Active Management of Labour (AML), a term given by the British Medical Journal in 1973, describes an approach to labour which was first initiated in 1963 in The National Maternity Hospital (NMH), Dublin, Ireland. Since then AML has continued to evolve, but has remained based on the principles summarised in Active Management of Labour. Regular international courses are held in the hospital for both midwives and obstetricians explaining these principles and has resulted in many of them being adopted elsewhere.

The philosophy behind AML has always been the prevention of prolonged labour, in particular the prevention of the physical and psychological morbidity that usually follows it. Prolonged labour was first defined as 36 hours in 1963, reduced to 24 hours in 1968 and finally to 12 hours in 1972. Ensuring efficient uterine action and fetal and maternal well-being are the key requirements needed to achieve this and the principles of AML described below, set out the framework within which those targets are achieved.

These principles include the importance of antenatal education, the difference between nulliparous and multiparous women, spontaneous and induced labour, single cephalic pregnancies and malpresentations and multiple pregnancies. Furthermore the specific attention and importance given to the diagnosis of labour, as well as fetal and maternal well-being, in particular the personal attention given to each woman during labour. Of most interest, but probably least known, is the organisation of the labour ward which is totally midwifery based, but benefits from a very close working relationship to senior obstetric colleagues resulting in a very satisfying working environment. Lastly all these principles are held together by continuous, rigorous peer review audit leading to constant changes in the management of labour. The main focus of AML however, has undoubtedly always been on the care in labour of the single cephalic, term pregnancy, in nulliparous women.

In the 1970s caesarean section rates started to increase particularly in the United States, and although there was a simultaneous decrease in the perinatal mortality rate O’Driscoll showed that a decrease in the perinatal mortality rate did not necessarily require an increase in the caesarean rate. Furthermore O’Driscoll maintained that the difference between the caesarean section rates in the United States and the NMH could be accounted for almost entirely by a different approach to the management of labour in nulliparous women and suggested AML as an alternative to caesarean section for dystocia. Since then AML has always unfortunately been associated with being the answer to rising caesarean section rates and although some have successfully reduced their caesarean section rates by using its principles, it must be emphasised that it was never the purpose of AML to reduce caesarean section rates.

AML will continue to evolve as informed maternal choice becomes more influential in intrapartum care, but the prevention of prolonged labour and its associated complications will be as important to women in the future as it has been to women in the past.
The impact of AML on outcome of labour is best demonstrated on examining the detailed outcome of spontaneously labouring nulliparous women with a single cephalic pregnancy at term. As far as advantages and disadvantages of AML are concerned, all women should have access to the relevant information on labour outcome. If they prefer a shorter (rather than longer) labour with a high chance of a normal delivery then they will be opting for AML.

References