ACOG Consensus Statement: Safe Prevention of the Primary Cesarean Delivery

More Questions than Answers?

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What I’ll cover today... 
1. A bit of history
2. Essential components of the guidelines
3. Their impact on diagnoses of “failure to progress,” “fetal intolerance of labor” and indications for induction and c/s
4. The clinical skills that doctors, midwives, and nurses will need in order to follow the new guidelines
5. Potential impact of the guidelines on childbearing women who have come to accept many of the practices now being rejected by ACOG
6. How childbirth education and doula care may contribute to success of the guidelines by helping women understand and cope with the new approach to labor
7. A dose of reality


Historical Perspective

- C/S Rate rose steadily from 1996 to 2009 (32.9%), then slowly dropped to 32.7% in 2010-13
- High cesarean rates did not result in improvement in maternal/neonatal morbidity or mortality
- Cesarean crisis led ACOG to review many questionable care practices
- ACOG issued many guidelines from 2009 to today, in hopes of reversing the trend.
- Examples... 

New or Revised Guidelines on -

- Definition of “Term Pregnancy” (2013)
  - Early Term: 37/0 weeks – 38/6
  - Full Term: 39/0 – 40/6
  - Late Term: 41/0 – 41/6
  - Postterm: 42/0 and beyond
- Prevention & Timing of Nonmedically Indicated Early-term Deliveries (2013)
  - Macrosomia NOT an indication
  - < 39 weeks NOT acceptable
- How to Define, Classify, Interpret FHR Tracings* (2009)

New statement integrates all these and goes much further

ESSENTIAL COMPONENTS OF THE SWEEPING 2014 ACOG STATEMENT
“6 is the new 4”

- Redefinition of normal labor progress: dilation from 4 to 6 cm can take 4 to 6 hours longer than Friedman’s work described.
- 6 cm is the threshold for active phase of labor
  - “6 cm is the new 4” applies only to clinical management of prolonged labor
  - not timing of admission to hospital
  - not frequency and intensity of contractions
- Arrest of labor: ≥6 cm with ruptured membranes and --
  - ≥4 hours adequate contractions (>200 Montevideo units*), OR ≥6 hours of inadequate contractions
  - with no cervical change

Components (cont.)

 Longer Second Stage

- ≥2 hours pushing in multiparous women
  - (+1 hr. with epidural)
- ≥3 hours pushing in nulliparous women
  - (+1 hr. with epidural)
- Since Guidelines were published, a new study reported the 95th percentile of second stage duration for nullips:
  - 3.25 hrs without an epidural
  - 5.5 hrs with epidural

Essential components (cont.)

- Improve diagnosis of presentation and position with U-S
- Improve manual skills (breech version, rotation of fetus).
- If macrosomia is suspected:
  - No induction for that indication
  - No planned cesarean unless EFW is ≥5000 grams (>11 lbs) without diabetes; 4500 g (9 lbs) w diabetes
  - No elective induction before 41 weeks*
  - Induction after 41 weeks is advised to reduce c/s and perinatal mortality and morbidity*
  - Increase use of fetal scalp stimulation and amnioinfusion
  - Increase skills and use of vacuum and forceps
  - Increase women’s access to continuous labor support

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Studie's of normal & abnormal nulliparous labor progress:
Friedman 1955-1965
Zhang 2002-2012
Large differences between the generations.
“Indeterminate” fetal heart rate tracings

- Most cesareans for fetal causes are in this category
- Confirm fetal intolerance with--
- Fetal scalp stimulation
- Intrauterine resuscitation
  - O₂, position changes, assessment (correctible cause?)
  - Let narcotics wear off, reduce Pitocin
  - IV fluid bolus
  - Tocolytics to reduce hypertonus or to slow rapid labor
- Amniinfusion?
- Education needed for caregivers and nurses*

Potential Impact of Guidelines on Nurses’ Care

- Longer occupancy of labor beds
- Longer duration of epidurals & duration-related side effects
  - Fever, density, malposition
  - Need for skills to support woman
  - Patience, psychological support, non-pharmacological measures for comfort and progress
  - Reduce side effects of epidural
  - Assess for correctible causes for indeterminate FHR patterns* and use intrauterine resuscitation
  - Nurses’ role with amniinfusion, fetal scalp stimulation?
  - Adjustment to caregivers’ views of the guidelines

Key Concepts

Time and Patience are Allies of the Woman!
But we have to convince her!

WHAT DO WOMEN THINK AND KNOW? HOW AND WHAT DO THEY LEARN?

