

Perinatal Frequently Asked Questions

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Recent publications to be knowledgeable of:

1. ACOG Practice Bulletin No. 97, August 2008 "Fetal Lung Maturity"
2. ACOG Practice Bulletin No. 106, July 2009, "Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles"
3. ACOG Practice Bulletin No. 107, August 2009, "Induction of Labor"

Please Note with regard to the previous term "hyperstimulation": ACOG Practice Bulletin No. 107

Labor Induction Terminology

"At a 2008 workshop sponsored by the American College of Obstetricians and Gynecologists, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the Society for Maternal-Fetal Medicine on intrapartum electronic FHR monitoring, the definitions for FHR pattern categorization were reviewed and updated. The existing classification systems for FHR patterns were assessed and new recommendations for use in the United States were made (32). In particular, it was determined that the terms hyperstimulation and hypercontractility should be abandoned. It was recommended that the term tachysystole, with or without corresponding FHR decelerations, be used instead. "

Uterine Contractions

"Uterine contractions are quantified as the number of contractions present in a 10-minute window, averaged over 30 minutes. Contraction frequency alone is a partial assessment of uterine activity. Other factors such as duration, intensity, and relaxation time between contractions are equally important in clinical practice." The following represents terminology to describe uterine activity:

- *Normal*: Five contractions or less in 10 minutes, averaged over a 30-minute window
- *Tachysystole*: More than five contractions in 10 minutes, averaged over a 30-minute window

Listed are characteristics of uterine contractions:

- Tachysystole should always be qualified as to the presence or absence of associated FHR decelerations.
- The term tachysystole applies to both spontaneous and stimulated labor. The clinical response to tachysystole may differ depending on whether contractions are spontaneous or stimulated. "

Please clarify "Pelvic Exam" Does that mean cervical check?

For induction, a pelvic exam includes a bishop score, 1) in order to assess the risks associated with induction (particularly failed induction and cesarean section) and 2) an evaluation to exclude contraindications to pitocin, namely absolute CPD, with an EFW and an assessment of pelvic adequacy, and a confirmation of fetal presentation. These are the two goals to be accomplished prior to pitocin induction. For augmentation, once again, in order to exclude contraindications to the proposed therapy (pitocin augmentation of labor) an evaluation for pelvic adequacy coupled with an EFW is required. The bishop score does not have a role in augmentation.

Describe the difference between the terms "readily available" and "immediately available".

Readily is defined as promptly, in a timely manner but does not have a time associated with it. Readily available is generally accepted as 20-30 minutes. Immediate availability is generally considered as 5-10 minutes. Example-For our (University of Vermont) situation it means being on campus; however if I am in the Med School Library it can be 10-15 minutes away from L&D so I need to consider what's going on before going there.

What is the definition of birth trauma used by teams during the Idealized Design of Perinatal Care?

The IHI Perinatal Community Teams are using the Perinatal Trigger Tool to identify and track harm (posted on ihi.org). This is one factor used to identify opportunities for improvement; other perinatal measures may be the AHRQ PSI's.

Does implementation of the bundles contribute to an increase in cesarean section rates?

In the data identified to date, there has not been an increase when corrected for time. That is, there has been a steady increase in the national C/S rate since about 2003 but, when corrected against that increase at other hospitals, there appears to be a slower increase in the hospitals using pitocin bundles. In addition, operative vaginal deliveries have decreased at the hospitals using these bundles (as well as other perinatal care improvement projects) without a concomitant increase in the C/S rate.

When holding elective induction to 39 weeks, early data (from Intermountain) suggests there is a decrease in length of labor, time spent on L&D, and in cesarean section for failed induction.

How do you propose handling pelvic assessment in a rural facility where the patient is scheduled for an induction from the clinic and presents to L&D three days later, where the nurse begins the induction process early in the a.m. Is the nurse then responsible for the pelvic assessment through the BISHOP score?

Someone needs to take the responsibility to exclude contraindications to the recommended therapy, that is, induction of labor. In addition the patient needs to be adequately counseled regarding the risks and benefits of the recommended therapy. Therefore, a Bishop's score needs to be performed to adequately address the risk of failed induction and cesarean section, and the pelvic assessment combined with an estimated fetal weight needs to be performed to rule out absolute C. P. D. The pelvic assessment and estimated fetal weight can be done prior to admission. Each hospital will have to decide when a Bishop's score is accurate when it has been done prior to admission. I might recommend within 24 hours. On the other hand, there are significant nursing skills in each of these areas which can be used at the time of admission. Any of these assessments can be done by a skilled provider whether physician, midwife, or nurse.

