AIMS For a better birth...

Vaginal Examinations

What are Vaginal Exams?

During labour, it is normal NHS policy to offer vaginal examinations, sometimes called a VE. It is important to know that they are entirely optional. This Birth Information Page explains some of the reasons why VEs are offered, and their benefits and risks, to help you to decide whether or not you would like to have them.

A VE involves a midwife or doctor inserting their fingers (after taking measures to reduce infection, including wearing gloves) into your vagina to feel the cervix and any changes that might be happening. This may be for a number of reasons; some of the most common reasons for offering VEs are:

- To try to decide whether labour is 'established' or 'active'
- To try to track the progress of labour by seeing how the cervix is dilating, thinning and changing over time
- To help the midwife or doctor to judge the position of your baby and/or how they are moving through your birth canal

For any reason that VEs may be offered, the midwife or doctor is obliged to ensure that you completely understand these reasons before they perform a VE. If you decide to not have one, they have to support and respect that decision. Remember that you can also decline some and accept others. It's up to you.

It is important to know that although VEs are offered to almost every labouring woman or person, and they are often seen as an essential part of labour, they are not actually essential to the way labour is progressing and may not directly influence or dictate the outcomes for you or your baby. However, there is information that they can give, which may or may not be valuable to you and the caregivers looking after you. This article is intended to help you to decide what's right for you.

What do vaginal examinations feel like?

VEs are experienced very differently by everyone. Some people don't mind them. Others find them to be uncomfortable or painful. For others, having fingers inserted into their vagina can be a distressing experience; this is especially common for people who have experienced sexual abuse, although anyone

can feel this way. While the midwife or doctor may have seen hundreds or thousands of vaginas, they may have never seen your vagina. How you feel each time an examination is carried out will also change, and so you cannot be expected to react to them the same way each time.

VEs are often done with the labouring woman or person lying on their back, because this is usually how midwives and doctors are taught to do them. This can be challenging for those who don't want to move out of a position they're in, and lying on our backs can make labour more painful than other positions. It is therefore useful to know that it is possible to do a VE in any position. Just ask!

Do you have to have vaginal examinations?

It is very important to know that no one can ever put their fingers into your vagina without your consent - ever.

Legally, VEs can only happen if you freely consent to them. Whether or not you choose to do so is up to you.

There are several reasons that vaginal examinations may be offered, some of which are listed above. It is important to note, however, that someone does not have to have a VE before they are provided with care of any kind (for example access to hospital, use of the pool, access to pain relief). Demanding this does not provide people with the genuine, free ability to say "no" and therefore is not informed consent.

Using vaginal examinations to decide whether labour is 'active'

The term 'active labour', or, sometimes, 'established labour', is intended to refer to the time when labour is progressing, rather than stop-starting, and the cervix has opened past a certain point. The way that labour happens can be very different for different people. A person can be 1cm dilated and be experiencing extremely painful contractions for which they need pain relief, and already be in 'active' labour. Another person may be 6cm dilated but still be having very slow, on-off labour which isn't yet ready to progress. Every labouring woman or person is different and relying only on vaginal examinations can lead to people being told that they're not in established labour and not being given access to hospital, even though they're ready for some additional support.

Labouring women and people might then additionally be denied adequate or appropriate pain relief because they are not considered to be at the right stage of labour. Some of these concerns have been increased during the Covid pandemic where women are, or were, sometimes denied the support of their partner until classed as being in the right stage of labour (i.e. 'active labour'). Such practices of relying on vaginal examinations to determine pain relief may invalidate a person's own need for the support of their partner and midwives. To stress this point, the fact that people are not as dilated as the hospital's guidelines state they should be when in 'active labour' does not change their needs.

While we acknowledge the sometimes confusing discussions about what is or isn't active labour, there is

evidence to show that going into hospital too early in labour can lead to a higher number of interventions [1], which is something that you might want to consider. On the other hand, being turned away when you are seeking help can be very distressing. When deciding what is best for you, remember only *you* know how you feel and what you can cope with. We don't know for sure why women who are admitted to hospital earlier are more likely to have interventions. It might be that just being in hospital puts them on the track of the 'cascade of intervention'. However, it is also possible that some of those women who go to hospital earlier in labour do so because their instinct tells them that they need the additional help, and that they attend earlier because they need an intervention. The real answer is probably that both of these are what is happening.

The important thing to know is that you don't have to have a VE to access any service and services cannot be withheld from you if you decline a VE. Yet, VEs are often used to decide if someone is in active labour or not.

