The “Rule of 10” Versus Women’s Primal Wisdom

by Lydi Owen

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There is a rule of labor that forbids a woman to push with contractions until her cervix is completely dilated to 10 cm. Women are warned that to push before this doorway is completely open and out of the way will result in a swollen and/or torn cervix.

What will supposedly happen if the cervix swells?

Doctors, nurses, midwives, doulas and childbirth educators all warn that a swollen cervix will impede labor and increase the chances of tearing the cervix, thus causing hemorrhage. They have been taught that a swollen cervix is easily broken or pulverized. If this is indeed the truth, then why do most women during labor have an irresistible urge to begin bearing down before dilation is complete?

Could it be that the instinctual wisdom of our bodies has become our enemy? Is Spirit trying to destroy us instead of guiding us? Why would we feel the need to begin bearing down at 5–6 cm (or sooner) if it would shatter the gateway to the baby’s outer world?

These were questions that I pondered as a midwife, as I watched woman after woman give birth in the 1970s. Each of us struggled through the phase of labor when we wanted to push, but we knew that we had to refrain from doing so because that was what we had been taught in childbirth education classes. We had learned this from previous births in the hospital.

By what authority should we doubt the information given to us by the learned men and women of science?

Collectively, women decided that remaining passive during labor was better than risking injury or death of themselves and/or their unborn babies by obeying “outdated” promptings of their bodies, whose wisdom hadn’t kept up with science.

Could professionals be mistaken about when women can begin bearing down during labor, because they forgot one simple part of the equation—that of observing non-medicated women in labor in their natural habitats?

Remember this: People at one time believed that the world was flat. Dr. Ignaz Semmelweiss was ridiculed until his death in 1865 for suggesting that germs were responsible for the widespread child bed fever that killed an epidemic number of women simply because doctors didn’t wash their hands.(1)

How did this “Rule of Ten” come about?

In 1951 doctors Greenhill and DeLee wrote “During the first stage of labor no abdominal pushing is allowed because the cervix will tear.”(2)

We can safely assume that the women being studied by Greenhill and DeLee were under the influence of drugs, because in the mid-20th century the orgy of drug interference during labor and birth was at its height of glory. Almost no women were informed enough to withstand the onslaught of drugs given to them during birth in the hospital. Unfortunately, the situation has not changed in the sixty years since.

Therefore, these doctors were *scientifically incorrect* in concluding that the “Rule of Ten” was valid, without simultaneously observing a control group of drug-free laboring women in the upright position (as opposed to being drugged and lying down in beds).

The only place that they would have been able to make these observations by comparison would have been at homebirths. In the 1950s, homebirths were almost non-existent.

In the early part of the 1970s many American women, tired of being dominated by wrong medical thinking, left the system and went home to birth their children. I was one of these women. That birth led to my becoming a midwife.

The first time I witnessed the cervix miraculously responding to being pushed on at 6 cm dilation was when a woman was giving birth to her third baby. Susan had a quick and easy labor. When she reached 6 cm, she could not hold back from pushing. Her body gave her clear signals that it was time for her to aid the uterus in the expulsion of her unborn child, himself pushing to be born. She began to grunt and bear down involuntarily, making primitive animal sounds that emanated from deep inside her throat.

I, supposedly the learned one, watched her break the cardinal rule in obstetrics. Aloud, I recited, “You must not push. You’re not fully dilated. You can tear or injure your cervix. Pant like a puppy!”

I was attending a lady in birth who had previously given birth to five children in the hospital. She wanted very much to try a homebirth this time. I spent hours with her explaining why it was okay for her to push before ten. She was afraid of birth because her other labors had taken such a long time and were very painful, yet some part of her believed that she could do it and do it well.

Despite her fear of pain, she called me when her labor started and I drove to her home in the middle of the night. She dilated quickly to 5 cm, at which time she wanted to get in the bathtub in warm water. She seemed to be handling the contractions very well, just breathing in and blowing out. I could tell by observing her that she felt like bearing down, but she held back. I told her it was okay to push a little if she felt like it, but I could also sense that she didn’t trust that it was really okay. She had consistently been taught otherwise by her doctor, the nurses and previous childbirth educators. After an hour in the tub, Cathy asked me if I would check her dilation, which I did. She was still at 5 cm.

Cathy moaned with disappointment, but got back in the water and continued with her breathing in, blowing out for another hour. She asked me to check her again, certain that she must surely be 10 cm by now. The look on her face when I told her that she was still 5 cm was one of discouragement and hopelessness.

“Tell me what to do!” she cried, ready to let go of

She obeyed with difficulty.

After thirty minutes of this ridiculous scenario, I checked her dilation again, hoping that she would now be dilated to 10 cm so that I could release her from her agony by giving her "permission" to push. Horror upon horrors greeted my fingers as I discovered that she was still only 6 cm, but now her cervix was swollen from not pushing.

