AIMS For a better birth...

Consultation Conundrums

AIMS Journal 2006, Vol 18, No 4

Gina Lowdon explores the consumer consultation process for the VBAC Guidelines

AIMS is frequently called upon to submit comments as part of the consultation process for various guidelines, policy documents, protocols and proposals relating to all manner of aspects of the maternity services. Documents vary in size and complexity and often deadlines for submission of comments are short.

Compiling each submission takes a considerable amount of time - a precious commodity for organisations such as AIMS who rely on volunteers. For each document we have to assess whether the effort and time involved is likely to bring a worthwhile return in terms of influence exerted on the final document. Some documents are just too important and time just has to be found from somewhere.

Sometimes it is clear that our efforts have not been taken on board and that can be very disheartening. Sometimes we are left with the distinct impression that our contribution has been ignored and that we have wasted our time and effort on a consultation that was little more than a tick box exercise. But sometimes important changes are achieved so that whereas the final document may not be all that was hoped for, it is at least considerably better than it would have been.

Being involved often means that we are in a better position to understand the shortcomings of the document, its research base and its conclusions, and are thus in a stronger position to criticise the final document effectively, and to use our greater understanding of the issues in our campaigning work.

In most cases AIMS' comments are actively sought, but in others documents are simply posted on the web and comments invited. This was the case with the Draft `Birth After Caesarean' guideline that one of our Committee Members spotted on the RCOG (Royal College of Obstetricians and Gynaecologists) website during April 2006.

RCOG Draft Guideline on `Birth After Caesarean´

With over a 100,000 caesarean operations taking place in the UK each year, this guideline has the potential to affect the births of the large number of women who subsequently become pregnant. Obstetricians have huge influence over whether women with a history of caesarean section are given the opportunity to labour and under what conditions. It is therefore very important that this guideline uses the right language, recognises the rights of pregnant and birthing women, and presents a clear assessment of the risks and benefits to women and babies of both VBAC (Vaginal Birth After Caesarean)

and ERCS (Elective Repeat Caesarean Section). In our opinion the Draft Guideline was woefully inadequate on all these counts.

The Draft guideline stated that `women may opt for either a trial of VBAC or ERCS.´ In our experience women are rarely given the freedom to opt for their preferred form of birth. We are contacted on a daily basis by women who would prefer a VBAC but who have been told that they must have a repeat caesarean. We are also receiving increasing numbers of contacts from women who are being denied an ERCS since the psychological needs of women are frequently disregarded in this as in many other areas of the maternity services.

There are times when we despair that obstetricians will ever listen to women and treat their concerns with respect. Women who want a VBAC are being forced to undergo caesarean operations while others who want an ERCS are being forced to labour!

Although the Draft guideline was entitled `Birth After Caesarean´, the focus was primarily on VBAC with very little consideration given to ERCS; the emphasis was on whether VBAC could or should be `attempted´ and how VBAC labour should be `conducted´.

Despite the acknowledgement that women may choose how their baby will be born this Draft appeared to be designed to help the obstetrician to decide what is best for the woman so she can be told which option she should `choose´.

The evidence presented in the Draft gave a somewhat narrow perspective focused on how women should be `managed´. Risks and benefits associated with the interventions that form part and parcel of the `management of women attempting VBAC´ were not discussed and it was seemingly inconceivable that women should be supported simply to labour and give birth unfettered by modern technology. Whilst the Draft did adopt the term VBAC which is now in widespread use, it is indicative of obstetric unease that the term was preceded with the words `trial of ´ throughout the document, demonstrating underlying mistrust of the natural birth process.

The Draft stated that this guideline `is primarily aimed at the management of women with an uncomplicated term singleton pregnancy.´ `Uncomplicated term singleton pregnancy´ is the closest this 17 page document came to an acknowledgement that these are essentially healthy women. Whilst it could perhaps be argued that this is obstetric speak for `healthy pregnancy´, it can also be seen as another example of obstetric expectation that women with a history of caesarean section are unlikely to labour `effectively´.