Is there a role for "Active Management of Labor" protocols within these parameters?

Active management of labor refers to using a specific diagnosis for the start of labor, higher doses of Pitocin and, importantly, only nulliparous patients. While the incidence of tachysystole is higher with this protocol, it can be appropriately used, as most Pitocin protocols can be used, as long as tachysystole is identified and responded to.

Can you be more specific in your discussion of reassuring FHT? Do you mean mod variability or only reactive tracing?

Accelerations are not part of normal (NICHD Classification) (reassuring) fetal assessment intrapartum, as opposed to antepartum where a non-stress test is well defined to include accelerations to be reactive, or reassuring.

Intrapartum variability is the most important parameter to assess fetal normoxia in the central nervous system of the fetus. Moderate variability is all that is needed for reassurance. Again, as the electronic fetal monitor is very good at detecting health, moderate variability predicts a baby with normal Apgars and a normal umbilical artery pH when delivered in this setting. The classic non-reassuring fetal strips include persistent variable decelerations or late decelerations in the face of minimal or absent variability.

Tachycardia may be present in the setting of persistent variable decelerations as variability diminishes. So, when using pitocin, there should be a Category I FHT or in some cases, Category II, unless the fetus is not being considered viable (lethal fetal anomaly or pre-viable dates) pitocin should not be used in the face of a Category III tracing.

Should there be a specific informed consent for an induction, medical and elective?

Dr. Cherouny does not believe it is currently standard of care to require a consent form for induction. A few hospitals have elected to go this route. The staff at the University of Vermont is considering informed consent for elective inductions in nulliparous patients with unfavorable cervixes. The important point is to have adequate documentation that a discussion with the patient took place regarding the risks and benefits of the recommended intervention. While we don't always view an induction as a significant intervention, because it is associated with significant perinatal harm we need to begin thinking of it this way.

What is the definition of augmentation of labor?

Augmentation is classically defined as the addition of Pitocin in a laboring patient in an effort to augment labor. This is a gray area when talking about rupture of membranes because we don't always clearly define when labor begins. Patients who were contracting would classically be considered an augmentation while those that are not would be considered an induction. This would then generally define patients with ruptured membranes as undergoing augmentation. However, while it is not unreasonable to consider a patient undergoing induction if they have PROM, some contractions but are not in the active phase of labor (beyond 3-4 cm), for the purposes of the bundles it would be best to consider these patients as undergoing augmentation of labor as gestational age issues (at least 39 weeks GA) would not be considered in this setting.

How does one estimate fetal weight? Who can estimate the fetal weight?

There are several ways to estimate fetal weight. In a multiparous patient, who has previously delivered at term, an estimated fetal weight by the mother has roughly the same error as our clinical estimate of fetal weight or ultrasonographic estimates of fetal weight. Several hospitals have elected to use only SGA, AGA and LGA instead of a specific number for estimated fetal weight. This is reasonable as long as the fetuses identified as LGA then have a more specific estimated fetal weight documented. This is because there are specific fetal weights, 4500 g in a fetus of a diabetic mother, and 5000 g in the fetus of a non-diabetic mother, where specific recommendations exist regarding counseling and care. In addition, ACOG specifically states that in the presence of a macrosomic fetus with failure to descend in the second stage of labor the treatment is cesarean section. It is not possible to assess for macrosomia without an estimated fetal weight. Any skilled practitioner can estimate fetal weight. This can be done by an obstetric provider, or an obstetrics nurse.

What is your opinion of the fundal pressure during 2nd stage?

Dr. Cherouny: I do not believe that fundal pressure on the uterus that still contains a fetus has any place in the current obstetric environment. Several recent medical legal cases have been lost due to this practice.

Residents are no longer taught to do clinical pelvimetry. Are there any convincing data that clinical pelvimetry predicts outcome (likelihood of C/S)?