Using Vaginal examinations to estimate the progression of labour

It is very normal, when talking about birth, to hear the midwife or doctor mention the number of centimetres dilated. Your cervix needs to dilate from closed or nearly closed to around 10cm in order for your baby to be born. But it is important to know that this is not an exact measurement, and even two people can sometimes give you different results. However, all the cervix needs to be is fully open to allow the baby to pass through.

Not everyone dilates to exactly 10cm. What is really happening is that the cervix opens sufficiently to allow the baby to pass through. Again, this is not an exact measurement.

Because the cervix dilates from a small opening before labour to around 10cm as the baby is ready to be born, it might seem logical to assume that at 5cm labour is halfway through. This, however, is not true. The opening of the cervix is not linear. For example, it may take 10 hours of labour to reach 3cm, then jump to 10cm in an hour. Or it may go from closed to completely open in 2 hours. It may even be at 2cm for three weeks, before taking 8 hours to be ready for birth. Therefore, it is clear that what the cervix has done previously cannot tell us what it *will* do in the future. It may *sometimes* give us an idea of what to expect when someone is in labour, which is discussed below, but it does not tell us when the baby or babies will be born.

The idea that the opening of the cervix should follow a line on a graph was introduced by a man called Dr. Emanuel Friedman, in 1955[2]. He tracked the length of labour of 500 women, all of White European backgrounds, and created a graph (The Friedman Curve) showing the 'average' length of labour, and how quickly the cervix supposedly opened. This data doesn't tell us whether there are differences in 'average labour' between people from different communities or ethnicities, as they were not included in the study. The graph plotted a line showing how much the cervix was expected to open each hour in order to be considered 'normal'.

An analogy might be to take all of the white children in a school. In each class, every child's height is measured, and then the average height of the children in class 1 is calculated, and the same for class 2, and class 3, and so on. It is then decided that the average height of the children in each class is the correct height, and all children who are smaller or taller than this average are wrong. Clearly, this makes no sense. Each child in the class is unique, and the right height for them.

Following the introduction of The Friedman Curve into obstetrics, it became expected that all women and birthing people's labours would follow this graph. If their cervix did not open sufficiently quickly, this was considered to be 'failure to progress' – a term that AIMS would like to see banned. Of course, not one of us is average, and our cervixes don't actually open according to Dr Friedman's graph. This means that using a vaginal examination to track the opening of the cervix in order to track labour progression, and to estimate how much longer labour may last, has little value. We simply cannot expect everyone to follow the "average".

There are exceptions to this. Sometimes, labour can stall for reasons such as the baby being in a position which makes it hard for them to press on the cervix (which helps it to open), or perhaps because the environment in the birth room means that the birthing woman or person doesn't feel safe, or cared for, which can trigger hormones which slow or stop labour. The cervix not dilating, or dilation slowing, might be an indication that changes in the room may need to happen, such as the people around, making the labouring woman or person feel more comfortable, or changes of position to help the baby to move. Other reasons may include dehydration, low blood sugar or exhaustion. See TheAIMS Guide to Giving Birth to Your Baby for a more detailed look at labour and birth. Sometimes, even when all the environmental conditions are met, it may be appropriate to consider interventions such as a caesarean if the baby appears to be in a position that would make vaginal birth unlikely or may not be coping well with labour. In these cases, though, there are likely to be other indications of a problem, which your midwife or doctor must explain to you.

Other reasons why a vaginal examination may be offered

Sometimes, a VE is done to try to help to determine the position of the baby, by feeling the 'presenting part' of the baby, which means the part which is pressing on the cervix. Normally this will be the head, and by feeling the lines on the skull of the baby, the midwife or doctor may be able to work out whether or not

the baby is coming down in a way that makes for an easier birth.

Sometimes, an examination of the vagina is offered as part of a check to see whether the waters have broken when it is not clear if this has happened. In this situation, this is likely to be done by using a speculum, which is a device to open the vagina and allow a midwife or doctor to more easily see inside and, if necessary and with your consent, to obtain a swab (a sample of fluid or discharge from within the vagina which is sent away to a lab to check against infection).

A VE is likely to also be offered before an induction, to see whether the cervix has already changed at all, and what would be the best option to try to encourage it to start to open.

Very rarely, a VE is offered during antenatal care although this is not normal practice in the UK.

What are the risks of vaginal examinations?

The most common risks of a vaginal examination are infection, pain and discomfort, so before you make a decision on whether or not to accept a VE, you may want to think about whether you want to know the information it may offer to you.