She had several more contractions while I was on the telephone (I was new at midwifery), frantically calling midwives in another state because there weren't any in Las Vegas, for advice on what to do about this "problem." The midwife I spoke to wasn't any more experienced than I was and apologized for not knowing what to tell me.

While I was on the phone, Susan, tired of panting like the puppy she wasn't, finally just went ahead and began pushing without my "permission." I threw down the telephone, rushed over and quickly slipped on a sterile glove. As she pushed, I felt her very puffy cervix, now 7 cm, slip over the baby's head. Out popped his little head, all in one contraction.

Her cervix didn't tear, the swelling subsided immediately, and mother and baby were both fine. Mom was no doubt relieved that she had survived her well-meaning, but ignorant, midwife.

I went home thinking about that one, convinced that we were just lucky that everything turned out okay in spite of the fact that this woman ignored science in favor of primal wisdom.

The next time I encountered a "defiant" woman was soon after, when another woman went into labor. Carol was expecting her second baby. During active labor, at 4 cm—when her cervix was soft and stretchy—Carol squatted by her bedroom door and hung onto the doorknob with both hands. She then began to bear down with each very strong contraction.

"Oh, great, here we go again," I thought as I advised her to desist from pushing.

Carol was less "obedient" than Susan had been and didn't give ear to my dire warning. She just grunted and pushed like an empowered woman, completely unafraid, and within 30 minutes dilated to 10 cm.

Her baby was fine, her cervix was fine, and this time I was fine. I now understood the power of fearless women and the primal (of first importance) wisdom of our bodies.

As I attended more and more births, I learned that women could safely push during labor sooner than what the textbooks claimed. However, the question wasn't *whether* a woman pushed, but *how* and *when*.

the old rules and try something different.

"Are you ready to trust in yourself, Cathy?" I asked her.

"Yes! Just help me please!"

I set up the birthing area on the floor (all the women I help give birth on the floor) and propped fat pillows next to the wall for shoulder and back support. I laid out a plastic shower curtain and plastic bed pads on top of it and then asked Cathy to position herself on the floor. Her husband held one leg and her sister helped hold her other leg up while she grabbed underneath her legs as the contraction started. I told her to go ahead and push is she felt like it (she had felt like doing so for two hours already, but didn't because of fear).

She began to grunt with the force of the contraction and then back off a little to catch her breath. She then grunted again, this time a little harder, and then relaxed for another breath. She did this three times during that one contraction. When it was over, she smiled and said, "You're right. It doesn't hurt as much when I push."

She naturally pushed harder with the next contraction as the baby began to rotate and move down, the cervix yielding and slipping over the baby's descending head a little more with each successive contraction. She gave birth in twenty minutes to a healthy baby boy. She cried out joyfully with tears of gratitude that it was over and that she had done it so fast.

I spoke with her recently, ten years later after her son's birth, and she still enjoys talking about how empowered that birth made her feel.

In my quest to “help” the next woman in labor with my newly discovered information, I wrongly decided to “assist” her to dilate faster by massaging and stretching her cervix when she was 4 cm dilated. What I didn’t yet understand was that the cervix has to be thin, soft and stretchy for this to work *and* the woman has to be getting the signal to bear down of her own accord, not my good intentions to help her get labor over with faster.

I ended up sending her into the hospital for “failure to progress,” when I caused the failure to progress. I was embarrassed that I had prevented her from having a good homebirth just because I was ignorant. I came to realize that I had much to learn about the different stages of labor from observation of women in their natural habitats. What we have been taught about labor and birth in medical textbooks comes from observation of medicated women in “laboratories” (hospitals), like mice in cages. Observations of women lying in beds, laboring under the influence of analgesics and anesthetics provide no real clue to the workings of the human body during labor and birth.

For decades women had been drugged during labor and put to sleep during the actual birth of the baby, so I can certainly understand how the “Rule of Ten” must have come about. If a woman was not dilated completely before the hands of the strong male doctor forcefully pushed, pulled and tugged the sedated infant out of a limp body, then certainly the doctor could easily have torn her cervix with his brute strength if it wasn’t completely out of the way (dilated to 10 cm). Gladys McGarey, MD, writes in the Women’s Wellness section of *Venture Inward*’s November/December 2007 issue, “Let’s respect nature’s wisdom…. Our job is to recognize and support the Divine order of things.”(3)

Dr. McGarey writes about the conditions of women in Afghanistan in 2005 as they gave birth to their babies. The attendants didn’t understand the anatomy and physiology of labor and birth and therefore used severe external pressure to deliver the babies. She also writes that this caused problems such as ruptured uteri and bladders, leading to many maternal deaths.

