

Florida Perinatal Quality Collaborative

AT THE LAWTON AND RHEA CHILES CENTER FOR HEALTHY MOTHERS AND BABIES



Partnering to Improve Health Care Quality
for Mothers and Babies

Literature E-Bulletin on Non-Medically Indicated Deliveries <39 Weeks Gestation

Dear Perinatal Care Providers: Below is a list of recent literature on the issue of non-medically indicated deliveries <39 weeks gestational age. These references are provided to you by the Florida Perinatal Quality Collaborative through the generous support of a grant from the March of Dimes. You can click on the reference and go directly to the PubMed abstract for the article and access available full text articles. If you have any questions, please contact us at fpqc@health.usf.edu or by phone at 813-974-8888.

[Doyle JL, Kenny TH, von Gruenigen VE, Butz AM, Burkett AM. Implementing an induction scheduling procedure and consent form to improve quality of care. *Journal of Obstetrics, Gynecology, and Neonatal Nurses*. 2012; 41:462-473.](#)

A quality improvement initiative was implemented in a level III hospital, with 3,000 births annually, to align with ACOG guidelines and eliminate elective deliveries before 39 weeks gestation. A multidisciplinary Perinatal Safety Team was established with representatives from nursing, medicine, administration, and scheduling, to implement an induction scheduling procedure and consent form. Since implementation, elective deliveries before 39 weeks gestation have decreased from a baseline of 5.6 per month to 0.7 per month; of the 28 months post-implementation, 25 of these had zero elective inductions and 17 of 28 months had zero elective inductions and elective cesareans. The authors address issues with hard and soft stops and conclude that “the hard stop is essential for ultimate success as patient safety must be the number one concern.” They also note the top reason for elective induction of labor was discomfort and as such, providers can support parents by reminding them that discomfort at the end of pregnancy is expected and normal, that babies take 40 weeks to fully develop, and due dates have an accuracy window of two weeks.

[Simpson KR, Newman G, & Chirino OR. Patients’ perspectives on the role of prepared childbirth education in decision making regarding elective labor induction. *Journal of Perinatal Education*. 2010; 19\(3\):21-32.](#)

This study was conducted to evaluate the reasons why nulliparous women choose an elective induction of labor and to identify the potential influence of prepared childbirth classes on their decision. The authors surveyed women about their choices for childbirth, participation in childbirth preparation classes, and experience with labor and birth. In a comparison of medical records and survey responses, researchers noted that 26.7% of inductions were listed for Macrosomia when 39.9% of induced patients cited “my baby was too big” as the reason for induction; the second most common reason women believed they had had an induction was for “due now or overdue”(20.3%), yet only 35 women (6.4%) who had an elective induction were 41 completed weeks of gestation and none were more than 41 3/7 weeks. Women who participated in prepared childbirth classes viewed them as positive, were more satisfied with their labor and birth experience, and felt more prepared for labor and birth than women who did not attend classes. The authors note that maternity care professionals should encourage nulliparous women to attend prepared childbirth classes. Results from the survey suggest that attendance at prepared childbirth classes can be an effective source of information regarding labor induction and influence women’s decisions regarding the induction of their labor.

[Ashton DM. Elective delivery at less than 39 weeks. *Current Opinions in Obstetrical Gynecology*. 2010; 22:506-510.](#)

This 2010 review article addresses the increasing occurrence of elective early-term deliveries before 39 weeks' gestation, whether by induction or cesarean section, which has risen substantially in recent years. Research in this area has demonstrated that early elective delivery, before 39 weeks' gestational age, is associated with increased risk of neonatal morbidity and mortality, including: neonatal death, respiratory complications, hypoglycemia, sepsis, seizures, necrotizing enterocolitis, hypoxic-ischemic encephalopathy, cardiopulmonary resuscitation or ventilator support, NICU admission, prolonged hospitalization, and more. The article addresses the changing definition of a term gestation from 37 weeks to 39 or even 40 weeks, adverse infant and maternal outcomes of early elective deliveries before 39 weeks, the absence of an increase in stillbirth rates when delivery is postponed to 39 weeks, issues of liability and cost, and finally, strategies to reduce elective deliveries before 39 weeks' gestation. Some suggested strategies to reduce early term deliveries include: early and accurate dating according to ACOG criteria, improving electronic information systems to reduce missing data and ease the analysis and tracking of data, and engaging delivery hospitals in quality improvement initiatives to improve birth outcomes and decrease costs through provider education and a hospital hard-stop policy.

[Main EK, Morton H, Melsop K, Hopkins D, Giuliani G, & Gould JB. Creating a public health agenda for maternity safety and quality in cesarean delivery. *Obstetrics and Gynecology*. 2012; 120\(5\):1194-8.](#)

This article is a commentary about the rising rates of primary cesareans experienced by first-time mothers in the United States and the associated health risks, economic costs, and negligible benefits for most mothers and newborns. Data show that cesarean deliveries put women at increased risk for obstetric hemorrhage, infection, deep vein thrombosis, and cesarean delivery of future pregnancies. In order to better understand the socio-cultural aspects related to the rise in cesarean deliveries, which cannot be explained by medical reasons, the authors reviewed the current science and health policy literature as well as conducting qualitative interviews with obstetric clinicians. The authors determine that a multi-strategy approach is needed to address the rising cesarean delivery rate including: clinical quality improvement strategies that carefully examine current labor practices and lead to the development of indications for cesarean deliveries, payment reform to eliminate negative or perverse incentives, healthcare provider and consumer education to recognize the value of normal vaginal birth, and full transparency through public reporting and continued public engagement.

[Spong CY, Berghella V, Wenstrom KD, Mercer BM & Saade GR. Preventing the first cesarean delivery. *Obstetrics & Gynecology*. 2012; 120\(5\):1181-93.](#)

This article summarizes the recommendations decided upon by the joint workshop convened by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists. This workshop was held to address the rising cesarean section rate and to determine the best strategies to reverse this trend. Cesarean delivery is the most commonly performed major surgery in the U.S. and in 2007, 26.5% of low-risk, first-time mothers were delivered by cesarean section. Also, rates for trial of labor and VBAC have decreased, contributing to the increase in all births delivered by cesarean. The article reviews commonly cited indications for a primary cesarean and recommendations are made based on the current evidence to decrease the use of these interventions in low-risk, first-time mothers, in order to decrease the primary cesarean section rate. The article summarizes that due to the health risks associated with cesarean delivery and the implications for future pregnancies after the first cesarean, the most effective approach to reduce overall morbidities related to cesarean delivery is to avoid the first cesarean. The authors discuss that before 39 weeks' gestation, labor induction should only be performed for a medical indication, and after 39 weeks the cervix should be favorable (having a Bishop score of more than 8), particularly in the nulliparous patient.

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