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Key Elements for Managing Shoulder Dystocia

Executive Summary

Sixteen hospitals throughout New York State responded to a request from ACOG District II to submit their written protocols regarding the management of shoulder dystocia. Although many contained excellent educational and instructional components, the committee did not identify a single protocol that could meet the needs of all hospitals in New York State.

Most of the submitted protocols lacked a systematic approach required to ensure an effective guideline or protocol. However, the District II Patient Safety Committee was able to identify key elements and model protocol language from four hospitals which may be useful as hospitals strive to further improve their shoulder dystocia protocols. The committee has chosen and enclosed protocol language from Arnot Ogden Medical Center, Nathan Littauer Hospital and Winthrop University Hospital.

The protocols should reflect current criteria used to manage deliveries at risk for or complicated by shoulder dystocia and should outline the treatment and maneuvers required during an emergency of shoulder dystocia. In addition to reviewing the submitted protocols, the committee used several resources to select ideal requirements for a comprehensive approach to the management of shoulder dystocia. Two of these included:

1. ACOG Practice Bulletin 40, Shoulder Dystocia (reaffirmed 2010)
2. ACOG Checklist for Documenting Shoulder Dystocia No. 6 (August 2012)

It is important that obstetrician-gynecologists take the lead in designing and collaboratively implementing standardized protocols and checklists in the hospital and the office setting. Each hospital must take into account the resources available within its own institution and community to design a protocol that will assist them in the optimal management of shoulder dystocia. Each institution is strongly encouraged to review its existing shoulder dystocia protocols, and modify them if necessary to maximize safe patient care, or if none exists consider the creation of a policy to optimize the management of shoulder dystocia.

Key Elements

The following is a list of the essential components of any protocol that is developed for the management of shoulder dystocia. **Hospitals should individualize their protocols based on an assessment of their own resources.**

- Definition & Risk Factors
- Monitoring & Pre-Delivery Preparations
- Diagnosis & Protocol Initiation
- Elements of the Protocol
- Debriefing
- Documentation

Medical literature demonstrates that when there are inadequate hospital protocols or there is a lack of consistent diagnosis, management, consultation, and/or referral, confusion and unnecessary variation in patient care may result.
Key Elements for Managing Shoulder Dystocia

**Purpose**

This document reflects emerging clinical, scientific and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. While the components of the protocols included in this document may be utilized as written, it is strongly recommended that they be reviewed in detail and adapted to local resources available within an institution as well as being modified if appropriate. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution.

Clearly explain the purpose of the protocol. The protocol should reflect current criteria used to manage deliveries at risk for or complicated by shoulder dystocia and should outline the treatment and maneuvers required during an emergency of shoulder dystocia.

**References**


**Definition & Risk Factors**

Shoulder dystocia is an event that occurs at delivery. Extra difficulty delivering fetal shoulders is encountered, requiring extra maneuvers.

Shoulder dystocia complicates 0.6 to 1.4% of vaginal deliveries of fetuses in the vertex presentation. Unfortunately, shoulder dystocia cannot be predicted or prevented because accurate methods for identifying which fetuses will experience this complication do not exist. Elective induction of labor or elective cesarean delivery for all women suspected of carrying a fetus with macrosomia is not appropriate. Planned cesarean delivery to prevent shoulder dystocia may be offered for suspected fetal macrosomia with estimated fetal weights exceeding 5000 gm in women without diabetes and 4500 gm in those with diabetes.