In the US, in the early part of the 20th century, the “Rule of Ten” no doubt came about for that same reason. Six to nine of every 1000 women died in childbirth in the early part of the 20th century.(4) If the cervix is not out of the way when severe fundal pressure is used, it will act as a counter-force to external fundal pressure and will inevitably result in either a torn cervix or uterus.

I have attended the labors and births of many, many Hispanic women. I have observed many friends and family members of the laboring women who do not have any medical or anatomical knowledge of the human body attempt to speed up labor in these same very unwise ways. I was attending a laboring woman who was pregnant with her first child. She was handling the contractions like a pro, but the labor was slow, which is normal for a first time mother.

Veronica preferred to walk during the contractions. Her cervix stayed at 4 cm for several hours (a normal occurrence), but now her cervix was beginning to soften from the repeated contractions. However, Veronica’s mother was getting impatient. As I had done in the past, she figured she would help her daughter get this labor over with more quickly. From the grandmother’s point of view, she was going to help get that big baby out of that small vaginal opening.

I had gone into the kitchen to get a drink of water when I heard Veronica let out an anguished moan from the bedroom. Alarmed, I rushed into the bedroom to find out what was wrong. Veronica sounded like she was in serious pain. I discovered that her mother was standing behind her with both her arms wrapped around her daughter’s abdomen, pressing down as hard as she could on the top of Veronica’s belly during a contraction.

Her mother believed that she was helping her daughter, but to me the way she was pushing on her stomach looked barbaric. The grandmother did not understand that there was another doorway (the cervix) inside her daughter’s body that had to open before the baby could be born through the exterior doorway—the vaginal opening. In her simple, uneducated mind, she thought she was helping. She did not know that she might tear the cervix by what she was doing because she didn’t even know that there was such a thing as the cervix in the way. I knew better than to insult this grandmother by telling her to stop doing that, so I just made eye contact with Veronica and motioned with my eyes that she

come into the other bedroom. Veronica kindly removed her mother's hands from her belly and followed me, telling her mother in Spanish that I was going to examine her.

Her mother was furious that she was unable to help her daughter the way she had been taught in the small farm town in Mexico where she was born. She clearly considered me an ignorant intruder. However, what she had been doing was dangerous. I wondered how many women and babies had actually died from uterine ruptures in Mexico during labor and birth because of attendants who unwittingly pushed on a mother's uterus to "help" her, the same way they do in Afghanistan and did in the US in the past.

Midwifery in itself isn't dangerous. Midwifery without proper education can be dangerous in the face of aggressive caregivers. Certainly we all need an understanding of anatomy and physiology to be effective midwives.

However, rather than accepting the "Rule of Ten" just because it is written in a medical textbook, we must question whether this rule is valid and examine how it came about, especially as we observe multitudes of women wanting to push before they are completely dilated. For over a century, women in the US have been conditioned to think that doctors are the experts. As a result, we have buried our primal instincts somewhere deep inside our subconscious minds. Just telling a laboring woman that she can trust her body won't wipe away centuries of conditioning that it isn't okay to do so without scientific proof. Unless a woman has been raised on an island far from civilization, she will likely have read or heard something that influences how she will give birth. Everything she has learned has the risk of interfering with or empowering her to listen to and respond to her primal instincts during birth.

I believe that the scientific evidence for eliminating the "Rule of Ten" comes from page 171 of Helen Varney's *Nurse Midwifery*, where she describes what happens in the phase of maximum slope.(5)

First let me say that a non medicated woman will never push so hard against her undilated cervix that it tears, because it will hurt. Pain is a natural deterrent to pushing too hard. However, when done in the correct manner, pushing to help rotate a baby and dilate oneself will actually eliminate a great deal of pain and cut hours off one's labor and birth.

Women feel greatly empowered when they can merge with their contractions, unafraid, because the pain diminishes as they do so and labor time is significantly reduced.

Stages of Labor

All textbooks define normal labor and birth as occurring in three stages: First stage is considered to be from the start of active labor until complete dilation; second stage is the birth of the baby or the pushing stage; third stage is the birth of the placenta.

The first stage of labor is further subdivided into the latent phase and the active phase. The active phase is then further subdivided into three more phases: the acceleration phase, the phase of maximum descent and the deceleration phase, also known as transition.

Yet, the same breathing technique is advocated for all the subdivisions of active phase and the "Rule of Ten" is adhered to no matter what.

How much sense does that make? It's like asking a woman sweeping the floor to breathe the same way that a woman running a marathon would do, or like asking a man digging a ditch with a shovel to breathe and blow instead of grunting as he throws a load of dirt over his shoulder.