Clinical pelvimetry is capable of excluding absolute CPD which is a contraindication for pitocin use. This is the goal of the assessment for pelvic adequacy prior to pitocin (ruling out contraindications to recommended therapy). That is not to say clinical pelvimetry (in experienced hands) is not useful. Concern over relative CPD, upon which we seem to be hung up, allows one to decide how to manage a labor because of overall increased risk of cesarean section, etc. For instance, a nulliparous patient presenting at term in labor with an unengaged presenting part has a 2-3 fold increased risk of cesarean section due to "failed labor" (active phase arrest or failure to descend). Knowing this, I tend to expedite their labor to shorten the time to delivery or decision for cesarean section which helps to reduce overall morbidity. The same would be true for a patient where I believe there is a borderline or restricted pelvis. For instance, I would tend to be more aggressive in their labor management and would tell the patient that I would not perform a mid-pelvic or a combined operative vaginal delivery.

Are the bundles designed to address the use of other agents used during induction?

With the exception of misoprostol, the prostaglandin preparations have cervical ripening as their only indication. Misoprostol is also used for labor induction but is primarily used as a cervical ripening agent. We are focusing on Pitocin first but it is certainly reasonable to expand the bundles to the beginning of the induction process which includes the period of cervical ripening. It is important to note, however, prostaglandin cervical ripening has not been associated with more successful inductions nor a lower cesarean section rate. Cervical ripening does shorten the period from induction to delivery by one to two hours on average. Therefore, it is reasonable to conclude that the bishop's score at the start of cervical ripening is the one that should be used in the discussion regarding risks and benefits of the induction procedure.

Is IUPC use recommended routinely with the use of pitocin? Is there difference for patients undergoing a trial of labor after a previous c-section?

IUPC use has not been shown to significantly change clinical outcome in the presence of Pitocin. Therefore, it is not required even in the patient with the prior cesarean section undergoing a trial of labor.

Is there data indicating that outcomes have improved using these bundles?

There has been an improvement in Perinatal outcome in hospitals using the bundles. Specifically, the Intermountain data supports that the relative risk for admission to the nursery ICU at 38 weeks is 1.5 when compared with 39 weeks. In addition, holding elective induction until 39 completed weeks, that is 39 weeks 0 days, there is a decreased induction rate, overall less time in labor and delivery and shorter inductions, and this is likely to lead to a lower cesarean section rate when we have enough numbers. From a neonatal standpoint, we are seeing less hyperbilirubinemia and a lower readmission rate for neonatal hyperbilirubinemia. As the numbers get higher, we will be able to better identify even smaller incident outcomes.

Should there be more documentation of the position of the fetal head i.e. LOA, LOP, etc?

As a clinician, I believe we should be documenting the position of the fetal head at every exam once the patient is in active labor. This allows us to minimally intervene to aid in helping the fetus to an OA position, such as with maternal positioning in labor. In addition, if an operative vaginal delivery is being considered, it is required that the fetal position be known.

What incentives have you used to improve provider documentation?

There are many incentives and disincentives that can be used. From an incentive standpoint, adequate documentation will allow the most efficient care of their patient. From a disincentive standpoint, failure to comply with documentation is a credentialing issue that would require review at the time of a request for re-credentialing. Therefore, administrative support is required.

What about 5 contractions with an IUPC and contractions not strong enough?

While we predominantly defined hyperstimulation as more than five contractions, or six or more contractions, in a 10 minute window, locally defined definitions have also included that the contractions must be moderate to strong by palpation or that the patient must be in active labor, often defined as greater than 3-4 cm. This is in an effort to avoid labeling as hyperstimulation the high-frequency low amplitude contractions of the latent phase of labor, which are often dysfunctional.

What are your definitions of "non-elective" induction (other than the really clear-cut/obvious ones)?

During the initiation of bundle use I would leave your focus on elective induction. You can then begin to look at indications for induction, such as PIH. At the University of Vermont, we struggle with that and are currently sitting down to define PIH so that a single blood pressure in the office does not lead to induction. Regarding macrosomia or "impending macrosomia", the data available strongly support not inducing labor for this indication. Ample study supports that this results only in an increased rate of cesarean delivery.

Does the IHI have any staffing models based on the studies results?

All staffing models should reflect and incorporate the most current recommendations from standard based organizations such as AWHONN, ACOG, and the Perinatal Guidelines which also include input from the AAP.

Please speak to any differentiation between "adequate"/strong contractions and mild contractions with patient not making any cervical change - this is in reference to the definition of tachysystole.

See above; overall you want to exclude over-managing frequent mild contractions in the latent phase of labor. At the University of Vermont, we use moderate to strong contractions; others require cervical dilation greater than 3-4 cm. Look at your local culture and decide what works better. What the bundles are emphasizing with the tachysystole part is that tachysystole is recognized and a management plan is formed; it is not acceptable to "Pit to distress".