**Risk Factors associated with Shoulder dystocia:**

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Fetal</th>
<th>Labor Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal pelvic anatomy</td>
<td>Suspected macrosomia</td>
<td>Operative vaginal delivery</td>
</tr>
<tr>
<td>Gestational or Pre-Gestational Diabetes</td>
<td></td>
<td>Protracted active phase</td>
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<tr>
<td>Post-term pregnancy</td>
<td></td>
<td>Prolonged second stage</td>
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<tr>
<td>Previous shoulder dystocia</td>
<td></td>
<td>Precipitous delivery</td>
</tr>
<tr>
<td>Short stature (less than 5feet tall)</td>
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<tr>
<td>Obesity (&gt;200lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous large infant (&gt;4000grams)</td>
<td></td>
<td></td>
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<tr>
<td>Excessive weight gain</td>
<td></td>
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</tbody>
</table>

Permission to utilize sample protocol language obtained from: Winthrop University Hospital: Guidelines for Shoulder Dystocia; Nursing Procedure Manual (2010)
**Key Elements for Managing Shoulder Dystocia**

**Monitoring & Pre-Delivery Preparations**

Ensure adequate personnel are present in the delivery room.

1. Experienced care provider
2. Two labor and delivery nurses

Notify, NICU neonatologist, and anesthesiologist if the shoulder dystocia is suspected.

Ensure that the bed is in a lowered position or a stool is available to assist with specific maneuvers.

The care provider should discuss with the nursing personnel the sequence and maneuvers that might be performed.

Remember the mnemonic **BE CALM**, which outlines interventions for the nurse and provider, and stands for:

- **B**reathe, do not push. Lower the head of the bed and encourage the woman to breathe or pant.
- **E**levate the legs into McRobert’s position. McRoberts Maneuver (knee/chest position while supine) is hyperflexion and abduction of the maternal hips. This procedure straightens the lumbar sacral angle and rotates the symphysis pubis anteriorly to dislodge the anterior shoulder.
- **C**all for help. Initiate OB emergency plan; includes, but not limited to, the following:
  - Additional nursing staff (prepare for newborn resuscitation)
  - Physician able to perform c-section
  - Anesthesia provider
  - Pediatric provider
  - Respiratory therapy (assist with newborn resuscitation).
- **A**pply suprapubic pressure (NOT fundal pressure).

Enlarge the vaginal opening. Provider may perform a large episiotomy when additional maneuvers are necessary to allow for more room.

**Maneuvers**— additional maneuvers may be needed (and are performed by the (Licensed Independent Practitioner) and listed below:

- Delivery of the Posterior Arm
- Woods Corkscrew
- Rubin
- Gaskin
- Zavanelli

These maneuvers are designed to rotate the baby NOT to pull on the shoulders, which may result in birth trauma.

Nurse audibly signals each one (1) minute interval after delivery of fetal head (due to decreasing fetal pH of 04. per minute, making resuscitation very difficult after seven (7) minutes.

**CAUTION:** NEVER USE FUNDAL PRESSURE.
Key Elements for Managing Shoulder Dystocia

**Diagnosis & Protocol Initiation**

1. “Turtle sign” = retraction of the fetal head against the maternal perineum.
2. Difficulty or failure to accomplish external rotation of the head after it has passed the perineum.
3. Resistance to the delivery of the anterior shoulder with the usual amount of traction applied to the fetal head.

**Elements of the Protocol**

**STEP 1.** Inform those in the room of the clinical condition and ask for cooperation; call for assistant to help with the delivery; ask that Anesthesiology and Neonatology should be summoned into the room.

Have someone note the exact time and signal each minute of time that passes. Avoid forceful downward traction on the fetal head while attempting to deliver the infant. Fundal pressure is not useful and is counterproductive.

Communicate with those in the room (charge nurse; float nurse; patient, and family). Clear the room of all unnecessary items and have a step stool available.

Ensure the patient’s bladder is empty.

**STEP 2. First Line Maneuvers:** First line maneuvers may be done alone, in combination, or in sequence.

**McRobert’s Maneuver:** Have assistants sharply flex the patient’s legs against the abdomen (this results in straightening of the sacrum relative to the lumbar vertebrae with a cephalic rotation of the pelvis).

**Suprapubic Pressure:** Have an assistant apply a moderate suprapubic pressure obliquely to the anterior shoulder (This may help to dislodge the impacted anterior shoulder).