I have frequently stated that most of the birthing women I have observed wish to begin pushing, bearing down or grunting at 5–6 cm. This is because they have entered the phase of maximum slope.

According to Varney, three sequential phases of active labor were defined and described by Dr. E.A. Friedman in 1978 in *Labor: Clinical Evaluation and Management*.(6) She states: "The phase of

maximum slope is the time when cervical dilatation is occurring most rapidly from 3–4 cm to about 8 cm."(7)

This dilation averages 3 cm per hour in nulliparas. In multiparas, it averages 5.7 cm per hour. The average maximum rate of descent in first-time mothers is 1.6 cm per hour and in multips it is 5.4 cm per hour.

This means that for both primips and multips, doctors observed that women dilated rapidly from 4–8 cm in approximately one hour or so. The descent of the baby's head in first-time mothers was naturally slower than for women who had already given birth to other children vaginally. Can you imagine the descent and dilation that occurs in women who give birth at home, who are walking during labor and who are not medicated? Can you understand now why the rule needs to change?

The phase of maximum slope is defined as dilation occurring most rapidly from 4–8 cm dilation, but my experience shows that it occurs most rapidly between 5 and 8 cm.

I believe that a Divine reason is behind the fact that the cervix stays at 4 cm for the majority of labor.

Each contraction starts in the top part of the uterus and spreads downward; it is stronger and persists longer in the upper region. On reaching the lower uterine segment the contraction weakens considerably, permitting the cervix to dilate. There is neuromuscular harmony between the upper and lower segment throughout labor. The muscular fibers of the upper segment contract strongly and retract (become progressively shorter), while the fibers of the lower segment contract only slightly and dilate. As the upper segment contracts and retracts, the lower uterine segment has to "thin out" to accommodate the descending baby. This continues until the cervix if fully dilated and the baby can leave the uterus.

The upper segment increases in thickness up to *four times*, diminishing the uterine cavity considerably where the baby is lying.(8) As this is happening, the lower segment becomes more and more yielding to the pressure of the baby's head against it. This is why at 5 cm, the cervix is usually so stretchy and thin that it can no longer hold back the flexing, rotating and descending baby.

Because of Divine design, as the uterine cavity itself diminishes in size due to the increased thickness of the upper segment and the increased thinness of the lower segment, the baby is protected from strangling on the cord because his position relative to the cord and placenta does not change as he drops farther and farther into the pelvis. Many babies get wrapped in their cords before birth. If this decrease in size of the uterine cavity didn't take place, the baby could easily strangle in the umbilical cord during labor and birth.

When the baby has reached its maximum descent before complete dilation (8 cm), the mother enters the deceleration phase. This phase is the end of the active phase. Dilation now temporarily slows. At this point, many mothers wish to lie down and rest, or get onto hands and knees to complete dilation. Many mothers I have observed have to rest for only a few minutes before the cervix relaxes and the mother feels like pushing again. The cervix can no longer withstand the pressure of both the baby and the mother's pushing efforts and relinquishes its hold on the baby.

In summary, after decades of believing the "Rule of Ten" to be gospel truth, many women have difficulty letting go of false beliefs. We will take a while before we again trust our primal wisdom. However, when we do, I truly believe that the cesarean rate will drop dramatically.

One of the main reasons for cesareans is because of slow labor; yet labor is often slow because of the rules we have made.

Lydi Owen is the mother of six, grandmother of six (another on the way) and great-grandmother of four. She has practiced midwifery for 36 years and helped over 2600 babies into the world. She has written three books, produced a DVD and is founder of the nonprofit Association for the Prevention of Maternal Attachment Disorders. Her Web site is www.powerbirth.com.

References:

1. www.cdc.gov/ncidod/EID/vol7no2/cover.htm. Accessed 13 Feb 2008.
2. Greenhill, J.P., and J. DeLee. 1951. *The Principles and Practice of Obstetrics,* 10th ed. Philadelphia: WB Saunders.
3. McGarey, G. 2007. *Venture Inward*. Virginia Beach, Virginia: Association for Research and Enlightenment, Inc., November/December.
4. "Achievements in Public Health, 1900–1999: Healthier Mothers and Babies," *MMWR*, 1 Oct 1999.
5. Varney, H. 1980. *Nurse Midwifery*. Boston: Blackwell Scientific Publications.
6. Friedman, E.A. 1955. Primipara Labor Curve. *Obstet Gynecol* 6: 569. Cited in Varney, p. 170.
7. Varney, p. 171.
8. Buhimschi, C.S., et al. Myometrial thickness during human labor and immediately post partum. *Am J Obstet Gynecol* 188: 553–59; Myles, M. 1981. *Textbook for Midwives,* 9th ed. New York: Churchill Livingstone.

http://www.midwiferytoday.com/articles/ruleof10.asp