AIMS For a better birth...

NICE guidelines for caesarean section

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Beverley Lawrence Beech reports on the caesarean section guidelines for parents, birth supporters and those who work in the maternity services, produced by the National Collaborating Centre for Women's and Children's Health

When AIMS was campaigning about maternity care in the 1970s, the caesarean section rate was already climbing, most likely as a result of the policy to bring all women into hospital for birth. By 1980, it had reached 9 per cent, but obstetricians confidently assured the critics that it would not exceed 10 per cent as caesareans over this rate could not be justified as they were not beneficial for either the mother or the baby.

Despite these assurances, caesarean rates continued to climb. In 1985, I was the lay representative for the whole of Europe (among one for North America and another for South America) to the World Health Organization (WHO) Conference on Appropriate Technology for Birth[1]. Invited representatives included obstetricians, paediatricians, epidemiologists, economists, statisticians and ethicists (and probably a few others I've forgotten to mention) - making 62 delegates in all.

The WHO had called the meeting because of its concerns over the continuing rise in medicalised birth worldwide. Caesarean rates were already over 30 per cent in the US and more than 90 per cent in many South American hospitals. In Britain, some hospitals were approaching 18 per cent.

After considerable debate and examination of the scientific evidence, the delegates agreed that they should make a recommendation that there was no justification for caesarean sections to exceed 10 per cent. Both North American and South American obstetricians threw their hands up in horror, stating that, if the recommendation was set that low, their colleagues will just laugh and do nothing. So, as a compromise, it was agreed that "there is no justification in any specific geographic region to have more than 10-15 per cent caesarean section births". I had some disquiet about this as I believed that hospitals would simply focus on the 15 per cent - which is precisely what they did.

Since then, caesarean rates have continued to rise in almost every country in the world. In the UK, the rate is now 23 per cent, but many hospitals have rates approaching 30 per cent. If you book into the Portland private maternity hospital, almost 90 per cent of their patients emerge with a scarred uterus.

It is estimated that over 140,000 women a year undergo caesarean sections. On the basis that any operation over 10 per cent is unnecessary and avoidable, this means that over 75,000 women a year are having unnecessary major surgery. We have every reason, therefore, to welcome the NICE Caesarean

Section Guidelines.

The guideline development group, comprising two consumer representatives, two obstetricians, two midwives, a neonatologist, an anaesthetist, a member of the UK Confidential Inquiry into Maternity and Child Health, and a GP.

The group's recommendations were graded A, B, C, D or GPP, depending on the strength and type of evidence (see box). Here are some of the graded recommendations.

Thirty-four were graded A

(based directly on level 1 evidence; see box):

- *Pregnant women with a singleton breech presentation at term, for whom cephalic version is contraindicated or has been unsuccessful, should be offered caesarean section (CS) as it reduces perinatal and neonatal morbidity.*
  Comment: Unfortunately, far too many women are not 'offered' CS - they are informed that they have to have one; a major flaw of the research is that it did not compare, or consider, a traditional midwifery approach to vaginal breech birth.
- *A partogram with a four-hour action line should be used to monitor progress of women in spontaneous labour with an uncomplicated singleton pregnancy at term because it reduces the likelihood of CS.*
  Comment: While a partogram may be useful in a busy unit where women fail to receive the individual attention of one midwife, its parameters were based on 'Friedman's curve' research, which involved only 100 women, almost a quarter of whom had caudal anaesthesia in place, and one in ten had oxytocin augmentation. What would the 'curve' have been like had the research been done on normal women having normal labours?
- *Healthy pregnant women with anticipated uncomplicated pregnancies should be informed that planned childbirth in a 'midwifery-led unit' does not reduce the likelihood of CS.*
  Comment: But what is a 'midwifery led unit'? Many of these units are down the corridor or up the stairs, and have policies determined by obstetricians. What are the outcomes of freestanding midwifery units, such as the Edgware Birth Centre vs nearby consultant units, where women are three times as likely to have a CS?
- *Women should be informed that eating a low-residue diet during labour (toast, crackers, low-fat cheese) results in larger gastric volumes, but that the effect on the risk of aspiration if anaesthesia is required is uncertain.*
  Comment: Many years ago, an Emeritus Professor of Anaesthesia informed me that "no properly anaesthetised woman has ever aspirated vomit" - in other words, the problem is not inhaling vomit while anaesthetised; the problem is ensuring an adequate level of anaesthesia.
- *Women having a CS should be offered prophylactic antibiotics, such as a single dose of a first-generation cephalosporin or ampicillin, to reduce the risk of postoperative infections, such as endometritis, and urinary tract and wound infections, which occur in about 8 per cent of such cases.*
  Comment: Infections following surgery are caused by poor aseptic techniques. It is a pity that the

