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The Task Force identified six barriers to supporting intended vaginal birth (Table 7).

Table 7. Barriers to Supporting Intended Vaginal Birth

Recognition and Prevention: Barriers to Supporting Intended Vaginal Birth
1. Lack of institutional support for the safe reduction of routine obstetric interventions
2. Admission in latent (early) labor without a medical indication
3. Inadequate labor support
4. Few choices to manage pain and improve coping during labor
5. Overuse of continuous fetal monitoring in low-risk women
6. Underutilization of the current treatment and prevention guidelines for potentially modifiable conditions (e.g. breech presentation and recurrent genital herpes simplex virus)

Lack of Institutional Support for the Safe Reduction of Routine Obstetric Interventions

A joint statement from ACOG, AWHONN, ACNM, AAFP, SMFM and others titled *Quality Patient Care in Labor and Delivery: A Call to Action* succinctly states, “pregnancy and birth are physiologic processes, unique for each woman, that usually proceed normally. Most women have normal conception, fetal growth, labor, and birth and require minimal-to-no intervention in the process.”⁵⁶ Despite the fact that most women are at low-risk for complications, the vast majority of women who deliver in hospitals are faced with liberal use of common obstetric interventions and procedures. These include routine use of pitocin, continuous fetal monitoring, and induction of labor. This suggests that many providers may not fully appreciate their role in the prevention of iatrogenesis through more judicious use of interventions.⁵⁵

Current obstetric care in the United States remains distinctly different from the rest of the world, applying a high-risk model to all women and overusing costly procedures that increase risk. At the same time, current care underutilizes beneficial, low-cost interventions that are readily available, easy to implement, and well suited for low-risk women.^{55,91}

Admission in latent (early labor without a medical indication)

The work by Zhang and colleagues in 2002 showed that half of patients entered the active phase of labor by 4 cm, three-quarters entered active phase by 5 cm, and nearly all by 6 cm.¹¹⁰ Zhang’s criteria reinforce something providers fully understand — that there is more to diagnosing active phase of labor than cervical dilation alone and that often it is a diagnosis that can only be made retrospectively.¹¹¹ The decision to admit is further complicated by the patient’s level of discomfort and the expectation by some patients to be admitted upon arrival.¹¹²

Despite these difficulties, thoughtful management at the point of admission is likely the first decision a provider will make in supporting vaginal birth.¹⁰⁷ The evidence is clear: latent phase admission is associated with higher rates of cesarean delivery^{86,113,114} and more interventions throughout the course of labor,¹¹³⁻¹¹⁵ including a “two-fold increased use of oxytocin.”¹⁰⁷ In a recent study of 20 hospital systems, NTSV cesarean rates were strongly correlated to specific modifiable hospital practices, including early labor admission rates.⁸⁶ Nonetheless, many patients are admitted to the labor and delivery suite while still in latent labor¹¹¹ and, in many cases, with only a presumptive diagnosis of active labor based solely on a cervical dilation of 3.5 to 4 cm.

Inadequate Labor Support

Historically, before the rise of hospital birth, labor and birth took place in a family’s home, with the laboring woman supported and cared for by her midwife, other experienced women, and her family. Though much has changed with modern birth, women’s need for such physiological and psychological support has not. This support includes providing information, emotional support, and physical comfort to a laboring woman, as well as advocating for her wants and needs.⁸² Labor support reduces the need for analgesia, operative vaginal delivery, potentially shortens labor, and is associated with a significant reduction in cesarean delivery.^{82,116-118} Additionally, women report that emotional support during labor is more meaningful to them than pain medication and physical support.¹¹⁹

Table 8. Benefits of Continuous Labor Support⁸²

Benefits of Continuous Labor Support
Less likely to have a cesarean birth
Slightly shorter labor
More likely to report satisfaction with birth experience
Less likely to need the assistance of vacuum or forceps
Less likely to need pain medications
Babies less likely to have low 5-minute Apgar scores