Is it appropriate to confirm of fetal lung maturity via amniocentesis if prior to 39 weeks?

This should be done if the laboratory and clinical parameters of gestational age do not support 39+0 weeks of gestational age. However, I do not feel the risk of amniocentesis, although small, is warranted for the elective delivery in order to proceed prior to 39 weeks. I think it would be difficult to defend a complication from an amniocentesis if the indication was to confirm fetal maturity prior to elective delivery prior to 39 weeks. There may be rare instances this may come up but it would get easy to blur that line.

How do organizations deal with situations where the doctor wants to induce prior to 39 weeks and thus provides an indication--PIH (normal bp's), ruptured membranes--no leaking, negative fern?

This becomes a different quality issue and one with which the hospital that needs to deal. The nurse is not expected to question the clinical honesty of a provider but should let their concerns be known. It is likely that this would carry over into other venues of which the administration should be very concerned. It would be important to make sure the clinician has documented his/her findings. We find that it becomes a different issue when we ask providers to document their findings of, for instance, rupture of the amniotic membranes, vs verbally telling someone. For instance, we have insisted that providers send their office records to L&D indicating the examination that confirmed ROM.

At the University of Vermont, we are currently sitting down and looking at PIH, for instance, in order to come up with definition that goes beyond one BP in the provider's office with normal pressures on L&D, no proteinuria, etc. I think there is justified disagreement here but one that can be worked through with all providers. Several of the IHI teams have incorporated a standing review of every record of patients who deliver prior to 39 weeks. This encourages learning from improvement and has been effective in changing certain patterns of behavior when the clinical diagnosis may not necessarily match the patient's record.

How strict should a hospital be with 39 weeks gestational age limit for elective inductions? What if you have a patient that is 38 6/7 weeks? 38 5/7? etc.?

39+0 is the consensus national recommendation. If you feel you can and want to electively deliver less than 39 weeks, like 38+5, than write a consensus document and protocol for your hospital with appropriate justification that allows you (and all other providers) to do that and have the obstetric powers that be and administration in your hospital sign off on it.

What is your opinion about inductions at 38 weeks for mom's with H/O large babies (elective induction for H/O macrosomia), and for diabetic moms where induction occurs at 38 weeks for various reasons.

Macrosomia and "pending macrosomia" as an indication for induction have been well vetted in the literature and the only outcome is an increase in cesarean section rate. It should not be accepted as an "indication" for induction; it is an elective procedure. In general, diabetics (insulin dependent) should be delivered prior to their due date. 38 weeks is acceptable (after mature amnio testing if all is clinically stable). Diet controlled gestational diabetics in good control do not have a higher perinatal risk prior to 41 weeks than the general population; therefore, induction is generally considered elective prior to 41 weeks.

In cases where the exact date of conception is known, such as in IVF pregnancies, can delivery date be moved to greater than or equal to 38 weeks?

The consensus for elective delivery is 39 weeks. While we are able to narrow the range of error of gestational dating with a myriad of clinical tools, there is growing evidence that neonates from 38 weeks have an increased risk of several clinical issues. Admission to NICU, hyperbilirubinemia, etc.(see above). There is also substantial clinical evidence that IVF pregnancies are different from normally conceived pregnancies and unless we have outcome data to show an equivalent outcome at 38 vs. 39 (which we don't) than we should wait until 39 +0 for elective delivery. In addition, if one is electively delivering by cesarean section, the rate of admission to the NICU will be increased due to TTN. If one is inducing labor in these pregnancies, there will be an increased risk of cesarean delivery, long labors, instrumented deliveries (all of which increase intracranial hemorrhage risk), chorioamnionitis, neonatal infection, etc. This data we have. I would also add here that patients do not have a positive right; that is, while they can demand we

(clinicians) do something that we feel is outside clinical care guidelines, we do not have to comply nor provide that care. They do have the negative right to refuse offered care, based on their right of autonomy.

Are the recommendations different for twin pregnancies?

Consensus guidelines (based on risks in twin pregnancies) state that delivery of twins should be considered by 38 completed weeks (without amnio). This is an indicated delivery.

Can you further define a discrepancy of 10 days between LMP and 18 week US? What is the correct date?