**Episiotomy:** If not performed previously, perform generous episiotomy or extend existing episiotomy as needed and repeat McRobert’s maneuver and suprapubic pressure (although the perineum is not the cause of the shoulder dystocia, an episiotomy can facilitate the performance of subsequent maneuvers and delivery).
Key Elements for Managing Shoulder Dystocia

Elements of the Protocol

(Continued)

STEP 3. Second Line Maneuvers: May be done in any sequence according to need.

**Delivery of the Posterior Arm:** Introduce a hand into the vagina along the fetal posterior humerus; maintain flexion at the elbow and sweep the arm across the fetal chest; the fetal hand is then grasped and the arm extended along the side of the face; the posterior arm is then delivered from the vagina (mechanism: the shoulders are rotated into an oblique diameter and subsequent delivery of the anterior shoulder and infant may be completed).

**Woods Corkscrew Maneuver:** Place a hand behind the posterior shoulder and rotate the posterior shoulder 180 degrees (this rotation will “corkscrew” the fetus out of the vagina).

![Image of delivery of the posterior arm](image)

**Rubin Maneuver:** Place a hand on the most easily accessible shoulder and push the shoulder toward the anterior surface of the fetal chest (this may result in abduction of both fetal shoulders and decrease the shoulder to shoulder dimension freeing the impacted anterior shoulder).

![Images of Rubin Maneuver](image)

Repeat first and second line maneuvers if the infant remains undelivered (repeating the maneuvers, listed in step 2 and 3 should be tired before proceeding to the following extraordinary maneuvers).

**Note:** There is no conclusive evidence that any particular management sequence is superior to another once the shoulder dystocia occurs. However, performance of McRobert's maneuver is a reasonable initial approach.
**Key Elements for Managing Shoulder Dystocia**

**Elements of the Protocol (Continued)**

**STEP 4. Extraordinary Maneuvers**

Last effort maneuvers that only should be used when the above steps are unsuccessful.

- **Fracture of the clavicle**: Deliberate fracture of the clavicle may be accomplished by pressing the anterior clavicle against the ramus of the pubis. Fractures of the clavicle usually heal rapidly without permanent sequelae.

- **Cephalic replacement**: (Zavanelli maneuver) return the fetal head to the OA or OP position; flex the fetal head and slowly push it back into the vagina. Uterine relaxation may be required for this maneuver, which is followed by emergency cesarean section.

- **Abdominal rescue**: If all maneuvers fail and unable to replace the fetal head into the vagina, a cesarean section can be performed to manually rotate the anterior shoulder into the oblique diameter; vaginal delivery is then accomplished (this results in a prolonged head-to-delivery interval and requires two skilled delivery attendants).

- **Symphysiotomy**: This should only be performed by individuals who have knowledge and experience in this procedure.

**Debriefing**

Following delivery, staff should debrief, analyze their actions, and confirm consistent documentation between nursing and practitioner notes. Debriefing helps to ensure accurate and complete documentation and that there are not disparate notes from the practitioners and the nurses. Use of a standardized form and/or checklist for shoulder dystocia delivery notes may provide the best solution to ensure appropriate documentation.

**Documentation**

- Type of delivery (spontaneous vs. instrumental)
- If instrumental, type of instrument, station and indication
- Anterior shoulder (right or left)
- Medication/anesthesia given
- Time of delivery of head and body
- Maneuvers used- sequence and duration of each
- Episiotomy— type and time
- Traction on vertex (none or standard)
- Personnel present
- Condition of the infant— Apgar scores, evidence of fractures and/or reduced movement of either arm
- Cord gasses sent
- Information given to the patient and her family

* Refer to the enclosed *ACOG Patient Safety Checklist Documenting Shoulder Dystocia, Number 6 August 2012*
Patient Safety Checklist

DOCUMENTING SHOULDER DYSTOCSIA

Date ___________  Patient __________________________  Date of birth ___________  MR # ___________
Physician or certified nurse–midwife __________________________  Gravidity/Parity __________________________
Timing:
Onset of active labor ___________  Start of second stage ___________
Delivery of head ___________  Time shoulder dystocia recognized and help called ___________
Delivery of posterior shoulder ___________  Delivery of infant ___________

