Healthy Birth Practice #4: Avoid Interventions Unless They Are Medically Necessary
健康分娩实践＃4: 避免不必要的医疗干预

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ABSTRACT
摘要

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.

美国的妇产照护常常遭受大力干预。大部分的分娩案例，都有对静脉输液、限制饮食、持续的电子胎心监控、硬膜外镇痛和催产的常规应用。会阴侧切的使用压根没有受到限制。这些干预措施都干扰了待产和分娩的正常生理机制，也限制了女性对分娩的应对能力。结果就造成了干预的瀑布效应，增加对母婴的风险，其中包括更高的剖宫产率。本文是对《围产教育杂志》里发表的《倡导正常分娩的国际拉玛泽照护实践，照护实践 #4:避免常规干预》2007，16(3)的最新循证评述。

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关键词：待产时的静脉输液、待产时限制饮食、电子胎儿监护、产程加速、硬膜外镇痛、会阴侧切、干预的瀑布效应、剖宫产、最佳照护

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照护实践 #4:避免常规干预》2007，16（3）的最新循证评述。

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.

美国的妇产照护遭受的干预程度很高。根据《倾听母亲 III》 (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013)，一项针对女性孕期、分娩和产后情况的全国性最新调查，在 2011 年 6 月至 2012 年 6 月期间分娩的女性中，89%的女性经历了待产时的电子胎儿监护（66%接受的是持续性的电子胎儿监护），62%经历了待产时的静脉输液，79%在待产时被限制进食，60%被限制饮水。顺产的女性中，67%采用了硬膜外镇痛，31%采用了匹脱新催产。20%的女性采用了人工破膜。17%的女性进行了会阴侧切，31%的人进行了剖宫产。这些干预措施的高频使用，反应了整个系统范围内盛行的这样一个产妇照护理念：期待会有麻烦发生。越来越多的研究显示，这些干预措施的常规使用不但没有减少待产和分娩的风险，反而增加了母婴并发症的发生。

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.

本文旨在对相关文献进行评述，该文献阐述了与美国的待产和分娩常规干预措施相关的证据基础和结果。研究结果强调了避免常规干预措施的妇产照护之重要意义。

NORMAL PHYSIOLOGY OF LABOR AND BIRTH

待产和分娩的正常生理过程

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.

待产和分娩的生理过程主要是由荷尔蒙驱动的，荷尔蒙对这一过程的调节很容易被打乱。荷尔蒙进行复杂的相互作用，帮身体为分娩做准备并调节产程，Buckley (2014)对此进行了开创性的系统评述。在孕期最后几周，宫颈在增加的催产素和泌乳素的作用下变软，开始消失和扩张。子宫对催产素越来越敏感。身体的这种准备对产程以最佳方式来推进来说至关重要。

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.

在产程中，不断增加的催产素能提高宫缩的力度和效率。愈发强劲的宫缩带来更强烈的疼痛感。在女性应对越来越痛的宫缩的过程中，更多的催产素也释放出来。如果疼痛消退（比如通过硬膜外镇痛），催产素的水平就会下降，宫缩的力度变小，效率变低。通常在这种情况下，就要用人工催产素来推动产程继续进行。但是，如果产妇能管理越来越痛的宫缩，宫缩就会更频繁、更有效。在催产素水平升高的某些时刻，内啡肽就释放出来。内啡肽可以导致一种朦胧的状态，降低痛感，这就让产妇更容易应对宫缩。内啡肽有时被称为待产中的"天然麻醉药"。如果产妇要求使用硬膜外镇痛和人工催产素加速产程，她就不会分泌内啡肽，因为外源性催产素（匹脱新）不会穿过血脑屏障。

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.

儿茶酚胺这种压力荷尔蒙，在女性害怕或者没有安全感的时候释放出来。在产程早期，高水平的儿茶酚胺可能会让产程变慢或停滞。不过在产程末期，即使此时妈妈已经精疲力竭，自然释放的大量儿茶酚胺会帮助让宝宝快速娩出。如果这种待产和分娩的自然生理过程不受到干扰，在宝宝出生时，妈妈和宝宝体内都有大量的催产素，其结果就是，妈妈处于清醒活跃的状态，她和宝宝都做好了彼此会面的准备，然后顺利开始母乳喂养。

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 posi- tions (to facilitate rotation and descent of the baby), and keeping mother and baby together (to facilitate transition of the baby to extrauterine life, breastfeed- ing, 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).