For some labouring women and people, the act of someone putting their fingers into their vagina can be hugely distressing. Any form of pain or distress can adversely affect labour, as this can release the hormone adrenaline, which inhibits a key labour hormone, oxytocin. This can slow labour down for some people, and sometimes stop it for a period of time. In addition, being told that you are 'not progressing', or not progressing as fast as expected, can lead to feeling disheartened and upset. As mentioned earlier, given that the dilation of the cervix at that moment gives no information as to the length that labour will ultimately be, this could be a pointless discouragement. The dilation measurement itself is not even necessarily accurate, and the estimate can differ from caregiver to caregiver.

Equally, for some labouring women and people, news that the cervix has dilated more can be reassuring and helpful, and give them the incentive to keep going!

Vaginal examinations can be a source of infection, and the more times they are done, the more chances there are of causing an infection[3]. Unfortunately, anything that is put into the vagina – including a sterile speculum or gloved finger – will increase the risk of an infection whether or not the waters have broken, as doing so pushes germs up the vagina towards the uterus.

Additionally, a VE can cause the waters to be broken by mistake, which can then increase the risk of infection as well as sometimes causing contractions to become more difficult to cope with. In some cases, as we have heard many times on the AIMS helpline, midwives and doctors have accidentally or deliberately used a VE to break the waters despite the woman or person not having consented to having them broken.

It is very common towards the end of pregnancy for midwives or doctors to offer a 'stretch and sweep'. This is sometimes also offered in early labour. A stretch and sweep, commonly called a sweep, is a form of induction of labour that involves the midwife or doctor inserting their fingers into the vagina, and through the cervix. The procedure is explained in The AIMS Guide to Induction of Labour. Sometimes, a stretch and sweep might be performed after consent has been given for a VE, but explicit consent for the stretch and sweep has not been given. This is an assault because consent must be given for any intervention to be done. Just because a midwife or doctor has their fingers in someone's vagina does not mean that they can do another procedure at the same time.

What are the alternatives

While it may be arguable that knowing the dilation of the cervix by any method has limited value, due to the fact that it does not open at a linear rate, sometimes it may be useful to have an indication of progress. For labouring women and people who decide to decline the offer of a VE, some midwives and birth workers describe using other ways to estimate how labour is progressing, based on their own experience.

1) Watch and listen. While every woman and birthing person labours differently, it is generally possible to judge by a woman's behaviour how her labour is progressing. While this can be more difficult where a midwife might be caring for a number of labouring women and people, huge amounts of information can be gathered by just watching and listening.

2) The dilation line (sometimes called 'the purple line') – In some women and birthing people (not all), a purple, silver, brown or red line can be seen, starting from the anus and developing up between the buttocks. This line tends to approximately reflect cervix dilation, with about 1cm of line equalling about 1cm of dilation of the cervix. This is not always the case - sometimes the line can be there but it does not relate to dilation - but it might be a useful indication in some cases.

3) Hot legs – as women and birthing people progress through labour, the extra blood needed by the uterus to do its hard work pulls blood away from their extremities. This can lead to the legs getting progressively colder, from the foot to the knee. When the colder part is at the mid calf, that equates roughly to 5cm dilated. This works less well for those who have had an epidural or some other pain relief. If they have been in a pool or warm bath, it will take around 20 minutes or so for the effect to be felt.

Summary

VEs might sometimes be useful for different reasons, but they do not provide benefits to all women and birthing people or their caregivers. It is always your choice whether or not you consent to having VEs, for any reason. If a healthcare provider coerces you into a VE, for instance by saying that you 'have to have one' before being given access to care, they leave themselves open to an accusation of criminal assault and battery, and other legal action (please see the AIMS information page on Obstetric Violence).

References:

[1] Miller et al, 2020, Variations in outcomes for women admitted to hospital in early versus active labour: an observational study: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03149-7

[2] Friedman, 1955, Primigravid labor; a graphicostatistical analysis: https://pubmed.ncbi.nlm.nih.gov/13272981

[3] Gluck et al, 2020, The correlation between the number of vaginal examinations during active labor and febrile morbidity, a retrospective cohort study: www.ncbi.nlm.nih.gov/pmc/articles/PMC7183634

Further reading about Vaginal Exams

VEs - Essential Diagnostic Tool?

Respectful Vaginal Examinations Project - Co-Production in Action

The Assessment of Progress

Vaginal examinations: a symptom of a cervical-centric birth culture

Assessing Progress in Labour

The purple line as a measure of labour progress: a longitudinal study