Six is the New Four: A Review of the Safe Prevention of the Primary Cesarean Delivery Consensus Report

Richard Waldman, MD, FACOG
REACHE Conference
Seattle, Washington March 20, 2015

Objectives

1. List two reasons why the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine developed a “Consensus for the Safe Prevention of Primary Cesarean Delivery.

2. Describe the definition and management of abnormally progressing first-stage labor.

3. Describe the definition and management of abnormal second-stage labor.
WHY IS THIS TOPIC IMPORTANT

1. Increased frequency of cesarean sections.
2. Failure to progress in labor is a major indication for the first cesarean.
3. Vaginal birth after cesarean section (VBAC) rate has decreased markedly thus making the prevention of the first cesarean much more important.
4. The Friedman curve has been replaced by the “Zhang curve”.
5. Increased public, payor, and government attention.

CESAREAN SECTIONS HAVE DRAMATICALLY INCREASED SINCE VBAC RATE DECREASE

Cesarean delivery rates vary considerably among US hospitals

Delivery volume and cesarean rates in US hospitals
Overall and by size, teaching status, and location, 2009

<table>
<thead>
<tr>
<th></th>
<th>All hospitals (n = 593)</th>
<th>Small hospitals (n = 131)</th>
<th>Medium hospitals (n = 179)</th>
<th>Large hospitals (n = 278)</th>
<th>Teaching hospitals (n = 142)</th>
<th>Rural hospitals (n = 185)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of obstetric deliveries</td>
<td>1378</td>
<td>581</td>
<td>1151</td>
<td>1926</td>
<td>2682</td>
<td>450</td>
</tr>
<tr>
<td>Mean cesarean delivery rate</td>
<td>32.8%</td>
<td>32.0%</td>
<td>32.3%</td>
<td>33.4%</td>
<td>32.6%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Mean lower-risk cesarean delivery rate</td>
<td>12.0%</td>
<td>12.1%</td>
<td>11.9%</td>
<td>12.1%</td>
<td>11.4%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Adapted from Health Aff; 2013;32(9):630.
INDUCTIONS HAVE BEEN INCREASING

- 23.9% of pregnancies resulted in an induction of labor in 2009, representing a 2.6 X increase since 1990. (1)

**Delaware Hospital**
- 44% induction rate (40% of the inductions were elective)
- 7,804 nulliparous women (2)

---

4. Labor Induction and the Risk of a Cesarean Delivery Among Nulliparous Women at Term. Ehrenthal, Deborah B. MD; Jiang, Xiaohong MD, MS; Strobino, Donna M. Ph

---


![Graph showing cesarean section and labor induction rates by week of gestation, 1992 and 2002.](image)

Source: NCHS, Final Natality Data, Prepared by March of Dimes Perinatal Data Center, April 2006.
IMPACT OF INDUCTION ON CESAREAN RATES

INDUCTIONS OF LABOR ARE PARTIALLY BUT SIGNIFICANTLY RESPONSIBLE FOR THE RISE IN THE CESAREAN DELIVERY RATE

- Nearly 3 times more likely to undergo cesarean when cervical ripening agents were used.

- For nulliparous patients, relative risk of cesarean delivery with elective induction 2.6X

- Nulliparous women undergoing elective induction of labor with low Bishop score face almost a 50% risk of cesarean delivery

1. Complications of labor induction among multiparous women in a community-based hospital system
   Presented at the 26th Annual Meeting of the Society for Maternal–Fetal Medicine, Miami, FL, Jan. 29-Feb. 4, 2006.