分娩的最佳照护，是促进而不是干扰正常生理过程的照护。有大量的证据支撑促进生理过程的五项分娩实践：让分娩自然开始（因此母婴都做好了分娩的准备）、自由移动（在胎儿转动和下降时，帮助女性应对疼痛，保护产道和宝宝）、待产支持（来减少恐惧，放松身心，并且提供私密性）、自发用力和直立姿势分娩（帮助胎儿转动和下降），以及母婴同室（帮助宝宝适应子宫外的环境，促进母乳喂养和胎盘分离；考柯蓝系统性评述数据库; Goer & Romano, 2012）。这些研究结果由 Amis (2014), Crenshaw (2014), DiFranco 和 Curl (2014), Green 和 Hotelling (2014), 以及 Ondeck (2014)在其发表的健康分娩实践论文中进行了总结。

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.

常规的干预随时可能会扰乱待产和分娩的过程，从而引发干预的瀑布效应，最终增加对母婴的风险。因此，最佳的照护模式是避免常规干预，除非有明确的医学指征——《健康分娩实践#4》。

ROUTINE INTERVENTIONS
常规干预

Restrictions on Eating and Drinking
限制进食和饮水

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 con- tents into the lungs, leading to severe lung disease or death.

根据《倾听母亲 III》，79%的女性在待产时被限制进食，60%被限制饮水。待产时限制饮食是依据 Mendelson 在 20 世纪 40 年代的调查。Mendelson 发现患者全麻时会增加呕吐和把胃含物吸入肺部的风险，可能会导致严重的肺病甚至死亡。

Obstetric anesthesia has changed dramati- cally 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 as- piration. It is also important to know that the stom- ach is never empty, and fasting doesn't ensure less acidic stomach contents, so restricting intake does not achieve the intended result of an empty stom- ach. 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 unpleas- ant, makes it more difficult for women to meet the demands of labor, and may cause longer and more painful labors (Singata, Tranmer, & Gyte, 2013).

产科麻醉自 20 世纪 40 年代起已经发生了重大改变。全麻已很少应用，而局部麻醉得到更广泛的使用，并且与 Mendelson 的年代不同，在全麻时气道会得到保护，从而减少吸入风险。另外重要的一点是，胃部永远也不会完全排空，禁食不能保证酸性胃含物更少，因此限制饮食无法达到空腹的目的。考虑到如今的技术进步，我们可做出合理推断：待产无需限制饮食。此外，待产时禁食令人不适，让产妇更难以完成分娩的要求，并且可能使产程更漫长更痛苦 (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 rec- ommended, although one study let women choose what they wished to eat and drink. There were nei- ther benefits nor harms associated with restricting eating and drinking in labor for woman at low risk for needing anesthesia. There were no studies iden- tified 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 litera- ture arrived at the same conclusion.

Singata 等人(2013)写了一篇关于待产中饮食的考科蓝评述，就待产中限制饮食和可以饮食的研究进行了比较。评述涉及了包括 3130 位女性的 5 项研究。其中大部分研究调查的是推荐的特定食物，不过有一项研究让女性随意选择食物和饮料。 对于麻醉需求度低的女性来说，待产时限制饮食既无益又无害。还没有针对麻醉需求度高的女性的研究。根据这些研究结果，考科蓝建议女性在待产时可以随意饮食。Goer 和 Romano (2012)对于研究文献的评述也得出相同的结论。

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

世界卫生组织(1996)和美国护士助产士协会(2008)建议女性在待产时饮水进食。不过尽管有种种支持饮食的证据，美国麻醉协会（2007）和美国妇产科学会（2009a）还是维持之前的建议：低风险女性只能饮用透明流食。

Intravenous Fluids

静脉输液

Dawood, Dowswell, and Quenby (2013) conducted a Cochrane review of the effect of intravenous flu- ids 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 in- take during labor, the practice should be abandoned and rather than routine administration of intrave- nous 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 ad- ministration of intravenous fluids, including large weight loss of infants whose mothers received intra- venous 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.

