Study shows national movement against non-medically indicated deliveries prior to 39 weeks

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A national movement to eliminate non-medically indicated (NMI) delivery before 39 weeks has prompted nearly two-thirds of all U.S. hospitals handling non-emergency births to adopt specific policies against the practice, according to new research from the Perelman School of Medicine at the University of Pennsylvania. The results of the nationwide survey represent a strong step in promoting maternal and perinatal health, and reducing the number of infants requiring admission to the neonatal intensive care unit (NICU). The full results of the survey are being presented today at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists.

Historically, babies born 37 weeks into gestation were considered "full term" and were thought to have the same risk of complication as those born at 38 or 39 weeks. However, recent data demonstrates that babies born at 37 or 38 weeks actually have higher complication rates than those delivered at 39 weeks. These babies born "near term" tend to have higher rates of respiratory distress syndrome and other complications requiring admission to the NICU.

As a result of the increased risk, ACOG has issued guidelines recommending that NMI delivery not be performed prior to 39 weeks gestation, as determined by appropriate pregnancy dating criteria. Though there has been a nationwide movement, including many state-wide initiatives, to increase awareness about the harm that NMI

deliveries can cause, these elective early deliveries continue to occur.

"Our results show that most hospitals do recognize the issues with early elective delivery, or non-medically indicated delivery prior to 39 weeks, and are adopting policies to prevent the practice," said Nathaniel G. DeNicola, MD, Robert Wood Johnson Clinical Scholar at the Perelman School of Medicine at the University of Pennsylvania, and lead author on the study. "State quality collaboratives and guidelines represent effective tools in raising awareness and promoting hospital policy adoption. However, variability still exists and barriers to compliance with ACOG guidelines are not well defined. These inconsistencies allow for flexible interpretation on how these hospital policies should be structured."

Researchers contacted all U.S. hospitals – including Washington DC and – with a registered labor and delivery unit (n = 2,641) to determine, via telephone interview with a nurse or nurse manager, the hospital's specific policy regarding timing of NMI delivery. The goal of the survey was to detail each hospital's policy, what type of policy exists, and the regions in greatest need of targeted intervention. Of the responding hospitals (n = 2,367), the majority (66.5 percent) reported having a formal policy in place against the practice, and 33.5 percent reported no policy. Of the hospitals without a formal policy, 53 percent said that NMI deliveries are against their standard of care. Of the hospitals with a formal policy, 69 percent said they had a "hard-stop" policy, a strictly enforced hospital policy against NMI deliveries less than 39 weeks.

DeNicola says the survey results show regional differences among states as a strong contributing factor to policy variation among hospitals. Policy variation, he says, may be explained by several influences such as regionalized practice norms within medicine, local hospital alliances, and state quality collaboratives. Further investigation into the states that have effective quality collaboratives may serve as useful models for states or

regions that have not yet seen widespread adoption of NMI policies.

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