2. Obstetrics & Gynecology: July 2010 - Volume 116 - Issue 1 - pp 35-42
   Labor Induction and the Risk of a Cesarean Delivery Among Nulliparous Women at Term
   Ehrenthal, Deborah B. MD; Jiang, Xiaochang MD, MS; Strobino, Donna M. Ph

---

**Fig. 3.** Indications for primary cesarean delivery. [Data from Barber EL, Lundsberg LS, Belanger K, Pettke CM, Funai EF, Illuzzi JL. Indications contributing to the increasing cesarean delivery rate. Obstet Gynecol 2011;118:29–38]

- Labor arrest 34%
- Preclampsia 3%
- Nonassuring fetal tracing 23%
- Macrosomia 4%
- Malpresentation 17%
- Maternal-fetal 5%
- Maternal request 3%
- Multiple gestation 7%
- Other obstetric indications 4%
SUMMARY

• C/S rate is high, labor arrest #1
• VBAC rate is low
• Induction rates have been increasing
• Inductions lead to more c/s
• Wide variation in induction rates an C/S rates

Friedman Curve

• In his landmark publications, Friedman was the first to depict a labor curve and divide the labor process into several stages and phases.
• Abnormal labor progression in the active phase was defined as cervical dilation less than 1.2 cm per hour in nulliparous women and less than 1.5 cm per hour in multiparous women.
• No appreciable change in cervical dilation in the presence of adequate uterine contraction more than 2 hours was considered as labor arrest.
• These concepts have come to govern labor management.
Friedman Curve is Obsolete

Created 60 years ago & no longer be applicable to contemporary obstetric populations and for current obstetric management.

Consortium on Safe Labor
- Multicenter,
- Retrospective,
- Observational study that
- Abstracted detailed labor and delivery information from electronic medical records in 12 clinical centers (with 19 hospitals)

Contemporary Patterns of Spontaneous Labor With Normal Neonatal Outcomes
Zhang, Jun PhD, MD; Landy, Helain J. MD; Ware-Branch, D. MD; Burkman, Ronald MD; Haberman, Shoshana MD, PhD; Gregory, Kimberly D. MD; Ramirez, Mildred M. MD; Barnik, Jennifer L. MD, MPH; Gonzales-Quintero, Victor M. MD, MPH; Hoffmann, Judith L. MD; Hoffman, Matthew K. MD, MPH; Kolanskiwski, Michelle MD; Learman, Lee A. MD, PhD; Van Velthuizen, Paul PhD; Troendle, James PhD; Reddy, Uma M. MD, MPH; for the Consortium on Safe Labor:

Obstetrics & Gynecology
December 2010 - Volume 116 - Issue 6 - pp 1281-1287
HOW DID WE GET HERE?

- METHODS: A total of 62,415 parturients were selected who had a singleton term gestation, spontaneous onset of labor, vertex presentation, vaginal delivery, and a normal perinatal outcome.

- CONCLUSION: Allowing labor to continue for a longer period before 6 cm of cervical dilation may reduce the rate of intrapartum and subsequent repeat cesarean deliveries in the United States.
From 4–6 cm, nulliparous and multiparous women dilated at essentially the same rate.
Table 2. Duration of Labor in Hours by Parity in Spontaneous Onset of Labor

<table>
<thead>
<tr>
<th>Cervical Dilation (cm)</th>
<th>Parity 0 (n=25,624)</th>
<th>Parity 1 (n=16,753)</th>
<th>Parity 2+ (n=16,219)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4</td>
<td>1.8 (8.1)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4-5</td>
<td>1.3 (6.4)</td>
<td>1.4 (7.3)</td>
<td>1.4 (7.0)</td>
</tr>
<tr>
<td>5-6</td>
<td>0.8 (3.2)</td>
<td>0.8 (3.4)</td>
<td>0.8 (3.4)</td>
</tr>
<tr>
<td>6-7</td>
<td>0.6 (2.2)</td>
<td>0.5 (1.9)</td>
<td>0.5 (1.8)</td>
</tr>
<tr>
<td>7-8</td>
<td>0.5 (1.6)</td>
<td>0.4 (1.3)</td>
<td>0.3 (0.9)</td>
</tr>
<tr>
<td>8-9</td>
<td>0.5 (1.4)</td>
<td>0.3 (1.0)</td>
<td>0.3 (0.9)</td>
</tr>
<tr>
<td>9-10</td>
<td>0.5 (1.8)</td>
<td>0.3 (0.9)</td>
<td>0.3 (0.8)</td>
</tr>
<tr>
<td>Second stage with epidural analgesia</td>
<td>1.1 (3.6)</td>
<td>0.4 (2.0)</td>
<td>0.3 (1.6)</td>
</tr>
<tr>
<td>Second stage without epidural analgesia</td>
<td>0.6 (2.8)</td>
<td>0.2 (1.3)</td>
<td>0.1 (1.1)</td>
</tr>
</tbody>
</table>

Data are median (95th percentile).