Dawood, Dowswell 和 Quenby (2013)就静脉输液对产程长短的影响撰写了一篇考科蓝综述。他们提出，如今的全麻已经几乎没有误吸的风险，且没有明确证据表明在待产时饮食有害，因此应摒弃禁食。如果一定要静脉输液，应该具有临床原因或者女性有酮症。他们还提出，不必要的静脉输液可能会导致母婴患病，比如说女性待产时接受静脉输液，婴儿体重大幅减轻(Chantry, Nommsen-Rivers, Peerson, Cohen, & Dewey, 2011)。这些系统性综述的结果并未提供静脉输液影响产程时长的证据，也未提供支持待产时进行常规静脉输液的证据。

Goer and Romano's (2012) review includes stud- ies suggesting that intravenous fluids in labor can cause symptomatic fluid overload, which can de- crease 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.

Goer 和 Romano (2012)的综述中包含的一些研究指出：待产时静脉输液会导致症状性液体过剩，从而可能减弱宫缩。也有证据表明，包含葡萄糖的静脉补液若不是缓慢输入体内，可能导致母胎出现高血糖症以及新生儿出现低血糖症

(Goer & Romano, 2012)。另有证据表明，由待产时液体过剩导致的乳房水肿会影响母乳喂养。

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.

对于待产时的常规静脉输液并没有证据基础，常规静脉输液似乎还伴有风险。尽管如此，《倾听母亲 III》指出有 62%的女性在待产时还是接受了静脉输液。(Declercq 等, 2013)

Electronic Fetal Monitoring
电子胎儿监护

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, intermit- tent auscultation is most often done using Dop pler 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).

电子胎儿监护（EFM）于 20 世纪 70 年代引入，当时被吹捧为一种减少脑性麻痹和围产儿死亡率的手段。尽管没有研究证实其价值，电子胎儿监护迅速成为常规做法。之前，胎心率的监测方法是用听诊器进行间断胎心听诊。如今，间断胎心听诊已经被多普勒超声所代替。根据《倾听母亲 III》，89%的女性都做过电子胎儿监护，66%的女性做过持续性的电子胎儿监护。只有 11%的女性是用间断胎心听诊来监测胎心(Declercq et al., 2013)

Randomized controlled trials dating from the late 1970s have consistently found no difference in infant outcomes but increased maternal morbid- ity 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 ausculta- tion groups.

自 20 世纪 70 年代起开始的随机对照试验（电子胎儿监护组和间断胎心听诊组）一直未发现两组在新生儿结果有何差异。但是在电子胎儿监护组里，与剖宫产率升高相关的母亲患病率相比间断胎心听诊组更高。最近，Alfirevic, Devane 和 Gyte (2013)撰写了一份针对 13 个随机对照试验的系统性综述，比较了女性待产时接受持续性电子胎儿监护或间断胎心听诊的新生儿结果和产妇结果。这些试验涉及了 37715 名女性。围产儿死亡率和大脑性麻痹率并无差异，但是接受持续性电子胎儿监护的女性，其剖宫产率或器械助产率更高。同样是接触了大剂量缩宫素的婴儿，电子监护组里的新生儿癫痫率比间断胎心听诊组更低。

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.

Goer 和 Romano (2012)也在综述里指出，持续性电子胎儿监护不仅不能降低大脑性麻痹的发生率，还增加了剖宫产手术和器械助产的可能性。此外，胎心监测带（用于持续性电子胎儿监护的限时常规使用）会增加干预，不会改善新生儿结果。

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.

持续性电子胎儿监护由于限制产妇移动，并可能干扰分娩支持（照护人员和家人只将注意力放在监测仪器上），从而影响分娩的自然生理过程。持续性电子胎儿监护明显会影响女性使用各种舒适和减痛措施，比如淋浴、盆浴和分娩球，最终增加女性使用硬脊膜外麻醉的几率，也更容易引发干预的瀑布效应。

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 discus- sion 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 aus- cultation rather than EFM for low-risk women as the preferred standard of care.