Antepartum documentation:
- Assessment of pelvis
- History of prior cesarean delivery: Indication for cesarean delivery: __________________________
- History of prior shoulder dystocia
- Largest prior newborn birth weight ___________  History of gestational diabetes
- Cesarean delivery offered if estimated fetal weight greater than 4,500 g (if the patient has diabetes mellitus) or greater than 5,000 g (if patient does not have diabetes mellitus)

Intrapartum documentation:
- Mode of delivery of vertex:
  - Spontaneous
  - Operative delivery: Indication: __________________________
    - Vacuum
    - Forceps
- Anterior shoulder:
  - Right
  - Left
- Traction on vertex:
  - None
  - Standard
- No fundal pressure applied
- Maneuvers utilized (1):
  - Hip flexion (McRoberts maneuver)
  - Suprapubic pressure (stand on the side of the occiput)
  - Delivery of posterior arm
  - All fours (Gaskin maneuver)
  - Posterior scapula (Woods maneuver)
  - Anterior scapula (Rubin maneuver)
  - Abdominal delivery
  - Zavanelli maneuver
- Episiotomy:
  - None
  - Median
  - Mediolateral
  - Proctoepisiotomy
- Extension of episiotomy:
  - None
  - Third degree
  - Fourth degree
- Laceration:
  - Third degree
  - Fourth degree
- Cord blood gases sent to the laboratory:
  - Yes: Results: __________________________
  - No

(continued)
(continued)

- Status of neonate prior to leaving delivery room or operating room:
  - Apgar scores ______________ 
  - Evidence of injury ______________ 
  - Birth weight (if available) ______________ 
- Staff present ____________________________________________________________________________
- Family members present __________________________________________________________________
- Patient and family counseled __________________________________________________________________
- Debriefing with appropriate personnel

Postpartum/neonatal documentation:
- Delivery discussed with family __________________________________________________________________
- Perineal assessment if third or fourth degree laceration
- Monitored for postpartum hemorrhage:
  - Yes: Results: ____________________________________________________________________
  - No
- Communication with pediatrics department if there is evidence of injury or asphyxia
- Coordination of follow-up care for mother and baby
- Monitored for postpartum depression:
  - Yes: Results: ____________________________________________________________________
  - No

**Procedural Elements for Shoulder Dystocia**

The following steps should be taken when managing shoulder dystocia:
1. Call for help from pediatrics, anesthesia, and neonatal intensive care unit staff, and assign a timekeeper
2. Initiate maneuver (eg, McRoberts maneuver)
3. Re-evaluate course of actions, including using other maneuvers or repeating maneuvers if unsuccessful
4. Consider abdominal delivery
5. Document event—move to documentation checklist

**Reference**


**How to Use This Checklist**

The Patient Safety Checklist on Documenting Shoulder Dystocia should be used to guide the documentation process if a patient has experienced shoulder dystocia.
Preparing for Clinical Emergencies in Obstetrics and Gynecology

ABSTRACT: Patient care emergencies may periodically occur at any time in any setting, particularly the inpatient setting. To respond to these emergencies, it is important that obstetrician–gynecologists prepare themselves by assessing potential emergencies that might occur, creating plans that include establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify strengths and opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.

A practicing obstetrician–gynecologist may be faced with a sudden patient emergency at any time. Whether it is severe shoulder dystocia, catastrophic surgical or obstetric hemorrhage, or an anaphylactic reaction to an injection in the office, it will require prompt response. Preparation for potential emergencies requires planning. Issues to consider include advance provisioning of resources, establishing an early warning system, designating specialized first responders, and holding drills to ensure that everyone knows what to do in an emergency. Beyond these basics, certain principles of communication and teamwork will increase the efficiency and effectiveness of the emergency response.

Planning
Planning for potential emergency events is challenging. At a minimum, it should involve an assessment of the potential or actual risks related to the practice setting or the patient population. For example, in the outpatient setting, are medications given or procedures performed that may result in anaphylaxis, airway compromise, or hemorrhage? In the inpatient setting, unit data or risk management data may reflect common and uncommon emergency situations that have occurred.