The benefits of the natural birth process to babies and women are not considered in the Draft guideline. Furthermore the Draft stated: `Trial of VBAC has been advocated as a safe method to reduce the number of caesarean sections performed.´ Thus the main benefit of VBAC was put forward as a means of reducing the caesarean section rate. Whilst the Draft acknowledges that `trial of ´ VBAC is `advocated´ as a safe method it is disappointing that the word `accepted´ was not used.

Safety of VBAC

The whole tone of this document made it clear that RCOG is far from convinced over the safety of VBAC, a view shared by many obstetricians, if the related experiences of the many caesarean mothers who contact us are anything to go by.

We have growing concerns that the obstetric profession seems to be entirely comfortable with subjecting large numbers of women and babies to what they consider to be risks of lesser consequence in order to save very small numbers of women and babies from what they consider to be more serious risks.

It was stated in the Draft under `Limitations of data used in guideline´ that: `Furthermore, many of the main outcomes of interest are relatively uncommon.´ The Draft guideline then went on to discuss risks associated with planned VBAC. Risks measured as a number per 10,000 included: symptomatic uterine rupture (74), hysterectomy (23), thromboembolic disease (4), maternal death (17), perinatal death not including fetal malformation (24), HIE (7.8). Added together, and assuming that no single woman would suffer from more than one of these conditions (which would be unlikely in practice) these risks add up to 150 per 10,000 deliveries. Therefore according to the figures presented in the Draft more than 9,850 women in every 10,000 will not have what this Draft considered to be a main outcome of interest.

Also according to the Draft guideline a further 1.7% of women planning a VBAC will require a blood transfusion and 2.9% will suffer endometritis. Since women planning a VBAC are rarely given information on these risks, despite their much higher incidence than other risks discussed, we assume that, although they are of interest to obstetricians, they are considered to be of less importance; perhaps because they are also associated with ERCS, although to a lesser degree (1% and 1.8% respectively according to figures quoted in the Draft, which seem inconsistent with any other figures that we have seen previously).

To my mind (and I am no mathematician) the language used in the Draft, when discussing risks, lacked balance since there was stated to be `no difference´ in the level of risk for maternal death at 17 per 10,000 for VBAC and 44 per 10,000 for ERCS (a difference of just 27 per 10,000). The higher figure (by 19) for perinatal death of 32 per 10,000 for VBAC versus 13 per 10,000 for ERCS was considered `significantly higher.´ VBAC was also stated to carry a `higher risk´ of antepartum stillbirth of just 10 per 10,000.

I appreciate that the mathematicians amongst us will look at the statistics from a different perspective and may argue that for ERCS the risk of maternal death is raised by 160%, and for VBAC the risk of perinatal death is increased by 145%, which are much more emotive figures. There is also the issue of whether mothers should be expected to, or would want to, give their lives to save their baby; an even more emotive issue. Perceptions of risks differ, but the reality is that the overall risk remains small, and it will be a whole complex range of circumstances rather than a cold set of statistics, which will determine whether these risks are going to have any real relevance to the experience or personal decision-making

process of an individual woman.

Antenatal counselling

The Draft also contained a large section giving information on the key issues that the RCOG considers should be discussed during `antenatal counselling of women eligible for VBAC.´ The following figures quoted are from the draft and could be challenged as we have seen higher successful VBAC rates and lower uterine rupture rates quoted elsewhere. The key issues included are:

- The high chance of successful VBAC in most cases (72%-76%)
- The absolute risk of uterine rupture being extremely low (74 per 10,000)
- The small increased risk of blood transfusion and endometritis compared to ERCS
- That VBAC probably carries a very small additional risk of perinatal death compared with ERCS but that the risk is comparable to the risk for women having their first birth
- The small additional risk of the infant developing HIE but that the long term effects of this for the infant are unknown

There was no mention that benefits of straightforward birth should be included in the recommended antenatal counselling sessions, and strangely it appeared to the lay reader that some of main benefits of successful VBAC were put forward as being a reduction of risks associated with ERCS.

