

Active Management of Labor

The protocol for “active management of labor” was first developed by Kieran O’Driscoll and his colleagues at the National Maternity Hospital in Dublin, Ireland. His report entitled, “Prevention of Prolonged Labor” was published in 1969 (1). Its basic principles are widely used in obstetrics today. His technique ensured that with active management of labor every woman would be delivered of her baby within 24 hours or less. O’Driscoll’s next paper, published in 1973, had been fine tuned into an assurance that every woman would be delivered of her first baby within 12 hours (2). Thus, he stated, “The aim should be to deliver every woman within eight hours and to perform cesarean section at 12 hours unless delivery is imminent.” (3) Today, physicians expect women to deliver within 12 hours of admittance to the hospital.

In his original Dublin report, O’Driscoll stated, “Amniotomy followed by oxytocin infusion is advocated to stimulate the progress of normal labor.”(4) O’Driscoll believed that oxytocin was falsely linked to uterine rupture and that, when properly supervised, was safe to mother and child.

When a woman presented in labor, her cervical dilatation was assessed and her membranes were ruptured. If progress was unsatisfactory, an oxytocin drip was begun and continued until the placenta was delivered. In some cases, oxytocin was administered when a woman presented to the hospital with her waters already broken.

Although the rate of cesarean delivery was only 4%, the rate of delivery by forceps was nearly 19%.(5) Active management of labor is met with controversy in the United States as it has not lead to a lower rate of cesarean delivery (6) as it had in Ireland.

O'Driscoll stressed the importance of first determining if, in fact, the woman was actually in labor, stating, "This decision must not be surrendered to the mother, assuming that she is in labor because she said so." (7) If the physician decides a woman is not in labor, no drugs are to be given and she is to be sent home or removed from the labor floor.

This is in sharp contrast to today's standards of practice where women are often induced before any signs of labor are observed; simply for convenience or due to postmaturity. The success of "active management of labor" rests entirely on the determination that a woman is indeed in labor - spontaneous labor - before implementing any of the practices described.

In a clinical trial of active management of labor(8), women were split into two groups. The active management group had strict criteria for diagnosing labor, early amniotomy, treatment with high dose oxytocin and one-to-one nursing care. The usual-care group was less defined by protocol. Overall, labor was shortened by 2.7 hours in the active management group. The rate of cesarean section was the same for both groups.

Another controlled study (9) found labor to be shortened by only 1.7 hours in the active management group, even though 55% of the women received epidurals. Women undergoing active management did indeed have shorter labors and were more likely to be delivered within 12 hours. Yet, the cesarean rate was not found to be lower. The trade-off is the danger of amniotomy, oxytocin augmentation and epidural use.