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EDITORIAL

The Use of Protocols in Obstetrics and Gynecology

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There was, is, and there always will be a clamor for a protocol-based approach to treat acute conditions in Obstetrics and Gynecology. Conditions like post-partum hemorrhage, rupture of the uterus, abruptio placenta, ectopic pregnancy, and gestational trophoblastic neoplasm come to mind readily. At times, severe differences can arise when protocols of different "schools of thought" are sought to be debated, and rightly so. Questions then arise and with it some doubts. Does labor have to be "programmed?" Should epidural analgesia be administered only when the patient is in active labor? Can protocols be designed broadly for the condition and specifically altered for each individual? Should doctors be "forced" to follow protocols? Why protocols anyway?

Well, protocols are intended to allow for a systematic approach to a condition, to make sure serious mistakes and variations are not made in treatment, and to ensure that correct investigations are asked for, a contemporary well-documented method of treatment is instituted, and cost effectiveness maintained. Litigation may be prevented as well. A surgical safety checklist developed by Haynes et al. [1] for the WHO is an example of a protocol that can be useful before, during, and after surgery. Protocols or checklists can and should be used when there is some leeway for a procedural approach; however, in cases of a dire emergency, resorting to such an approach may be costly in term of loss of precious time, and in such cases learned memory and a robust "common sense" approach may be best suited. Pronovost et al. [2] described a protocol to reduce infections when introducing central venous catheters due to which the median infection rate at a typical ICU dropped from 2.7 per 1,000 to zero in 3 months. The protocol consisted of seemingly a simple approach of washing hands with soap; cleaning the patient's skin with chlorhexidine; putting sterile drapes over the whole patient; wearing sterile hat, mask, gown, and gloves; and putting a sterile dressing over the catheter site. A simple solution for a complex problem.

Protocols exist for the management of eclampsia, yet after the initiation of investigations and initial treatment, the condition of the patient and any existing complications that present, e.g., renal failure, disseminated intravascular coagulation, may indicate a delay for delivery; in other cases, labor may be induced or a cesarean section may be proceeded with promptly. Similarly, in cases of obstetric hemorrhage protocols, the use of packed red blood cells, fresh frozen plasma, and cryoprecipitate in certain ratios may be advocated, yet the anesthetist/intensivist managing a particular case may ultimately decide upon how the massive transfusion protocol needs to be administered. However, institution protocols and drills go a long way to ensure that a critical obstetric case is treated competently regardless of the individual in charge at that point in time. Maintaining a well-researched and documented protocol or a checklist for the management of labor is almost mandatory. This could include recording via the history and initial

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findings, the raising of "red flags"—previous cesarean section, diabetes, placenta previa, pregnancy-induced hypertension—the maintenance of a partogram, the correct use of oxytocics, a recording of intrapartum monitoring when deemed necessary, and a well-timed intervention to end labor. There are several established protocols for the use of oxytocin and any of these could be followed with good results. However, a protocol of hand washing, the use of sterile gowns, and a clean environment to maintain hygiene when delivery is conducted in the labor room is almost mandatory to prevent post-partum morbidity.

Protocols in the management of preterm labor could include documentation of contractions by cardiotocography, obtaining a high vaginal swab, a baseline ECG when tocolytics are considered, and the stoppage of treatment when uterine contractions are controlled. Likewise, the use of steroids in such cases is also dictated by several established protocols.

An ideal protocol that can be adopted universally is non-existent. Protocols can and should vary marginally depending on local resources and work ethic. However, some standardized methodology has to be adopted in every institution or nursing home so that the essentials are kept in sight and the endpoints of treatment are achieved. Protocols have to be reviewed and altered whenever necessary to maintain a "contemporary" value to treatment. No archaic treatment based on "experience" or anecdotal evidence will be tolerated by anyone anymore.

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