Childbearing women seek knowledge from --

In order of frequency . . .
1. Their care providers
2. Experienced mothers
3. Childbirth classes (of varying quality, length, and purpose)
4. Pregnancy and childbirth websites

Some Findings From LtM III

Childbirthconnection.org
A program of the National Partnership for Women and Families

LtM III, 2013
Some Important Findings:
Most women trust their caregivers.
• Yet, caregivers often give inaccurate incomplete info.
• Women usually follow caregiver’s recommendation
• But they feel they made their own decisions
• Generally, they were poorly informed

Listening to Mothers III found . .
Most pregnant women poorly informed, when asked:*  
1. Safest gestational age to deliver a healthy baby 
2. Cesarean complications, such as--  
   a. Likelihood of placenta problems in future pregnancies 
   b. Likelihood of breathing problems in newborn 
3. Whether induction for “big baby” makes sense  
   Even though they wanted knowledge, most were poorly informed!

Providers’ misinformation led to less safe choices  
Big baby (Macrosomia)—  
• 32% of women were told near term the baby might be large. 
• 62% discussed induction. 
• 49% discussed C/S. 
• Most women felt the final decision on induction (80%) and C/S (62%) was their own. 
• In the end, their decisions were usually what the doctor suggested (80% and 72%). *  

Common beliefs of many birthing women, loved ones (& doctors) 
As interventions have become common, many women now believe . . .  
• Planned elective inductions and cesareans are safe if done >37 wks 
• Induction for a big baby improves outcomes, prevents c-s and injury 
• Long labors cause harm and should be avoided.

Common beliefs of many childbearing women, their loved ones & doctors  
• Cesareans, planned & unplanned, are as safe as vaginal birth 
• Forceps, vacuum extraction are more dangerous than c/s 
• Cesarean births of all twins, breech babies are safer 
• Fetal distress can be identified by EFM, and a c/s often saves a baby from brain damage 
• The safety, predictability, convenience, and absence of labor pain of c/s appeals

Ban Sacred Cows! 
Now, with this statement, women who accepted the practices (“sacred cows”) that increase cesareans will be expected to go along with a reversal of these “sacred cows.”  
Easier said than done!
The Catch 22 for promoters of normal birth
• While educators, doulas, and many nurses applaud these guidelines, the women may not.
• The guidelines require more effort and participation from women than today’s “usual care.”

Childbirth Education and Doula Care are crucial to the success of these guidelines
When women understand why and how to avoid a c-, and are assisted along the way, odds of success improve.

Concepts in teaching
Teaching to avoid induction
Rather than teaching from a risk-benefit perspective.
• Begin with how labor normally begins.
• The baby starts labor when he/she is ready to thrive outside the uterus.
• When the fetal lungs mature and produce surfactant, that starts the process.
• Under normal circumstances (89-90% of the time), the fetus continues to benefit from time in the womb.
• Does the parent realize that her baby may not be quite ready to be born if induced when nothing is wrong?
• Then cover risks and benefits and alternatives.

Concepts in teaching
Techniques for comfort and progress
• Many (most?) teachers shortchange their students in this area.
• If people haven’t done it in class, they are unlikely to recall or do it in labor.
• If necessary, start a class or two with rehearsal of labor techniques.
• A doula is invaluable in helping apply the techniques in labor, but
  • Doulas love it if their clients know how to do them.

Concepts in teaching
• Students need to understand that interventions can be either beneficial, ineffective, or detrimental, depending on the circumstances.
• Importance of flexibility to adapt according to the circumstances.
• And how to tell whether good or bad.
• Key questions: BRA BRAN BRAT BRAIN, etc.
• When trust between client and caregiver is absent (for any reason), it’s a crapshoot.

The Guidelines call for continuous labor support, “such as a doula.”
• Doulas can assist women through longer and more demanding labors, and can be valuable allies with the maternity care team.
• How do doulas support women with epidurals to keep birth as normal as possible?
  As much as possible, doulas treat them as if they do not have an epidural.
How doulas care for women with an epidural like women without one.
• Keep her moving, but let her rest if exhausted
• Keep her cool
• Never leave her alone, even if resting
• Provide help, emotional support & encouragement
• Help her mimic spontaneous pushing

A dose of reality
Even though almost every one of today’s common procedures causes more harm than good,
And even though ACOG has provided an evidence-based statement outlining proven ways to safely reduce cesareans,
It will take years before most obstetricians will accept these changes in their care

Conclusions
• This ACOG statement calls for sweeping reforms in obstetric management to reduce cesareans
• This model of care closely resembles the MIDWIFERY MODEL!
• Many lost skills and abandoned practices are being revived, and many current practices are being revised
• The changes may catch the public by surprise since they have been counseled for years that the present ways are best
• Nurses’ roles will change as inductions, augmentation, and cesareans decline.
• Childbirth educators and doulas can contribute in making these changes successful.

THANK YOU!
QUESTIONS?