**THE 95TH PERCENTILES**

Duration of labor from one centimeter of dilation to the next. 4 cm, it could take more than 6 hours to progress to 5 cm, at 5 cm, it may take more than 3 hours to progress to 6 cm.

Surprisingly, the medians and 95th percentiles of duration of labor before 6 cm were similar between nulliparous and multiparous women.
Table 2. Duration of Labor in Hours by Parity in Spontaneous Onset of Labor

<table>
<thead>
<tr>
<th>Cervical Dilation (cm)</th>
<th>Parity 0 (n=25,624)</th>
<th>Parity 1 (n=16,755)</th>
<th>Parity 2+ (n=16,219)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–4</td>
<td>1.8 (8.1)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4–5</td>
<td>1.3 (6.4)</td>
<td>1.4 (7.3)</td>
<td>1.4 (7.0)</td>
</tr>
<tr>
<td>5–6</td>
<td>0.8 (3.2)</td>
<td>0.8 (3.4)</td>
<td>0.8 (3.4)</td>
</tr>
<tr>
<td>6–7</td>
<td>0.6 (2.2)</td>
<td>0.5 (1.9)</td>
<td>0.5 (1.8)</td>
</tr>
<tr>
<td>7–8</td>
<td>0.5 (1.6)</td>
<td>0.4 (1.3)</td>
<td>0.4 (1.2)</td>
</tr>
<tr>
<td>8–9</td>
<td>0.5 (1.4)</td>
<td>0.3 (1.0)</td>
<td>0.3 (0.9)</td>
</tr>
<tr>
<td>9–10</td>
<td>0.5 (1.8)</td>
<td>0.3 (0.9)</td>
<td>0.3 (0.8)</td>
</tr>
<tr>
<td>Second stage with epidural analgesia</td>
<td>1.1 (3.6)</td>
<td>0.4 (2.0)</td>
<td>0.3 (1.6)</td>
</tr>
<tr>
<td>Second stage without epidural analgesia</td>
<td>0.6 (2.8)</td>
<td>0.2 (1.3)</td>
<td>0.1 (1.1)</td>
</tr>
</tbody>
</table>

Data are median (95th percentile).

Duration of labor from one centimeter of dilation to the next. Only after 6 cm did multiparous women show faster labor than nulliparous women, which is consistent with the labor curves.

Fig. 4. Average labor curves by parity in single term pregnancies with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes. Abbreviations: P0, nulliparous women; P1, women of parity 1; P2+, women of parity 2 or higher. (Modified from Zhang J, Lande HJ, Branch GW, Bukman R, Hiebeman S, Gregory RD, et al. Contemporary patterns of spontaneous labor with normal neonatal outcomes. Consortium on Safe Labor. Obstet Gynecol 2010;116:761–71)
Friedman Curve: An Obsolete Approach to Labor Assessment

**MARKED DIFFERENCES:**
- Anesthesia and augmentation are much more common
- Birth and maternal weights have increased substantially
- Methodological differences: Friedman actually plotted 500 individual curves and then synthesized them into 1 curve, whereas the current researchers used repeated-measures analysis with 10th-order polynomial function
- Friedman curve likely represents an ideal, rather than an average.

"Because they are contemporary and robust, it seems that the Consortium on Safe Labor data, rather than the standards proposed by Friedman, should inform evidence-based labor management"

Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery

---

The consortium on safe labor data do not directly address an optimal duration for the diagnosis of active phase protraction or labor arrest, but do suggest that neither should be diagnosed before 6 cm of dilation.
MICHELE ODENT: YOU DO NOT LOOK LIKE YOU ARE IN LABOR”!