剖宫产率上升的一部分原因可能是对电子胎心监护结果的解读存在问题。美国妇产科学会（ACOG）和母胎医学学会（2014）在《安全规避首次剖宫产》一文中指出，复发的变异减速似乎是针对脐带重复按压的生理反应，而非病态。这是医学思想的重大改变。该文深入探讨了胎心率模式，以及非剖宫产的临床干预措施。不过他们并没有确认间断胎心听诊（而非电子胎儿监护）是针对低风险女性的更佳照护模式。

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:

与此同时，产科医生还是坚持常规电子胎儿监护，这种情况令人忧心忡忡，很多文献里对此进行了讨论。Sartwelle (2012)在《法医杂志》里就电子胎儿监护写道：

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 in- cidence 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)

尽管在临床产科实践中有广泛应用，电子胎儿监护有如下这些鲜为人知但又十分重要的方面：它的科学依据十分薄弱；观察者之间/自身可靠度较低；胎儿窘迫的假阳性预测值高于99%；极大提高剖宫产率，且伴随死亡率和发病率；连最初声称的作用--将大脑性麻痹（CP）、智力迟钝（MR）和围产儿死亡率减半也未实现。如果说还有哪项医疗措施像它一样来路不明，那只有中世纪理发师的放血疗法了。(p. 313)

Obstetricians continue to be concerned with liti- gation 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 inter- mittent auscultation as equally acceptable.

产科医生们一直担心的是，如果他们不用电子胎儿监护会被起诉，但是 Lent (1999)在《斯坦福法律综述》里指出，永久的电子胎心监护记录不但不能保护产科医生免于诉讼，反而因监护结果的解读问题而增加被诉风险。她继续指出，有大量文献支持使用间断胎心听诊而非电子胎儿监护，这应使法庭至少认识到，间断胎心听诊是同样可行的监测方式。

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.

美国妇产科学会(2009b)针对胎儿监测的最新实践公告指出，有充足证据证明，电子胎儿监护相对于间断胎心听诊并无额外益处，因此对于无并发症的病人来说，这两种监测方式都是可行的。女性健康、产科和新生儿护理协会（2008）建议对无并发症的健康女性，采取间断胎心听诊而非电子胎儿监护。尽管有这些建议，以及充足的证据证明电子胎儿监护没有明显益处，且增加了女性的风险，电子胎儿监护仍是标准照护的一部分。

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.

理想的照护应包含对低风险女性的间断胎心听诊，也不应绑胎心监测带。如果的确有电子胎心监护的医学理由，应用远程监测来保证产妇可以移动。

Epidurals
硬膜外镇痛

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.

硬膜外麻醉是很好的镇痛方法，但它会从好几个方面扰乱分娩的生理机制。若没有疼痛，催产素水平就会大幅下降，产妇就会需要静脉注射催产素（匹脱新）。匹脱新不通过血脑屏障，因此接受硬膜外麻醉的产妇不分泌内啡肽。骨盆肌肉的放松让胎儿的旋转和下降变得更加困难。因此，这些就在无意中增加了并发症的风险。

Anim-Somuah, Smyth, and Jones (2011) re- viewed

38 randomized controlled studies involv- ing 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.

Anim-Somuah, Smyth 和 Jones (2011)对 38 组随机对照试验进行了综述。这些试验涉及了 9658 名女性， 其中有 33 组是硬膜外镇痛与类鸦片镇痛作比较，其余 5 组是对硬膜外镇痛与无镇痛作比较。硬膜外镇痛相对于其它镇痛药物来说，减轻产痛的效果更好，但更容易导致器械助产。总的来说，剖宫产手术率并无差异，不过在硬膜外镇痛组里，由胎儿窘迫而导致的剖宫产案例更多。并未发现硬膜外镇痛对于刚出生的婴儿有何影响。采用硬膜外镇痛的女性往往分娩过程（第二产程）延长，需要催产素来刺激宫缩，还会产生低血压，分娩后一段时间无法移动（运动阻滞），并发生液体潴留和产中发热。

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 ad- ministration appears to increase the risk of persis- tent 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 vagi- nal 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.