Advance Provision of Resources in the Outpatient Setting
A common practice for health care–related emergencies is the availability of the crash cart. All physicians should be familiar with the crash cart. Placing all necessary items in a known, central location ensures that time is not lost gathering supplies in an emergency. Appropriate changes should be made to the crash cart as evidence-based changes are made to the Advanced Cardiac Life Support protocol. Advance provision of resources also may be extended, for example, to the management of eclampsia and malignant hyperthermia. Physicians in outpatient settings may wish to create a small kit for handling allergic reactions if they are not able to maintain a full crash cart. As with a crash cart, the kit must be checked regularly to ensure that perishable supplies have not been retained beyond expiration dates. All health care providers need to know how to use the allergic reaction kit.

Early Warning Systems in the Inpatient Setting
Some emergencies are truly sudden and catastrophic, such as a ruptured aneurysm, massive pulmonary embolus, or complete abruptio placentae in the setting of trauma. However, many emergencies are preceded by a period of instability during which timely intervention may help avoid disaster. The rapid response team is set up to handle such emergencies. However, even without the use of a rapid response team, nurses and other bedside caregivers need to recognize that certain changes in a patient’s condition can indicate an emergency that requires immediate intervention. These changes include some events not usually considered to be emergencies, such as agitation or
new onset difficulty with movement. Ideally, each service will examine its own historical call data to determine which events require activation of the early warning system. It is imperative that bedside personnel be able to request immediate help, without recrimination, when such changes occur. For example, the nurse who calls the rapid response team regarding the anxious postoperative patient with new onset shortness of breath must not be dismissed as failing to recognize a panic attack but instead praised for following protocol. The protocol should provide for a full evaluation of the problem. Some organizations have formalized the emergency communication process using a standardized communication tool, such as “SBAR” (Situation, Background, Assessment, and Recommendation); all health care providers are encouraged to follow it to clearly communicate the patient care issue. Standardized responses will increase the efficiency of care and allow a continuous quality improvement process to assess the effectiveness of the interventions.

Rapid Response Team
Medical emergency teams, otherwise known as rapid response teams, are designated emergency response teams. These teams of clinicians bring critical care expertise to the patient’s bedside or wherever it is needed. Activation of rapid response team intervention occurs when predefined criteria are met, although the team intervention also may be activated for other reasons. Rapid response team intervention should be a no-fault process. The team is available at all times with authority to summon further help as needed. By designating criteria that define an emergency, it becomes clear when to call for help. For example, if a maternal or postoperative heart rate of more than 140 beats per minute is the criterion, the nurse who notes such a heart rate would immediately call the medical emergency team. This contrasts with the common practice of calling an attending physician and awaiting a call back for orders before intervention. Activation of rapid response team intervention before a full arrest may lead to improved survival of hospitalized patients and decreased admissions to an intensive care unit (1). It is important to emphasize that if there is a teaching service, calling the house officer does not substitute for triggering rapid response team intervention. Similarly, calling the in-house physician in a nonteaching setting does not substitute activating rapid response team intervention. Rapid response teams usually have advanced practice nurses and respiratory therapists as first responders and are expected to respond to the problem in a standardized fashion.

The goal of standardized response and rapid effective recognition and correction of problems is better met with a small stable group. Development of a rapid response system is one of the patient safety initiatives currently being promoted by the Institute for Healthcare Improvement (2) and the Agency for Healthcare Research and Quality. Blueprints for setting up such a system, as well as other resources, may be found on the web sites of these organizations.

Establishing a rapid response system involves a multistep process (3–5). First, key staff must be identified for the response team. Second, the criteria for activation of intervention by the response team should be determined. Third, the staff involved with the rapid response system must be educated on their respective roles. Fourth, a means of evaluating feedback and process improvement must be established. Finally, the effectiveness of the rapid response system must be monitored. The rapid response system can be divided into four components: 1) activators, 2) responders, 3) quality improvement, and 4) administration (6).