95th percentiles of cumulative duration of labor from admission among singleton term nulliparous women

SUMMARY

- Normal labor is much slower than Friedman thought.
- Active phase starts at 6 cm’s not 4cm’s
- Active phase protraction or labor arrest, should not be diagnosed before 6 cm of dilation.
- The surgeon from France (Odent) was right!
• Preventing the First Cesarean Delivery: Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, SMFM, and ACOG Workshop

Spong, Catherine Y. MD; Berghella, Vincenzo MD; Wenstrom, Katharine D. MD; Mercer, Brian M. MD; Saade, George R. MD

"With more than one third of pregnancies in the United States being delivered by cesarean and the growing knowledge of morbidities associated with repeat cesarean deliveries, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the Society for Maternal-Fetal Medicine, and the American College of Obstetricians and Gynecologists convened a workshop"

---

"Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused."

Aaron B. Caughey, MD, PhD; Alison G. Cahill, MD, MSCI; Jeanne-Marie Guise, MD, MPH; and Dwight J. Rouse, MD, MSPH.
• Cesarean delivery is the most commonly performed major surgery in the United States (more than 1 million surgeries each year.)
• In 2007, 26.5% of low-risk women giving birth for the first time had a cesarean delivery.
• A large population-based study from Canada found that the risk of severe maternal morbidities—increased threefold for cesarean delivery as compared with vaginal delivery (2.7% versus 0.9%, respectively)(CMAJ 2007;176:455–60)
• Risk of Placenta Previa/ Accreta and repeat cesarean sections

Thus, although the initial cesarean delivery is associated with some increases in morbidity and mortality, the downstream effects are even greater because of the risks from repeat cesareans in future pregnancies.

Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery

• Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed.
• The most common indications for primary cesarean delivery is labor dystocia.
• Contemporary labor progresses at a rate substantially slower than what was historically taught.
WHAT IS THE APPROPRIATE DEFINITION OF ABNORMALLY PROGRESSING FIRST-STAGE LABOR?

FIRST STAGE OF LABOR

• A prolonged latent phase (eg, >20 h in nulliparous women and >14 h in multiparous women) should not be indication for cesarean delivery.

1B
Strong recommendation, moderate-quality evidence
FIRST STAGE OF LABOR

Slow but progressive labor in first stage of labor should not be indication for cesarean delivery!

1B

Strong recommendation, moderate-quality evidence

FIRST STAGE OF LABOR

Cervical dilation of 6 cm should be considered threshold for active phase of most women in labor. Thus, before 6 cm of dilation is achieved, standards of active-phase progress should not be applied.

1B

Strong recommendation, moderate-quality evidence
FIRST STAGE OF LABOR

Cesarean delivery for active-phase arrest in first stage of labor should be reserved for women ≥6 cm of dilation with ruptured membranes who fail to progress despite 4 h of adequate uterine activity, or at least 6 h of oxytocin administration with inadequate uterine activity and no cervical change.

1B Strong recommendation, moderate-quality evidence.

SECOND STAGE OF LABOR

A specific absolute maximum length of time spent in the second stage of labor beyond which all women should undergo operative delivery has not been identified.

1C Strong recommendation, Low-quality evidence
SECOND STAGE OF LABOR

• Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for the following:
  • At least 2 hours of pushing in multiparous women (1B)
  • At least 3 hours of pushing in nulliparous women (1B)
  • Longer durations may be appropriate on an individualized basis (eg, with the use of epidural analgesia or with fetal malposition) as long as progress is being documented. (1B)

6 is the new 4
At least 2 is the new 1
At least 3 is the new 2
PREVENTING THE FIRST CESAREAN DELIVERY

1. Labor induction should be **performed primarily for medical indication**;
2. Elective (nonmedical) inductions, the gestational age should be at least 39 weeks or more and the cervix should be favorable, especially in the nulliparous patient.
3. Diagnosis of “failed induction” should only be made after an adequate attempt.
4. **Adequate time** for normal latent and active phases of the first stage, and for the second stage, should be allowed as long as the maternal and fetal conditions permit. The adequate time for each of these stages appears to be longer than traditionally estimated.