Goer 和 Romano (2012)对研究的系统性综述中也指出，硬膜外镇痛会降低自发阴道顺产的几率。他们还发现，早期进行硬膜外镇痛会增加持续性胎位不正的风险，从而更提高剖宫产和器械助产的比率。硬膜外镇痛也增加产妇发热的风险，这伴有直接或间接的后果，包括母婴分离，以及把新生儿送到重症监护室做评估。硬膜外镇痛也影响早期的母乳喂养。“似乎芬太尼就是罪魁祸首”(Goer & Romano, 2012, p. 286)。延迟用力似乎可以降低器械助产率，尽管器械助产率还是居高不下。延迟用力似乎对剖宫产率没有影响。在第二产程采用直立的姿势可能会降低器械助产和剖宫产率。

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.

在很多医院，硬膜外镇痛是女性分娩减痛的唯一选择。一旦开始硬膜外镇痛，就会引发干预的瀑布效应：静脉输液、持续性电子胎儿监护、限制移动。提供多样的减痛和安抚措施如盆浴、淋浴、自由移动和分娩支持，可以帮助女性管理产程，而无需用到硬膜外镇痛。使用非药理性的安抚措施，使得女性可以在产程充分推进以后才使用硬膜外镇痛。将硬膜外镇痛推迟至产程活跃期（6cm）才使用，可以降低枕后位和硬膜外引发的发热。根据现有的证据，如果做硬膜外镇痛，建议使用低剂量的麻醉药 --- 只使用硬膜外麻醉药。侧躺和直立姿势可能会降低器械助产的几率。

Augmentation

催产

Labor can take a long time. Women, especially women who are admitted to hospitals early in labor, are likely to experience pressure to move though labor quickly. Until recently, the definition of dystocia did not reflect an understanding of just how long spontaneous labor can take. The startlingly high ce- sarean 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 de- crease the incidence of augmentation of labor (and induction of labor) and at the same time decrease the cesarean rate.

待产的过程可能持续很久。女性，尤其是在产程早期就入院的女性，很可能面临要快速推进产程的压力。之前，关于难产的定义都没有反映自发性待产到底要持续多久。美国惊人的高剖宫产率促使美国妇产科学会和母胎医学学会对研究进行系统性综述，旨在制订减少首次剖宫产的策略(美国妇产科学会，美国胎医学学会，2014)。他们的研究综述以及基于研究结果的建议可能会帮助降低催产（和引产）率，且降低剖宫产率。

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 ac- tive 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 ad- equate uterine activity or at least 6 hr of oxytocin administration with inadequate uterine activity and no cervical change.

最重要的建议与产程图有关。联合声明里建议把安全分娩联合会的数据作为产程管理的依据，而非 Friedman 产程图。第一产程缓慢但循序渐进，这不应被视为剖宫产或者药物催产的征兆。除了少数例外情况，延长的潜伏期（初产妇长于 20 小时，经产妇长于 14 个小时）不应被视为剖宫产的征兆。只要母胎都正常，宫口开到 6cm 才意味着活跃期的开始。活跃期停滞是指宫口至少 6cm 且胎膜已破的女性，在充分宫缩 4 小时后产程仍然不推进，或者因宫缩不充分、宫口无变化而使用人工催产素 6 小时后产程仍然不推进。

The report also identifies the importance of la- bor support and specifically mentions the effect of doulas on birth outcomes including cesarean rates. Continuous labor support, including support pro- vided by doulas, is one of the most effective ways to decrease the cesarean rate. The authors note that this resource is probably underused.

该报告也指出待产支持的重要性，尤其提到导乐对于包括剖宫产在内的分娩结果的影响。持续性的待产支持，包括导乐支持，是降低剖宫产率的最有效方法之一。该报告认为导乐这一措施没有得到充分使用。

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.

催产率可能由于这些指导方针的影响而下降，不过改变可能需要假以时日。

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

催产的医疗干预有人工破膜、匹脱新、或两者结合使用。

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).

