in second stage may decrease both instrumental births and cesarean surgeries.

In many hospitals, the only option women have for pain relief is the epidural. Once an epidural is started, there is a cascade of additional interventions: intravenous fluids, continuous EFM, and restrictions on movement. Providing a wide variety of pain coping and comfort measures including tubs, showers, unrestricted movement, and labor support helps women manage labor without needing an epidural. The availability and use of nonpharmacological comfort measures make it possible to delay receiving the epidural until labor is well-established. Delaying the epidural until active labor (6 cm) decreases the risk of both occiput posterior presentations and epidural fever. Based on the available evidence, if an epidural is required, low-dose anesthetic-only epidurals are recommended. Side-lying and upright positions are likely to decrease the risk of instrumental birth.

Augmentation

Labor can take a long time. Women, especially women who are admitted to hospitals early in labor, are likely to experience pressure to move through labor quickly. Until recently, the definition of dystocia did not reflect an understanding of just how long spontaneous labor can take. The startlingly high cesarean rate in the United States prompted the ACOG and SMFM to do a systematic review of the research in an effort to develop strategies that might reduce the primary cesarean rate (ACOG, SMFM, 2014). Their review of the research and recommendations based on those findings have the potential to decrease the incidence of augmentation of labor (and induction of labor) and at the same time decrease the cesarean rate.

The most important recommendations relate to the labor curve. The joint statement recommends that the Consortium on Safe Labor data, rather than the Friedman standards, should inform labor management. Slow but progressive labor in the first stage should not be an indication for cesarean or for medical augmentation. With a few exceptions, a prolonged latent 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.

The report also identifies the importance of labor support and specifically mentions the effect of doulas on birth outcomes including cesarean rates. 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.

We are likely to see a drop in augmentation of labor based on these guidelines, although it is also likely that change will take some time.

The medical interventions for augmenting a slow labor are amniotomy, Pitocin, or both. There are several systematic reviews of both interventions.

Amniotomy has been a standard practice, and in some hospitals, it is done routinely on all women. In the United States, 20% of women report having their membranes ruptured (Declercq et al., 2013), although

that number may be an underestimate because often, women are unaware that an amniotomy has been done. There are several serious, although rare, risks associated with amniotomy, including problems with the umbilical cord and fetal heart rate. In addition, once the membranes rupture, there is an increased risk of infection. Amniotomy also increases the risk of persistent occiput posterior fetal positions (Goer & Romano, 2012).

A Cochrane review (Smyth, Markham, & Dowswell, 2013) assessed the use of amniotomy in all labors that started spontaneously. There were 15 studies identified, involving 5,583 women. The evidence showed no shortening of the length of first stage of labor and a possible increase in cesarean surgery. There may be a shorter second stage in first-time mothers. The researchers conclude that routine amniotomy is not recommended as part of standard labor management and care. Evidence does not support routinely breaking the waters for women in normally progressing spontaneous labor or even when labors are prolonged. Goer and Romano (2012) in reviewing the research also conclude that routine early amniotomy probably increases the likelihood of cesarean surgery and should not be done routinely.

Thirty percent of women in the United States have their spontaneous labors stimulated with exogenous oxytocin (Pitocin; Declercq et al., 2013). Oxytocin augmentation is not without risk. Pitocin disrupts the normal physiology of labor. Because Pitocin does not pass the blood-brain barrier, there is no endorphin release. The stronger, harder contractions are difficult for the mother to manage and put additional stress on the uterine muscle. To manage the very strong contractions, epidural analgesia is often given as soon as the Pitocin is started. Epidural analgesia interferes in its own ways with the physiology of labor and adds additional risks for mother and baby.

Active management of labor includes rupturing membranes and then administering Pitocin to stimulate labor. Brown, Paranjothy, Dowswell, and Thomas (2008), in their systematic review evaluating active management for reducing cesarean in low-risk women, found a modest decrease in the cesarean rate among the women who received amniotomy and oxytocin if their labors were delayed. A more recent Cochrane review (Wei et al., 2013) of the active management of labor included 14 trials and 8,033 women, and, again, this review showed

a modest reduction in the cesarean rate compared with expectant management. The researchers do point out that the trials did not provide sufficient evidence related to outcomes of maternal (e.g., uterine hyperstimulation) or neonatal (e.g., fetal heart rate problems) morbidities or women's satisfaction with the experience. They also note that continuous professional support and movement and positioning during labor, both care practices that can stimulate a sluggish labor, were limited in both the intervention and the control groups.

Goer and Romano (2012) identify that early admission in latent labor increases the risk of all interventions and ultimately increases the risk of cesarean surgery. Optimal care, they suggest, should include encouraging women to delay admission to the hospital until they are in active labor (now considered 6 cm dilated). A supportive environment goes a long way toward moving a slow labor along. Nonmedical interventions such as support, ambulation, rest, and oral intake can also move a slow labor along. There is some evidence that breast stimulation, which stimulates oxytocin release, as well as ambulation can resolve slow progress (Goer & Romano, 2012). It makes sense to use these simple interventions before initiating riskier medical interventions.

Episiotomy

Seventeen percent of the women in the *Listening to Mothers III* study reported having an episiotomy. Although this represents a significant reduction from the rate of 35% in the *Listening to Mothers I* study (Declercq, Sakala, Corry, Applebaum, & Risher, 2002), and a dramatic drop from the nearly 100% episiotomy rate 50 years ago, the rate is still higher than it should be. A systematic review of episiotomy in 2005 suggests that the episiotomy rate could be 10% (Hartmann et al., 2005), and this is the percentage goal that the World Health Organization set in 1996.