INDUCTION OF LABOR

- If the maternal and fetal status allow, cesarean deliveries for failed induction of labor in the latent phase can be avoided by allowing longer durations of the latent phase (up to 24 hours or longer) and requiring that oxytocin be administered for at least 12–18 hours after membrane rupture before deeming the induction a failure.
CONCLUSION: The latent phase of labor is significantly longer in induced labor compared with spontaneous labor, although the active phase of labor (greater than 6 cm) is similar between the two groups.

Arrest diagnoses before 6 cm in women undergoing induction should be made cautiously.

Obstetrics & Gynecology:
June 2012 - Volume 119 - Issue 6 - p 1113–1118

SUSPECTED FETAL MACROSOMIA
NON-DIABETIC POPULATION

262 pregnancies EFW >90%

<table>
<thead>
<tr>
<th>Elective group:</th>
<th>Spontaneous labor group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 57% cesarean delivery rate</td>
<td>– 31% cesarean delivery</td>
</tr>
<tr>
<td>• 5.3% shoulder dystocia</td>
<td>– 2.5% shoulder dystocia</td>
</tr>
<tr>
<td>• Does not reduce risk of shoulder dystocia</td>
<td>Routine induction of labor for macrosomia is not recommended.</td>
</tr>
<tr>
<td>• Doubles risk of cesarean delivery</td>
<td></td>
</tr>
</tbody>
</table>

Combs et al. Obstet Gynecol 1993; 81:492-496
Recommendations

- Cesarean delivery to avoid potential birth trauma should be limited to EFW of at least 5,000 grams in non diabetic and at least 4500 in women with diabetes. Women should be counseled that efw’s are imprecise.

Other Recommendations

- Fetal Presentation should be assessed and documented after 36 week gestation to allow for external cephalic version
  - Strong recommendation, moderate-quality evidence.
- Perinatal outcome for twin gestation in which twin a is cephalic are not improved by cd women should be counseled to attempt vaginal birth
Fetal Heart Monitoring

- Amnioinfusion for repetitive variable fetal heart decelerations may safely reduce the rate of CD
- Scalp Stimulation can be used as a means of assessing fetal acid base status when abnormal or indeterminate FH patterns are present and is a safe alternative to CD in this setting

OPERATIVE VAGINAL DELIVERY

In the second stage by experienced physicians should be considered a safe, acceptable, alternative to CD. Training in, and ongoing maintenance of practical skills related to operative vaginal delivery should be encouraged.
A study of more than 500 women found that extending the minimum period of oxytocin augmentation for active phase arrest from 2 hours to at least 4 hours allowed the majority of women who had not progressed at the 2-hour mark to give birth vaginally without adversely affecting neonatal outcome.


2012 COCHRANE META-ANALYSIS

- Induction of labor at 41 0/7 weeks of gestation and beyond was associated with a reduction in perinatal mortality when compared with expectant management.
- Therefore, before 41 0/7 weeks of gestation, induction of labor generally should be performed based on maternal and fetal medical indications.
- Inductions at 41 0/7 weeks of gestation and beyond should be performed to reduce the risk of cesarean delivery and the risk of perinatal morbidity and mortality.

INDUCTION OF LABOR

Before 41 0/7 weeks of gestation, induction of labor generally should be performed based on maternal and fetal medical indications.

Inductions at 41 0/7 weeks of gestation and beyond should be performed to reduce the risk of cesarean delivery and the risk of perinatal morbidity and mortality.

• 1A Strong recommendation, high quality evidence

FAILED INDUCTION
No Universal Standard

The key principle is to allow adequate time!

a) failure to generate regular contractions approximately every three minutes and cervical change after at least 24 hours of oxytocin administration. Membranes should be artificially ruptured, if safe and feasible. or

b) In this setting, failed induction can be defined as failure to generate regular contractions and cervical change with oxytocin administration for 12 hours after rupture of membranes

Membrane rupture and oxytocin administration, except in rare circumstances, should be considered prerequisites to any definition of failed labor induction, and experts have proposed waiting at least 24 hours in the setting of oxytocin and ruptured membranes before declaring an induction failed.
Cervical ripening methods should be used when labor is induced in women with an unfavorable cervix.