That is at the outside limit of error of the ultrasound when performed in a skilled unit. Clinical correlation is often required to decide on best dating. Generally this doesn't matter but if the patient is going to have an elective delivery, it would be safest to delivery at 39 weeks by the earliest gestational dating parameter. Not uncommonly when this occurs and we review dating with a patient, they state they are not that sure of their menstrual dating, leaving the ultrasound dating as the best parameter. All the genetic screening tools use ultrasound dating as it is more accurate on a population basis (it narrows the bell curve).

Please comment on the use of laborists? At what point does it make financial and clinical sense?

Each hospital has to decide on a cost/risk basis whether this works best in their setting. This is becoming more popular as the cost of doing business, particularly taking liability concerns into account, goes up. It standardizes care; anytime you standardize routine, your processes become more reliable. Overall, more standardized care and less variability results in more reliable systems. In the obstetric team based approach, this also occurs as all care is vetted in the "light of day" and appropriately questioned when not understood.

Please comment on defining decreased variability. The definition of reassuring fetal status is defined as variability of 6-15 bpm. A patient who has been given a narcotic, or who is on MgSo4 will have a decreased variability and may also need augmentation of the labor. Using this definition of variability, we will always fail. How do we deal with this?

Moderate variability is defined as 6-25 B/M, as you note below. In addition, variability is not the only component making up fetal reassurance (or lack thereof) and does not dictate fetal condition, especially as we know decrease or absent variability is a nonspecific marker for fetal hypoxemia. The full clinical picture is important when making an assessment of fetal status and that includes the medications which have been given to the patient. In addition, if a fetus shows moderate variability before the medication and there has not been intervening decelerations and it shows minimal or absent variability after the medication, the medication is the likely cause. Other aspects of the FHT then need evaluation, for instance a response to scalp stimulation or the presence of accelerations, to be reassured. Overall, in the development of hypoxemia (assuming the presence of contractions) in the truly pathologic state, late decelerations are the first concerning event seen, followed by loss of accelerations, then decreasing to absent variability plus or minus tachycardia prior to bradycardia and death. Understanding these chronologic events helps in the interpretation of fetal assessment in the presence of things like drugs that affect the variability.

I have reservations about the components of the bundle and their appropriateness and definition.

Importantly, while we offer evidence based guidelines, the final definitions within the bundles (that is, what you get "credit" for) is driven locally. This issue has also been discussed during other points in our communications.

When considering pelvic adequacy, what is the role in multiples for a pelvis that's "proven to..."?

Yes, there certainly is. If a patient delivered a 10 pounder and the EFW is now 8 pounds in this pregnancy and the patient has not had any intervening issues which would affect pelvic architecture (Pelvic fracture, development of lower segment fibroids) then the pelvis is defacto adequate.

Does even one late deceleration contraindicate induction in an otherwise reactive FHR strip?

Approximately 10% of patients have decelerations that appear to be late in configuration. The importance of any deceleration is the persistent and consistent nature of them, if they are truly pathologic, as it is unlikely the chronic placental insufficiency, for instance, will get better before the next contraction. However, acute events do improve, such as late decelerations in a patient hypotensive from an epidural bolus. That should be managed conservatively and will most likely improve with appropriate care. A single deceleration of any type does not preclude induction but may be concerning enough to indicate delivery via induction.

In a nonacademic center with all independent practitioners how do you get buy in for the bundles when some physicians do not agree with some of the components (i.e. 39 weeks)?

Each component is driven by data. If, for instance, an individual does not want to wait until 39 weeks for elective deliveries, that individual needs to write a protocol for delivery prior to 39 weeks, sign their name to it and vet it through the OB and administrative channels in your hospital. We are not dictating care but we expect an individual to be accountable for the care they deliver. As we gain more data on the difference between 38 and 39 weeks, it is becoming better and better supported that increases in NICU referral and other morbidities are increased in the group delivered prior to 39 completed weeks (39+0). Then the powers that be have to decide to accept this individual's variance or not.

Do you have specific parameters for how to define "High Risk"? For example: is it just maternal issues or do they become high risk when you see certain FHR patterns.

High risk is a loose term that generally is used for fetal or maternal risks higher than the general population.

Please explain why amniocentesis is needed for GA>39 wk, when ACOG guideline does not recommend unless less than 39wk

Amniocentesis should be performed for confirmation of fetal maturity in patients undergoing elective deliver at greater than 39 weeks if they do not fulfill the dating criteria spelled out in the ACOG information. For instance, a patient presenting for care at 32 weeks, when the error of the ultrasound is + or - 3 weeks would not be considered as having dating that supports fetal maturity if delivered electively at, for instance 39+5 weeks.