focus was not on this instead of recommending exposing the majority of women and babies to unnecessary antibiotic drugs.

- *Women who have had a CS should be offered additional support to help them start to breastfeed as soon as possible after the birth of the baby.*
  Comment: Hooray! But where is the staff to do so? Postnatal care is notorious for midwifery staff shortages.
- *Women who are recovering well after CS and who do not have complications can eat and drink when they feel hungry or thirsty.*
  Comment: Hooray!

Seventeen were graded B

(based directly on level 2 or extrapolated from level 1 evidence; seebox):

- *Planned CS for uncomplicated twin pregnancy should not be carried out before 38 weeks because this increases the risk of respiratory problems in these babies.*
  Comment: Where is the evidence that planned CS for uncomplicated twin pregnancy is beneficial? There's none.
- *During discussions about options for birth, healthy pregnant women with anticipated uncomplicated pregnancies should be informed that delivering at home reduces the likelihood of CS.*
  Comment: Hooray! Why, then, did the press ignore this recommendation and instead focus on 'women choosing CS'?
- *Electronic fetal monitoring is associated with an increased likelihood of CS. When CS is contemplated because of an abnormal fetal heart-rate pattern or in cases of suspected fetal acidosis, fetal blood sampling should be offered if it is technically possible and there are no contraindications.*
  Comment: With many units continuing to use the 'admission strip', will women be informed of the increased risks of CS?
- *The risk of respiratory morbidity is increased in babies born by CS before labour, but this risk decreases significantly after 39 weeks. Therefore, planned CS should not be routinely carried out before 39 weeks.*
  Comment: Hooray! The effectiveness and safety of single-layer closure of the uterine incision is uncertain.
- *Except within the context of research, the uterine incision should be sutured with two layers.*
  Comment: Anecdotal evidence from the US reports alarming numbers of women with postnatal uterine rupture. Women would do well to check whether or not they have had one- or two-layer suturing.

Twenty-one were graded C

(based directly on level 3 evidence or extrapolated from level 1 or 2 evidence; seebox):

- *In otherwise uncomplicated twin pregnancies at term where the presentation of the first twin is cephalic, perinatal morbidity and mortality is increased for the second twin. However, whether planned CS improves the outcome for the second twin remains uncertain, so CS should not be routinely offered*

outside of a research context.
Comment: It is essential that all women expecting twins be informed of this.

- *The risk of neonatal morbidity and mortality is higher with 'small for gestational age' babies. However, the effect of planned CS in improving this outcome remains uncertain and, therefore, CS should not routinely be offered outside of a research context.*
  Comment: It is essential that all women with 'small for gestational age' babies be informed of this - but the recommendations make no mention of how accurate this diagnosis is in the first place.
- *Consultant obstetricians should be involved in the decision-making for CS as this reduces the likelihood of CS.*
  Comment: Hooray!

Thirteen were graded D

(based directly on level 4 evidence or extrapolated from level 1, 2 or 3 evidence; seebox):

- *A competent pregnant woman is entitled to refuse the offer of treatment such as CS, even when the treatment would clearly benefit her or her baby's health. Refusal of treatment needs to be one of the patient's options.*
  Comment: It is very welcome that NICE has made this right patently clear in their recommendations.
- *Women who have had a CS should resume activities such as driving a vehicle, carrying heavy items, formal exercise and sexual intercourse once they have fully recovered from the CS (including any physical restrictions or distracting effect due to pain).*
  Comment: Unfortunately, there is little research evidence to determine how much postnatal pain and problems women have following a CS.