Numerous studies have found that the use of cervical ripening methods—such as misoprostol, dinoprostone, prostaglandin E2 gel, Foley bulbs, and laminaria tents—lead to lower rates of cesarean delivery than induction of labor without cervical ripening.

1. Cervical ripening lowers the rate of cesarean delivery compared with oxytocin induction alone.
2. Tachysystole notwithstanding, no method of cervical ripening (eg, the various available prostaglandin preparations, Foley catheter) is clearly superior to any other method.
CONCLUSION: Labor induction is significantly associated with a cesarean delivery among nulliparous women at term for those with and without medical or obstetric complications. Reducing the use of elective labor induction may lead to decreased rates of cesarean delivery for a population.

Elective induction of labor in nulliparas should be discouraged!!

- It has been widely assumed that induction of labor itself increases the risk of cesarean delivery. However, this assumption is predicated on a faulty comparison of women who are induced versus women in spontaneous labor.
- Studies that compare induction of labor to its actual alternative, expectant management awaiting spontaneous labor, have found either no difference or a decreased risk of cesarean delivery among women who are induced.
- This appears to be true even for women with an unfavorable cervix.
OXYTOCIN EXPOSURE DURING LABOR AMONG WOMEN WITH POSTPARTUM HEMORRHAGE SECONDARY TO UTERINE ATONY


- Women with severe PPH secondary to uterine atony were exposed to significantly more oxytocin during labor compared to matched controls. *American Journal of Obstetrics & Gynecology* Volume 204, Issue 1, January 2011

- A recent multicenter study conducted by the Maternal-Fetal Medicine Unit Network of the NICHD found that subjects with uterine atony following primary cesarean delivery were exposed to a longer duration of oxytocin compared to women without uterine atony
ACOG CHOOSING WISELY® CAMPAIGN

- Don’t schedule elective, non-medically indicated inductions of labor between 39 weeks 0 days and 41 weeks 0 days unless the cervix is deemed favorable.
- Ideally, labor should start on its own initiative whenever possible.
- Higher cesarean delivery rates result from inductions of labor when the cervix is unfavorable.
- Health care practitioners should discuss the risks and benefits with their patients before considering inductions of labor without medical indications.

Is this an important and significant problem?

- YES-involves a substantial proportion of obstetric practice in the United States
- Has quality and safety implications due to potential for increased maternal and neonatal morbidity
Crucial Conversations

• Can have a huge impact on the quality of your birth experience

• And therefore the quality of your life

Choices in Facing “Difficult” Conversations

1. Avoid

2. Handle Poorly

3. Face Them And Handle Well
IT TAKES TWO TO TANGO

1) at least two participants—physician and patient be involved;
2) both parties share information;
3) both parties take steps to build a consensus about the preferred treatment; and
4) an agreement is reached on the treatment to implement.

**Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)**
*Cathy Charles*

Barriers to Effective Communication

**Hierarchy issues:** Beliefs about who may speak to whom, both within and among clinical disciplines, limit access to informational and intellectual resources that can improve decision making and coordinated action.
Barriers to Effective Communication - the "Don'ts"

- Judgmental attitude
- Condescension, arrogance or submissiveness
- Excessive questioning
- False reassurances
- Insincere, stereotypical comments
- Emotionally charged or challenging language
- Negative body language - fidgeting, avoiding eye contact, tapping fingers, repeatedly glancing at your watch; assuming a higher position or stance

It Takes Skill

- In risky, controversial and emotional conversations it takes skill (education and training) to have a dialogue to get all the relevant information out on the table.
- Good dialogue allows an open an honest expression of feelings and the ability to articulate your belief system even if they are unpopular and against the grain
• Establish eye contact at the beginning

• Use “active listening” to clarify what the care giver says—that is, respond to cues about problems and concerns by clarifying and exploring them.

• Avoid interrupting before the care provider has completed important statements

Thank you!