人工破膜一直以来是一项标准做法，一些医院会对所有产妇进行常规的人工破膜。在美国有 20%的女性报告说她们接受了人工破膜(Declercq 等, 2013)，但实际的数字可能不止 20%，因为女性常常都不知道自己接受了这一干预。人工破膜有一些少见但是非常严重的风险，包括与脐带和胎儿心率有关的问题。此外，一旦破膜，感染的风险也增加了。人工破膜也增加持续枕后位的风险(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 cesar- ean 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 Ro- mano (2012) in reviewing the research also conclude that routine early amniotomy probably increases the likelihood of cesarean surgery and should not be done routinely.

一篇考科蓝综述(Smyth, Markham, & Dowswell, 2013)评估了在自然开始的待产中进行人工破膜的结果。该综述包含 15 项研究，涉及 5583 名女性。证据显示，人工破膜不会缩短第一产程，还可能增加剖宫产率，但会缩短初产妇的第二产程。研究者由此认为，不建议将常规人工破膜纳入标准的分娩管理和照护。证据不支持常规的破水，这不仅适用于产程自然开始、正常推进的产妇，也适用于产程延长的产妇。Goer and Romano (2012)在研究综述里也认为，常规的早期人工破膜可能增加剖宫产的风险，应该摒弃这种常规做法。

Thirty percent of women in the United States have their spontaneous labors stimulated with ex- ogenous 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 con- tractions are difficult for the mother to manage and put additional stress on the uterine muscle. To man- age the very strong contractions, epidural analgesia is often given as soon as the Pitocin is started. Epi- dural analgesia interferes in its own ways with the physiology of labor and adds additional risks for mother and baby.

美国 30%的女性在接受外源性催产素的刺激后，自然发动分娩(匹脱新; Declercq 等人, 2013)。用催产素催产也存在风险。匹脱新干扰分娩的正常生理过程。由于匹脱新不穿过血脑屏障，因此女性不会分泌内啡肽。增强的宫缩不仅让产妇难以管理，还对子宫肌肉增加额外压力。为了管理这种增强的宫缩，使用匹脱新后往往立即进行硬膜外镇痛。硬膜外镇痛又以其自身的方式影响分娩的生理过程，增加母婴风险。

Active management of labor includes ruptur- ing membranes and then administering Pitocin to stimulate labor. Brown, Paranjothy, Dowswell, and Thomas (2008), in their systematic review evaluat- ing active management for reducing cesarean in low-risk women, found a modest decrease in the cesarean rate among the women who received am- niotomy and oxytocin if their labors were delayed. A more recent Cochrane review (Wei et al., 2013) of the active management of labor included 14 tri- als 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., uter- ine hyperstimulation) or neonatal (e.g., fetal heart rate problems) morbidities or women's satisfaction with the experience. They also note that continu- ous professional support and movement and po- sitioning during labor, both care practices that can stimulate a sluggish labor, were limited in both the intervention and the control groups.

产程的积极管理包括破膜，然后使用匹脱来推进产程。Brown, Paranjothy, Dowswell 和 Thomas (2008)在一项系统性综述中，对降低低风险女性剖宫产率的积极管理做了评估。他们发现，对产程延长的女性进行人工破膜和匹脱新注射，可以小幅度降低剖宫产率。一篇较新的考科蓝综述(Wei et al., 2013)针对产程积极管理，研究了 14 项研究，涉及了 8033 名女性。这篇综述指出，与期待性管理相比，积极管理可以稍微降低剖宫产率。研究者确实指出，这些试验并未就如下方面提供充足证据：母亲发病率（如子宫过度刺激）和新生儿发病率（如胎心问题）的结果，以及女性对分娩过程的满意度。他们还指出，推动产程的两项照护措施---待产中持续性的专业支持，以及移动和调整体位---在干预组和控制组都受到了限制。

Goer and Romano (2012) identify that early ad- mission in latent labor increases the risk of all inter- ventions and ultimately increases the risk of cesarean surgery. Optimal care, they suggest, should include encouraging women to delay admission to the hos- pital 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.