Although the Draft was entitled `Birth After Caesarean´ with a stated aim of providing evidence-based information on both VBAC and ERCS, there was scant information on ERCS. Risks and benefits of ERCS were only discussed briefly in terms of antenatal counselling of `women considering mode of delivery who are eligible for VBAC,´ who, according to the Draft, should be counselled that `an attempt at vaginal birth probably reduces the risk that the infant will develop respiratory problems in the neonatal period´ and should also be counselled that this additional risk `can be reduced - but not eliminated - by delaying the procedure until 39 weeks.´ Such subtle indications that ERCS was the more accepted course were present throughout the Draft.

There was a notable acceptance that it is entirely logical that a reduction of risk can be achieved by delaying an intervention when considering ERCS (i.e. carrying out a caesarean a few days later), but that conversely risk was considered to be reduced by early intervention where VBAC is concerned (i.e. the lower thresholds for resorting to caesarean delivery in prolonged pregnancies or during labour). Perhaps more thought needs to be given to deciding at what point birth becomes pathological and requires treatment.

There was also an interesting attempt at `balance´ in the statement that `Women considering mode of delivery who are eligible for VBAC should be counselled that risk of severe anaesthetic complications is very low irrespective of the chosen mode of delivery.´ Clearly when coming to this conclusion the authors of this Draft guideline did not have in mind a comparison of straightforward home birth (HBAC) attended by an Independent Midwife with an elective caesarean carried out under general anaesthetic. But then,

guidelines are based on available research evidence so this is not really surprising.

There is an acknowledgement that `an ERCS may increase the risk of serious complications in future pregnancies´ followed by a brief discussion of these. Again, this information was to be given to `women considering trial of VBAC.´ There was no indication in the Draft guideline that women preferring an ERCS should be given any information or antenatal counselling nor was there any indication that their preferences should be treated with respect, and the underlying reasons for their preference explored.

Conduct of `an attempt at´ VBAC

The Draft then went on to the outline recommendations for the `conduct of an attempt at VBAC,´ which included many of the standard criteria such as `Trial of VBAC should be conducted in a suitably staffed and equipped delivery suite with resources for immediate caesarean section and neonatal resuscitation,´ and `Women should be advised to have continuous electronic fetal monitoring following onset of uterine contractions for the duration of trial of VBAC,´ both of which have a questionable research base that would require separate articles to cover adequately.

Evidence-based Restrictions

Compiling comments for submissions on any consultation process can be a very frustrating and exasperating exercise and this was no exception. The more times one reads draft documents the deeper the despair at the approach taken, the language used, and the sheer lack of understanding of the needs of women during childbirth.

The problem is that all guidelines, this one included, are based on current medical practice and research evidence. Unfortunately common sense and women's psychological health needs do not feature in research findings and therefore are not included in the evidence base underpinning guidelines. While that base remains narrow women's experiences of childbirth will continue to be rocky and many will continue to be denied the opportunity to labour and birth in peace and unfettered safety.

Which is the Intervention?

Being involved in any consultation process can have less obvious benefits. Apart from the potential opportunity to influence a document and thereby the daily practice of maternity units, to a greater or lesser degree, there are valuable insights to be gained.

It can be extremely useful to have an understanding of the background and research base of guidelines and policies that inform common practice, especially when these are being used as a justification for denying women access to birth options and forms of care to which they are fully entitled and/or from which they would greatly benefit.

Occasionally we gain a deeper understanding. Whilst working on this Draft guideline it dawned on us that `trial of VBAC´ was being addressed as a potential intervention and that conversely ERCS was

considered the norm. The entire Draft guideline was the wrong way around! The Draft comments that there has been `a recent decline in clinicians offering, and women accepting, trial of VBAC delivery´. How incongruous it is that labour and birth could be considered something a pregnant woman can be offered? It is a testament to how topsy-turvy childbirth has become that so many actually go along with this way of thinking.