Twenty-four were graded a Good Practice Point

(GPP; based on the view of the Guideline Development Group; seebox):

- *Pregnant women should be given evidence-based information about CS during the antenatal period as about one in five will have a CS. This should include information such as:*
  - indications for CS (such as presumed fetal compromise, 'failure to progress' in labour, or a breech presentation)
  - what the procedure involves
  - associated risks and benefits
  - implications for future pregnancies and birth after a CS.

  Comment: This recommendation is most welcome, but women also need to know how the attitudes and ethos within the unit has a significant effect on the progress of labour.
- *In twin pregnancies where the first twin is not cephalic, the effect of CS in improving outcome is*

uncertain, but the current practice is to offer a planned CS.
Comment: If the outcome is uncertain, why suggest an intervention that is not proven to improve the outcome?

- *Women who have had a CS should be offered the opportunity to discuss with their healthcare providers the reasons for the CS and its implications for the child or future pregnancies.*
  Comment: This recommendation is very welcome, providing that the discussion is with the obstetrician (assuming that the woman also wishes to have such a discussion). Obstetricians may then begin to understand the effects of CS on women and their families.
- *Women who have had a previous CS should be offered electronic fetal monitoring during labour.*
  Comment: Bearing in mind that EFM increases the risk of a CS, a woman who has already had one will reduce her chances of a normal birth even further.

While the NICE guidelines are a step in the right direction, it should be remembered that they are based on medical evidence - with the holistic and midwifery approach to birth in second place. Randomised controlled trials, and research in general, is set up by the medical profession for the medical profession and for drug companies. Encouraging the powerful self-interest groups involved to undertake trials that users and midwives want is exceedingly difficult. Because of this bias, midwifery practice is sidelined, and little attention is paid by researchers to what women's views and needs are.

While there is an extensive list suggesting future research issues, the guidelines have some glaring omissions - for example, research into midwifery-managed breech birth, active birth, water birth, midwifery-managed twin birth or into the basis for women's requests for caesarean section.

However, these recommendations do gain a number of plus-points for suggesting that research be carried out to look into the reasons that lead a pregnant woman to request a caesarean, and to compare planned births in a 'stand-alone' birthing centre with births in conventional maternity facilities or midwifery-led units.

Finally, user organisations have been vigorously encouraged to sign on as 'stakeholder organisations'. Rather than spend weeks compiling a written submission, we decided - this time - that we would contact the user representative, Debbie Chippington Derrick, directly so that she could include our views in the discussions.

Initially, the consumer representatives were not paid for the enormous amount of time and effort they had to dedicate to guideline development but, eventually, NICE agreed to an honorarium for the two user representatives.

Having now listed AIMS as a 'stakeholder organisation', we expected at the very least to be given a complimentary ticket to the launch and a complimentary copy of the final guidelines.

Not so! Instead, we were asked to pay £34 for a copy of the report (but RCOG members got a discount and 50 per cent off the £260 ticket).

So, it should come as no surprise that consumers consider that the main objective of user-group

stakeholder 'involvement' is to enable NICE to put the consumer organisations' names on the publication. But as for respecting user groups as valued contributors - well, that clearly is another thing.

References

1. World Health Organization. Appropriate Technology for Birth, ICP/NCH 102/m02s. Geneva: WHO, 1985

Levels of Evidence

1a	Systematic review or meta-analysis of randomised controlled trials
1b	At least one well-designed controlled study without randomisation
2a	At least one well-designed controlled study without randomisation
2b	At least one well-designed quasi-experimental study, such as a cohort study
3	Well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, case-control studies and case series
4	Expert-committee reports or opinions and/or clinical experience of respected authorities.