Goer 和 Romano (2012)指出，提早进入产程潜伏期，增加了各种干预措施的风险，最终增加剖宫产的风险。他们认为最佳的照护应鼓励女性推迟入院时间，直到进入产程活跃期（目前的标准是宫口开 6cm）再入院。一个支持性的环境可以极大的帮助推进缓慢的产程。非药物的干预，如支持、移动、休息和饮食都可以推进缓慢的产程。也有证据证明，刺激乳房（促分泌催产素）和移动都可以解决产程过缓的问题(Goer & Romano, 2012)。在采用风险更大的医疗干预之前，我们应该先尝试这些简单的干预措施。

Episiotomy
会阴侧切

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 Moth- ers 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 epi- siotomy in 2005 suggests that the episiotomy rate could be 10% (Hartmann et al., 2005), and this is the percentage goal that the World Health Organiza- tion set in 1996.

在《倾听母亲 III》的研究里，17%的女性做了会阴侧切术。尽管与《倾听母亲 I》(Declercq, Sakala, Corry, Applebaum, & Risher, 2002)里的 35%相比有了大幅下降，比起 50 年前几乎 100%的会阴侧切率更是有了巨幅下降，但是这一数字还应该更低。2005 年一篇针对会阴侧切的系统性综述提出，会阴侧切率应该为 10% (Hartmann 等人, 2005)，这是世界卫生组织在 1996 年设定的目标。

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

一篇关于会阴侧切的考科蓝综述(Carroli & Mignini, 2009)探讨了是否应该把它作为一项常规做法。研究者们发现，会阴侧切的限制性使用可以降低发病率，如严重的会阴损伤、后部会阴损伤和 7 天后的愈合并发症，也可降低对于损伤的会阴进行缝合的需要。研究并未发现其对如下严重后果的发生率有影响：严重的阴道和会阴损伤或疼痛、性交困难或尿失禁。会阴侧切的限制性使用唯一的缺点是增加前位会阴损伤的风险。研究者得出结论，与常规使用会阴侧切相比，有充足的证据支持要限制使用会阴侧切。

Goer and Romano (2012) in their systematic re- view 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 im- portantly, episiotomy does not preserve pelvic floor functioning and may indeed contribute to urinary and anal incontinence.

Goer 和 Romano (2012)在一篇针对会阴侧切的系统性评述中指出，会阴侧切的造成的疼痛比自然撕裂更强烈，比自然撕裂导致更多的愈合并发症，且对新生儿结果没有什么影响。尤其重要的是，会阴侧切对保护盆底功能无益，还可能造成尿失禁和肛门失禁。

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 in- cludes 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).

Goer 和 Romano (2012)认为最佳的照护应包含以不损伤会阴为目的的做法和规程，只有在特殊情况下才使用会阴侧切。第二产程中的最佳照护包括鼓励产妇利用平躺以外的姿势，变换体位，顺应本能自然用力，不要屏气。采用硬膜外麻醉的女性也要等待身体的自发冲力再积极用力。

SUMMARY

小结

There is abundant evidence that the routine use of the interventions documented here has the poten- tial to, and often does, disrupt the normal physiol- ogy 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 auscul- tation, 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.

有充足的证据可以证明，本文所列的常规干预措施可能会、往往也的确会，扰乱待产的正常生理过程，且因此增加并发症的风险。为了尽可能实现安全和健康的分娩，女性应该正常吃喝，用间断胎心听诊来检测宝宝的心率，尝试多种减痛方法来避免硬膜外麻醉的常规使用，照护者应该耐心等待产程自然推进。

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.

如果我们注重支持正常生理过程的照护实践（让分娩自然开始、移动和变换体位、分娩支持、避免平躺、顺应身体本能用力、母婴同室），并且只在有医学指征的情况下进行干预，那么我们就可能会改善结果，让待产和分娩更安全，让母婴更健康。

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.

女性如果对待产和分娩的正常生理过程有充分的了解和信心，相信其自身分娩的能力，那么她就更容易摒弃技术和常规干预会让母婴更安全的老观念。

IMPLICATIONS
启示

Childbirth Education
分娩教育

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:

很明显，干预措施的常规使用会干扰待产和分娩的正常生理过程。如果早入院，干预措施的使用明显也会增加。女性应了解如下信息：

- Eating and drinking in labor is not dangerous and, if desired, is beneficial. There is usually no need for intravenous lines.
  待产时饮食并不危险，按自己的意愿进食进水是有益的，一般无需静脉输液。
- EFM does not make labor safer for the baby and increases the mother's risk of having an unneces- sary cesarean.