For women who are pregnant following previous caesarean surgery VBAC is the natural course of events unless repeat surgery intervenes, thus VBAC cannot be considered an intervention. ERCS is an intervention and one which can only be accessed via a doctor. Pregnant women, regardless as to their obstetric history, do not need anyone's permission to go into labour. The question should not be which women are `eligible´ for a `trial of VBAC´, but rather which women should be offered an ERCS and on what basis.

There is also an urgent need to clarify psychological need as a valid medical reason for scheduling an ERCS. It is wrong to deny a woman the opportunity to labour and give birth to her baby and it is equally wrong to force a woman to labour against her will in an age when there is a perfectly viable alternative, especially when the maternity services are unable to provide women with one-to-one support from a midwife she knows and trusts, when the potential for psychological damage to women is high, and when the rate of suicide following traumatic births is so significant.

Unfortunately for women and babies we have reached the point where many of those working in the maternity services have lost sight of what is the normal course of events and what is an intervention. Pregnancy, labour and birth are now almost universally accepted as conditions requiring treatment and VBAC is particularly susceptible to this view.

Consent Issues

Many forms of care and treatments are now so commonplace as to be considered normal practice, which has huge implications for consent. No form of care or treatment should be administered without first acquiring fully informed consent. Unless consent has been obtained, maternity staff leave themselves open to charges of assault. Unfortunately few women are aware of this and most believe they have no choice but to acquiesce.

Where there is confusion over what is the normal course of events and what is normal practice, then common procedures are no longer being recognised as interventions and therefore maternity staff seem to be unaware of the need to obtain valid consent.

If a medical professional believes that something must be done to safeguard the baby women are not expected to question their judgement or to have a different view, and therefore there is no notion of the need or advisability of explaining what is being `advised´ and on what basis, and consequently no thought is given to obtaining consent, valid or otherwise.

In situations where staff do have a rudimentary understanding of consent we are aware that this can lead

to the woman being persuaded, coerced or bullied into uttering the required agreement.

Those few women who do question the need for procedures are often met with hostility. Procedures that form part of maternity practice requirements are viewed as mandatory, without regard to the woman's needs or feelings - benefit is simply assumed.

Women planning a VBAC are particularly vulnerable to routine interventions due to the scar on their uterus. The intervention of caesarean section does not end with discharge from the hospital - it continues into the next pregnancy and beyond.

The Draft `Birth After Caesarean´ guideline disappeared from the RCOG website at the end of the consultation period and we did not receive any acknowledgement of our submission. To date, some nine months later, there seems to have been no further development although we have kept an eye on the website.

It is our hope that the RCOG will take this opportunity to produce a guideline that truly helps obstetricians to support women who are making a decision about whether to plan a VBAC or ERCS. In order to achieve this we feel the guideline needs to cover much more than a brief summary of research evidence.

At the very least we believe:

- there is a need for acknowledgement that both VBAC and ERCS are acceptable birth options and that it is reasonable to leave women free choice;
- that women should have access to full information on risks and benefits of both VBAC and ERCS in order to inform their decision;
- that VBAC should not be treated as an intervention (even when the woman is not deemed to be an ideal candidate), but should be considered the norm;
- that women requesting an ERCS deserve to have their preference treated with respect and due consideration;

and

- that women's psychological health should be taken into account when considering both options.

Each consultation brings its own trials, tribulations, and conundrums, but many also bring nuggets of information and valuable insights. AIMS' submissions continue to form an important part of our efforts to improve the maternity services, some of which are welcomed and valued by those seeking to consult, some of which are not.

HIE - hypoxic ischaemic encephalopathy - lack of oxygen to the baby causing brain damage

Note:
The Draft guideline `Birth After Caesarean´ was downloaded from the RCOG website

(www.RCOG.org.uk) in April 2006 and was removed from the website at the end of the consultation period. Full copies of the AIMS submission can be provided to AIMS Members on request.

Resources

- AIMS publication: `Birth After Caesarean´ by Jenny Lesley, details on the AIMS website and the AIMS Publications List.
- www.caesarean.org.uk Website co-owned by two AIMS committee members which provides information on caesarean birth and VBAC.