Waiting for a Baby

Avoiding elective delivery until 39 weeks gestation

Waiting for anything is hard for most of us. Waiting for the joyfully anticipated delivery of a baby can be especially difficult. Somewhere between interrupted sleep, swollen ankles and a burgeoning belly are the seemingly incessant exclamations, “You’re still pregnant?” from well-meaning friends and family.

Over the months of their prenatal care, parents form a trusting bond with the obstetric care practitioner they’ve chosen to guide them through labor and delivery. “What if my doctor goes on vacation or isn’t on-call, when I go into labor?” Soon-to-be-grandparents, or a beloved aunt, may travel cross-country hoping they’ll be present for the delivery and homecoming of baby. “What if I don’t go into labor before Mom has to return home?”

Fear about labor and delivery, or anxiety about the transition to post-baby life can also leave parents searching for a sense of control. “What if we get stuck in a storm and can’t get to the hospital in time for delivery?”

These and other factors may prompt parents to ask, even plead, to have labor induced. However, the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) have long advised against elective labor induction or delivery prior to 39 weeks gestation in the absence of medical indications. Yet, in the decades since ACOG’s 1979 statement, elective inductions of labor and surgical delivery have increased, and the number of patients presenting in spontaneous labor have increased, and the number of patients presenting in spontaneous labor has declined.

Comparing U.S. delivery data from 1990 to 2006, deliveries occurring between 37 and 386/7 weeks gestation increased by nearly 50 percent. The Centers for Disease Control and Prevention (CDC) reports induced births accounting for 23.1 percent of all 2008 births; an increase from 9.5 percent of births in 1990. Other studies report induction rates as high as 34 percent.

The public’s lack of knowledge also produces pressure for earlier induction and delivery. A study of pregnant women’s perceptions demonstrates that 75 percent consider 34-38 weeks to be “full term” and more than 90 percent believe it is “safe to deliver” prior to 39 weeks.

Early elective delivery (EED) is linked to higher rates of newborn complications. Delivery data comparing the outcomes of EED’s at 37 and 38 weeks, with delivery at 39 weeks, demonstrate increases in neonatal intensive care unit (NICU) admissions, rates of transient tachypnea of the newborn (TTN), respiratory distress syndrome (RDS), ventilator use, feeding problems and longer newborn hospital stays. A study conducted at a large, integrated health care system showed rates of RDS, requiring ventilator use, were 22.5 and 7.5 times higher respectively for infants born at 37 and 38 weeks, when compared to infants born at 39 weeks. What is especially striking is that the frequency of these complications are equal to, or often worse, for infants born between 37-386/7 weeks, than those born at 41 and 42 weeks.

Gestational age should be established by firm last menstrual period, ultrasound measurement prior to 20 weeks, or fetal heart tones by Doppler for 36 weeks. ACOG has noted in Practice Bulletins that “a mature
fetal lung maturity test result before 30 weeks of gestation in the absence of appropriate clinical circumstances is not an indication for delivery.”

Maternal outcomes are also impacted. Compared to women going into spontaneous labor, those having elective induction of labor; especially with a Bishop score of < 6, are more likely to require a cesarean delivery for arrested labor.6,7 Oxytocin, frequently used with elective induction, increases the risk of hemorrhage, postpartum anemia and tachysystole with potential uterine rupture.

Certainly there are medical considerations when balancing whether to facilitate an early delivery or get closer to 39 weeks. ACOG considers this appropriate when managing pregnancies complicated by issues such as maternal medical conditions, gestational or chronic hypertension, intrauterine growth restriction, premature rupture of membranes, placental bleeding issues, chorioamnionitis, fetal demise or post-term pregnancy.

There is a movement toward heeding ACOG and AAP’s original advice to wait until 39 weeks before elective induction of labor or delivery. The March of Dimes, in collaboration with the California Maternal Quality Care Collaborative and the California Department of Health – Maternal Child and Adolescent Health Division, launched a comprehensive quality improvement tool kit toward eliminating elective delivery before 39 weeks. With data collected through 2011, The Leapfrog Group issued a national report on hospital rates of EED. The report shows a small overall decrease between 2010 and 2011, but hospital rates of EED still vary from 5 percent to more than 40 percent. Clark, et al. put forth, “A 5 percent rate of elective early term delivery would be reasonable as a national quality benchmark.”8

What can be done?

Collaborate

Obstetric care providers, hospital leadership and nurses should come together to measure current outcome data, review available tools and resources, set a course, and establish the timeline for implementation and sustaining improvements. Hospital Engagement Networks (HENs) in many states have launched initiatives to reduce EED.

Standardize

ACOG evidenced-based practices and March of Dimes tools are already available. Having a hard-stop approach produces better results than practitioner education alone. Clinical situations requiring appeal should be anticipated. Strong leadership will be required for both appeal decisions and to support front-line staff expected to “hold the line.”

Utilize tools

- Policy: Set expectations and hard-stops for elective induction practice
- Checklists: Professional organizations and tool kits contain examples of standardized clinical criteria, scheduling and induction processes

Patient and public education

- Incorporate fetal development and EED risk information into childbirth/parenting classes and clinic-based patient information
- March of Dimes patient education and graphics are readily available. This includes easily understood illustration of fetal brain development differences between 35 and 39 weeks
- Raise public awareness and health literacy through community outreach and education
Resources

- The American Congress of Obstetricians and Gynecologists (formerly The American College of Obstetricians and Gynecologists): www.acog.org
- American Academy of Family Physicians: www.aafp.org
- March of Dimes: www.marchofdimes.com
- Quality Improvement Tool Kit: Elimination of Non-Medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age: www.prematurityprevention.org (free registration)
- Patient Education: Healthy Babies are Worth the Wait; including the Late Preterm Brain Development Card:
  www.marchofdimes.com/pregnancy/getready_atleast39weeks.html
- Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN): www.awhonn.org
- “Go the Full Forty” consumer campaign: www.gothefull40.com
- LeapFrog: www.leapfroggroup.org
- Peer-reviewed articles, tools, fact sheet and other documentation: www.leapfroggroup.org/56440/StopEarlyElectiveDeliveries

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References