In a multi-provider system how do you ensure compliance with documentation, particularly among physicians?

You need to review the documentation. For instance, if you are referring to bundle compliance documentation, chart review needs to be performed to identify areas for improvement.

Can you site the evidence for harm with tachysystole without fetal compromise?

As you stated, there is not harm if there is no fetal compromise. However, persistent tachysystole does lead to uterine rupture, on rare occasions, which would incur an acute fetal and maternal compromise and associated morbidity so the identification and management of the tachysystole is an important step in prevention of this clinical event. We also know that any placenta/baby dyad can be stressed enough by contraction activity to produce fetal compromise. As tachysystole is a complication of pitocin therapy and

we do not want to wait until the fetus is compromised, we are obliged to identify the tachysystole and manage it, as we would the complication of any medicine we use.

What about strips that are tachycardic. Also in the case of mothers that are febrile? What then it would be an automatic fail?

You have described clinical situations which have a higher risk of non-reassuring fetal assessment and true fetal hypoxemia. You need to identify fetal reassurance if you are going to move ahead with pitocin use in this setting. An understanding of fetal response to developing hypoxemia (above) helps in these situations. Clinically, Tylenol is often used in these clinical settings in order to lower maternal and fetal temp and pulse to facilitate in interpretation of the fetal state.

If a patient reports for induction and contractions are present, is this case now to be classified as an augmentation?

Induction is generally defined as the use of uterotonics in order to initiate uterine contractions before the onset of spontaneous labor. As we do not well define the start of labor, this is open to some interpretation. In general, at my hospital, labor is considered induced if a patient has not begun active labor and augmented for slow or stalled progress in the active phase.

What is the recommended documentation for a strip-signed monitor strip and/or chart documentation?

Both are acceptable, depending on your clinical set up. There is no consensus on this issue.

Elective inductions are an expectation of our physicians and patients, how do we utilize the tools and literature provided to build a safe, effective elective induction program?

Elective induction is recognized as having a place in obstetric care. Each hospital needs to identify the safe way to perform this care and the bundles outline an evidence based approach that can be used and individualized for each hospital setting in order to have a reliable means of safely offering this option.

How would you respond to the practice of "pitting through contraction patterns?" This would be increasing the pitocin when the contractions are close, but not strong, and the FHR looks great.

This is the larger problem and comes into the definition of tachysystole. We recognize it is not just a frequency issue as high frequency low amplitude contractions are frequently seen with labor inductions before the patient is in active labor. You may choose to use the frequency definition (> or equal to 6 contractions in a 10 minute window) plus require either mod to strong contractions (palpable) or the patient beyond 3 or 4 centimeters. This helps to avoid responses to frequency alone issues where there is no fetal concern.

Please comment on the use of terbutaline for tachysystole that does not respond to other interventions

Well published and accepted. I would not use terbutaline when there is no immediate fetal concern as the short half-life of pitocin will deal with the hyperstimulation with pitocin being discontinued or reduced.

Can you comment on the use of cervical ripening agents: cervidil, misoprostol, foley balloon catheter based on bishop score, duration of time Pitocin induction, and birth trauma resulting in NICU admission? Thanks!

Cervical ripening agents (any) do not decrease the cesarean risk associated with induction. Therefore, the bishop's score prior to the ripening agent still is the predictor of induction success or failure. The use of cervical ripening agents does decrease the induction to delivery interval by 1-2 hours.

Can you summarize a good response to those who see this as "cookbook medicine?" Thanks!

Every patient needs their care individualized because their situation is unique. However, obstetric care is made up of many components brought to a given patient as required by their clinical situation; that's the clinical skill. If one insists on calling consistently and reliably performing those components of care (once they are decided upon) that are well vetted in the literature and generally universally agreed upon as necessary for appropriate and safe care, "cookbook", so be it. And if this is not believed, look at the myocardial infarction data where there is still a failure to give B-blockers and aspirin up to 40% of the time. General Note: There is no current standard for EFM strip documentation. If you are using NICHD definitions, the assessment can be reflected in the chart or on the strip, assuming you are using paper strips. As electronic strips and storage are becoming more popular, notations right in the electronic EFM records are being used.