电子胎儿监护不会增加分娩的安全性，反而增加不必要的剖宫产风险。

- Epidurals provide excellent pain relief but that re- lief comes at a cost. Some of the risks of epidural analgesia can be lessened by delaying the epidural.

硬膜外麻醉是很有效的镇痛方法，但它也有风险和缺点。延迟进行硬膜外镇痛，可以降低一些风险。

- 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).

很少有进行催产的必要。分娩可能会也经常会是一个较长的过程。耐心、移动、变换体位，分娩支持，饮食饮水——对大部分女性来说，这些已足够推进产程。等到产程活跃期（宫口 6cm）再来医院是个不错的选择。

- Routine episiotomy is harmful and its use should be restricted.

常规会阴侧切有害，应限制其使用。

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 tech- nology 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.

女性如果对待产和分娩的正常生理过程有充分的了解和信心，相信其自身分娩的能力，那么她就更容易摒弃技术和常规干预会让母婴更安全的老观念。向女性提供关于研究成果在内的"事实"，往往不足以改变女性已有的价值观和信念，但是讲故事是一种不错的选择。同样重要的是，分娩教育者、护士、助产士和医生要向女性传达明晰且一致的信息。我们不能跟女性说她们完全可以自然分娩，不会有并发症；然后又跟她们说常规干预"在需要时"让分娩更安全。

CHOICE OF HEALTH-CARE PROVIDER AND PLACE OF BIRTH
选择医疗服务提供者和分娩场所

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

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.

女性在选择照护者和分娩场所时应该做充分的研究。如果我们向女性隐瞒信息，或者引导女性认为：在照护者会常规干预待产和分娩的正常生理过程的那些场所，可以实现安全健康的分娩，那么我们会违背职业道德。高居不下的并发症率和剖宫产率应该警示所有人：生理性分娩没有得到提倡、支持或保护。

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).

助产士最有可能提供包含健康分娩实践全部 6 条原则的最佳照护，包括只有在医学指征的情况下才进行干预。医院外的分娩环境最可能提供最佳的、无干预的特别照护 (Goer & Romano, 2012)。

Evidence-Based Hospital Policies
循证的医院规定

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.

最佳妇产照护的核心是几条简单的实践准则，包括避免常规干预。医院的规定需要反映认可这些核心实践的证据。如果做不到这一点，就不要在该医院进行分娩。

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.

实现这种改变，需要对很多护士、医生和管理者进行再教育。这种教育的核心（实际上也是改变旧观念的核心），就是关于正常生理过程的知识，以及促成改变的照护实践的知识，包括避免常规干预。

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 dis- cussion 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 hap- pen 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 will- ing 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.

护士和分娩教育者需要维护患者的利益，帮助受其照护的女性变得更强大，教她们拒绝常规干预。在共同决策的模式下，要向女性提供信息，包括充分讨论待产和分娩的自然生理过程，以及就个体干预的、基于最佳证据的利弊。要探讨该女性的最大关切是什么，然后探讨各个方案、替代方案和风险。女性做出知情选择，照护者和医院也都支持她的选择。该模式成功的关键是要有广泛详尽和开诚布公的讨论(Hersh, Megregian, & Emeis, 2014)。分娩课程使这种开诚布公和多次进行的讨论成为可能。应鼓励女性探索自己的感受，制订能反映自己喜好的分娩计划。女性在分娩之前也需要与其照护者进行同样广泛真诚的讨论。若无法达成一致，该女性需要考虑更换照护者。护士也要乐意与产妇讨论，支持产妇的选择，即使这些选择与该医疗机构的通常照护实践相反，或者与护士自己的想法不一致。这是护士维护产妇权利的机会，并由此开始改变整个体系。

CONCLUSION
结论

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.

最佳照护是提倡、支持和保护待产和分娩正常生理过程的照护。常规使用的干预会扰乱待产和分娩的正常生理过程。因此，避免不必要的医疗干预有助于安全和健康的待产和分娩。

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