The Cochrane review of episiotomy (Carroll & Mignini, 2009) sought to determine whether or not episiotomy should be used routinely. They found that the *restrictive* use of episiotomy showed a lower risk of morbidities including severe perineal trauma, posterior perineal trauma, need for suturing perineal trauma, and healing complications at 7 days. They reported no differences in the incidence of major outcomes such as severe vaginal and perineal trauma or in pain, dyspareunia, or urinary incontinence. The only disadvantage

shown in the restrictive use of episiotomy is an increased risk of anterior perineal trauma. They conclude that there is evidence to support the restrictive use of episiotomy compared with the routine use of episiotomy.

Goer and Romano (2012) in their systematic review of episiotomy found, however, that episiotomy causes more pain than spontaneous tears, causes more healing complications than spontaneous tears, and has no effect on neonatal outcomes. Very importantly, episiotomy does not preserve pelvic floor functioning and may indeed contribute to urinary and anal incontinence.

Goer and Romano (2012) suggest strategies for optimal care that include engaging practices and policies that promote an intact perineum as well as limiting the use of episiotomy to extraordinary circumstances. Optimal care in the second stage includes encouraging nonsupine positions, changing positions, spontaneous bearing down in response to an urge to push, discouraging prolonged breath holding, and waiting for a spontaneous urge to push for women with epidurals before actively pushing (DiFranco & Curl, 2014).

SUMMARY

There is abundant evidence that the routine use of the interventions documented here has the potential to, and often does, disrupt the normal physiology of labor and, as a consequence, increases the risk of complications. To keep birth as safe and healthy as possible, women should eat and drink, have the baby's heart rate assessed with intermittent auscultation, have access to a wide variety of ways to relieve pain to avoid the routine use of epidurals, and give birth in environments where there is an appreciation for the time that labor takes.

A focus on the care practices that facilitate the normal physiologic process (letting labor start on its own, movement and positioning, labor support, spontaneous pushing in nonsupine positions, and keeping mother and baby together) and saving inter-

ventions for when they are medically indicated has the potential to improve outcomes and make labor and birth safer and healthier for mothers and babies.

IMPLICATIONS

Childbirth Education

It is clear that the routine use of these interventions disrupts the normal physiologic process of labor and birth. It is also clear that the number of interventions increase with early admission to the hospital. This is what women need to know:

- Eating and drinking in labor is not dangerous and, if desired, is beneficial. There is usually no need for intravenous lines.
- EFM does not make labor safer for the baby and increases the mother's risk of having an unnecessary cesarean.
- Epidurals provide excellent pain relief but that relief comes at a cost. Some of the risks of epidural analgesia can be lessened by delaying the epidural.
- Augmentation is rarely necessary. Labor can and usually does take a long time. Patience, movement, and position change; excellent labor support; and eating and drinking are all that most women need to keep labor moving. It also helps to stay at home until active labor (6 cm).
- Routine episiotomy is harmful and its use should be restricted.

Having a deep understanding and confidence in the normal physiologic process of labor and birth and confidence in her own ability to give birth makes it easier for a woman to let go of the belief that technology and routine interventions make birth safer for mothers and babies. Providing women with "the facts," including the research, isn't usually enough to change values and beliefs. Storytelling is a powerful way to make that happen. Just as importantly, the childbirth educator, the nurse, and the midwife and physician need to send a clear, consistent message to women. We can't tell women that they have all it takes to give birth simply without complications and then tell them that routine interventions "just in case" make birth safer.

CHOICE OF HEALTH-CARE PROVIDER AND PLACE OF BIRTH

Women should carefully research options related to care provider and place of birth. There are ethical implications if we either withhold information or lead women to believe that they can have

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a safe, healthy birth in settings and with providers that routinely interfere in the normal, physiologic process of labor and birth. A high rate of complications and a high cesarean rate should raise red flags for all of us that physiologic birth is not being promoted, supported, or protected.

Midwives are most likely to provide optimal care that includes all six healthy birth practices, including avoiding interventions unless they are medically indicated. Out-of-hospital birth settings are most likely to provide optimal, non-intervention-intensive care (Goer & Romano, 2012).

Evidence-Based Hospital Policies

Optimal maternity care has at its core a few simple practices, including avoiding routine interventions. Hospital policies need to reflect the evidence that identifies those core practices. If that cannot happen, birth will need to move out of the hospital.

Change will require the reeducation of many nurses, physicians, and administrators. At the very heart of that education, in fact, what may change the tide is knowledge of the normal physiologic processes and knowledge of the care practices that facilitate the process, including avoiding the routine use of interventions.

Nurses and childbirth educators need to advocate for patients and empower the women they care for and teach to refuse routine interventions. In a shared decision-making model, women are provided with information including a thorough discussion of the normal physiology of labor and birth and then the benefits and risks of individual interventions based on best evidence. There is a discussion of what is important to the individual woman and then a discussion of the options, alternatives, and challenges. Women make an informed decision that is then supported by the provider and the hospital. Key to the success of this model is the extensive, open, honest discussion (Hersh, Megregian, & Emeis, 2014). Childbirth classes provide the opportunity for honest, back-and-forth discussion. Women are encouraged to explore their own feelings and make birth plans that reflect their preferences. This same extensive, honest “talking it through” needs to happen with her provider before the birth. If there is no agreement, the woman needs to consider the option of changing her provider. The nurse, when she meets the woman in labor, also needs to be willing to have the discussion and support the woman’s choices even if they are contrary to usual care in the

institution or if the woman’s choices are not ones that she herself would make. This is an opportunity for nurses to advocate for women and, in doing so, begin to shake up the system.

CONCLUSION

Optimal care is care that promotes, supports, and protects the normal physiologic processes of labor and birth. Interventions used routinely disrupt the normal physiologic processes of labor and birth. Because of this, safe, healthy labor and birth are facilitated by avoiding interventions unless there is a clear medical indication.

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