The activators are those individuals who may activate the rapid response system. Activators may be floor staff, a patient, a family member, specialists, or anyone concerned about the condition of a particular patient. Team members from the nursing staff or floor staff are trained to monitor for disturbances in any indicators of acute distress. These indicators are determined by the individual medical treatment facilities.

Once the rapid response system is activated, the responders arrive at the bedside, along with the attending physician, to treat the patient and stabilize her condition. Responders will then determine the disposition of the patient. Options for this can include transfer to a higher level of care, a handoff to the primary team (nurse or physician or both), or revision of the current treatment plan. Activators may become responders to help aid in stabilizing the patient’s condition.

When the responders arrive, the activators must be prepared to exchange information. A communication protocol such as SBAR may be used. Using such a protocol allows the activators to exchange information with the responders in a clear and concise manner. This will help ensure that expeditious care is provided to the patient.

During the response phase, other tools may be implemented to help facilitate care for the patient. Before initiation of the response phase, a discussion, or brief, should be conducted to assign essential roles, establish expectations and climate, and anticipate outcomes and likely contingencies. The primary purpose of the communication protocol is to develop a common understanding of the patient’s issues so that a consensus for the patient’s treatment plan can be reached. A team huddle, designed to reinforce plans already in place and to assess the need to adjust the plan, also may be used to review situational awareness and to troubleshoot and revise the current plan of action, if needed. A check back, time out, or call out may be used to ensure closed-loop communication.

The quality improvement team supports activators and responders by reviewing the events surrounding the activation of the rapid response system and evaluating the process. An informal information exchange, or debrief, is designed to improve team performance and effectiveness as part of the action review. Once the review is complete,
the administration team then provides organizational resources to implement improvements in the process.

**Emergency Drills and Simulation**

The principle that standardized care can result in safe care applies to emergencies as well as to routine care. Thus, each service should consider a protocol for management of common emergencies, such as emergency cesarean deliveries or postpartum hemorrhage. This training may use a sophisticated simulated environment, but it also may use the everyday workspace in a mock event. Protocols also can be reinforced by being prominently displayed as posters, pocket cards, or other aids.

Using drills to train physicians to respond to emergencies has several theoretical advantages. Adult learning theory supports the importance of experiential learning. Emergencies occur in a specific physical setting and may involve a group of nurses, physicians, and other health care providers attempting to respond. By conducting a drill in a realistic simulator or in the actual patient care setting, issues related to the physical environment become obvious.

Emergency drills also allow physicians and others to practice principles of effective communication in a crisis. Many aspects of the medical environment work against effective communication, including the often hierarchical hospital structure, and the nature of the training, work setting, and the different educational backgrounds and levels of understanding of the health care team. Many physicians are accustomed to talking to nurses. Effective teamwork requires talking with each other. It requires that there be a team leader coordinating the response, but it also should empower all members of the team to share information. By practicing together, barriers hindering communication and teamwork can be overcome. Effective drills may lead to improved standardization of response, health care provider satisfaction, and patient outcomes.

Simulator training also may be beneficial with respect to identifying common clinical errors made during emergencies and correcting those deficiencies (7). Although this is promising, there are limited data to suggest that improved proficiency with simulation models correlates with increased proficiency during actual emergencies (8).

**Conclusion**

The obstetrician–gynecologist practices in an environment where true emergencies will periodically occur. Preparation for these in-hospital situations requires that emergency supplies be placed in locations well known to members of the rapid response team. In addition, the members of the rapid response team must clearly be defined. The criteria used to activate rapid response team intervention also must be clearly defined and disseminated among potential activators well in advance of any emergency. It is also important for members of the rapid response team to receive ongoing education and training regarding important changes in the management of any potential emergency to ensure maximal preparedness. The exact nature of the preparation will depend on the work environment and the resources available.

**References**


ACOG District II Patient Safety & Quality Improvement Committee

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