FOR THE MANAGEMENT OF LABOR, PATIENCE IS A VIRTUE
ROBERT L. BARBIERI, MD
(EDITORIAL; AUGUST 2017)

Questions value of ACOG/SMFM guidelines

The labor management guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG) and the Society of Maternal-Fetal Medicine (SMFM) are terrible. Now retired, I trained in 1959–1963. In my career as an obstetrician, my primary cesarean delivery rate was 10% or less, and part of that was external pressure from people who did not know how to deliver a baby. Persistent occiput posterior position is a problem of inadequate flexion of the head, often due to ineffective contractions earlier. In such a situation, "pit" early! Rotate the head if you must, and teach residents how, please. The guidelines do not discuss the exhausted mother who goes home after a long labor or hours of pushing. I have interviewed new obstetricians in my community as early as 1980 who did not know what deep transverse arrest was. There, I am done voicing my disgust with obstetrics as it is practiced today.

James Honig, MD
Merritt Island, Florida

Managing difficult labor scenarios

I concur with Dr. Barbieri's views on labor management that watchful waiting and giving the patient adequate time to progress naturally is the key to increase the chances of vaginal delivery. After all, labor is a physiologic process and should progress naturally. Having said that, I would like to know Dr. Barbieri's views on handling certain circumstances in which patients these days land in the labor room, including 1) postdated

DECEMBER 2017

pregnancy with reduced fetal movements and not in labor; 2) full-term/postterm pregnancy with free-floating head and poor Bishop score; 3) full-term pregnancy with niggling pains for more than 1 week; and many such conditions that place you in the dilemma of whether to induce, knowing that chances of failure are high.

Manju Hotchandani, MD
New Delhi, India

Midwives always use patience to guide labor

As a Certified Nurse-Midwife since 1985 (now retired), "patience" in managing labor has always been my guide, as it has been for my midwifery colleagues. This is another example of ACOG finally acknowledging the truths we women have always known, without crediting the wisdom of midwives over the centuries. Lamaze International's 6 Healthy Birth Practices also must have been their guide. "Evolving concepts of normal labor progress," as though this was new information, would be humorous if it were not so frustrating!

Marsha Kelly, CNM
Charlotte, North Carolina

Dr. Barbieri responds

The readers of OBG MANAGEMENT have vast clinical experience, and we can all learn from their insights and guidance. On behalf of all our readers, I thank Drs. Honig and Hotchandani and Ms. Kelly for taking the time to share their expert advice.

Every clinician involved in the birth process is deeply committed to a safe delivery for both mother and baby. Clinicians guide the birth process based on the unique characteristics and needs of each woman. Dr. Honig advocates for the active management of the labor process, while Ms. Kelly advocates for less intervention. Both approaches to labor management may be optimal depending on the unique clinical needs of each woman. Dr. Hotchandani inquires about managing common obstetric presentations. In my practice, induction is recommended for all women postterm who report consistently reduced fetal movement with the goal of reducing the risk of sudden intrauterine fetal demise. For healthy women at term with painful contractions and reassuring fetal status, but no cervical change, we support and counsel the patient and offer therapeutic rest with morphine. For women at term with a floating head and poor Bishop score, we would not intervene, until 41 weeks' gestation when we would initiate gentle cervical ripening with mechanical or pharmacologic treatment.

WE WANT TO HEAR FROM YOU!

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Please include the city and state in which you practice.