AIMS For a better birth...

Intrapartum Care Guideline

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Gill Boden reports on the Educational Launch Meeting of the NICE Guideline Intrapartum Care: Care of healthy women and their babies during childbirth

We have followed the development of this guideline with great interest for the last two years. After a consultation which resulted in an overwhelming and record response, AIMS sent a very detailed response pointing out inconsistencies, a lack of robust evidence to support many recommendations and a tone which sometimes suggested that women were recipients of care rather than partners in the process.

The launch was held in the RCOG conference centre just off Regent's Park. It is grand and extremely impressive. Incidentally there was a dramatic colourful and moving exhibition of illustrations in the hallways commemorating individual women who have died in childbirth around the world, Mothers Lost in Childbirth, a very strange juxtaposition with such formal and august surroundings.

The large lecture theatre was packed with women and a handful of men, mostly midwives with some obstetricians present. Members of the Guideline Development Group, (GDG), took us through the guidelines, which are about normal birth and woman centred care. Communication between health professionals and with women was mentioned a lot and became a key theme of the day.

Planning place of birth came up early. This was obviously the most contentious issue and the group has deliberated long and hard over the final wording. What they have come up with is:

- Giving birth is generally very safe for both the woman and her baby.

and

- The available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife-led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth.

then the guideline group have added the 'common sense' statement that

- If something does go unexpectedly seriously wrong during labour at home or in a MLU, the outcomes for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.

From the point of view of a woman planning her first baby this is not a very helpful set of statements.

After the first reassuring general statement there is the rather puzzling lack of evidence for relative safety of planned birth places. You could understand why a woman might ask, in that case, why a generation of women has been persuaded to give birth in hospital on grounds of safety if the evidence for it doesn't exist. Finally there is the worrying statement that if things go wrong 'outcomes could be worse' outside an obstetric unit.

While these statements are clearly true, many other things are also true. You could equally say that the almost universal recent practice in most industrialised countries of moving in labour to a hospital setting is a risky thing to do. It is likely to slow down and inhibit labour and the interventions that then ver y frequently follow are not good for mothers or babies. The real question women would like answered is whether or not planning their birth at home or bir th centre and being prepared to transfer if complications arise is actually likely to result in worse outcomes, taking into account local conditions.

But what I find most difficult is the underlying set of assumptions which are a bit like Alice through the Looking Glass. I would like to see a more frank admission that obstetric practice has largely not been based on evidence and that we will now start to see research on the safety of hospital birth instead of having to demonstrate the safety of home or birth centres.

Another point of contention is the advice on the third stage. Again, in 'looking glass language', the third stage is described in terms of two contrasting 'management schemes'. The advice is to use 'active management' rather than 'physiological management'. It seems to me that we should be talking about normal birth or an intervention. There is some evidence that active management might improve the outcomes for some women but for healthy women in the West this evidence is not strong. It is argued that women are happy to have their third stages actively managed however I have yet to meet women who having had a physiological, or normal, third stage would then opt for a managed one.

Discussing the section on pain relief, Dr Julia Sanders, a consultant midwife from Cardiff, said that 'our message is that immersion in water is the most effective and least used pain relief', apart, of course, from epidurals which are effective but have side effects. Immersion in water is more effective than pethidine or nitrous oxide. She also mentioned a study that showed that even very small amounts of touch from the midwife when women are feeling anxious is associated with significant reduction in anxiety. I don't think that most AIMS readers will be surprised by that. Massage by a trained partner is effective, tens machines are not. Despite the fact thatopioids give limited relief and cause side effects for both mother and baby, the advice is that they should be available in all birth settings. During another paper, Steve Walkinshaw, a consultant obstetrician from Liverpool, said in relation to oxytocin during labour that if women knew that it increased the pain, increased monitoring and, at recommended levels, does not increase the chance of a vaginal birth and shortens labour by only about an hour, then women would not choose it. I agree with him!

There were a few nice points to celebrate during the day for me, Steve Walkinshaw explained how he has been persuaded to talk about 'birth' rather than the 'd' word to the mirth of all the midwives; apparently there is no evidence that directed or coached pushing is helpful at all so, hurrah, an end to any thought of

teams of people shouting 'Push'; there is no evidence from high income countries on the timing of cord clamping so perhaps there will be a move to leaving babies to get their full complement of blood

Maureen Treadwell from the Birth Trauma Association gave a presentation reminding us that mental health problems are a leading cause of maternal death and cause significant morbidity. She spoke feelingly about how loss of control, unendurable unrelieved pain, feelings of violation and degradation, fear of death or death of the baby are the leading causes of psychological trauma. She said, 'In obstetrics more women suffer from what goes on above the neck than from what goes on below the waist.'

It is hard to know how far the guidelines may be seen as a progressive force. There is a strong emphasis on communication; woman centred care is urged and, notwithstanding my earlier reser vations, a choice of settings for birth is central to the provision of maternity care. There is a call for further research and the NPEU has already star ted a study on the outcomes associated with different birth settings.

The midwives I spoke to were all very positive about the guidelines. They feel that they will constitute a support to them in helping women to achieve normal birth. Some suggested that the advice on vaginal examinations was unnecessarily encouraging midwives to offer regular examinations, however overall within these guidelines there is a doctrine of urging health professionals not to intervene in normal birth.

Possibly one of the most progressive points is the section on how long labours actually take. The advice is that it is not unusual for normal labour to progress more slowly than has always been allowed and no harm results from this, so progress of half a centimetre per hour is within the normal range if women are not accelerated. This guidance has been followed for two years now in Wales where women have been following the All-Wales Normal Care Pathway. A clear idea of how long normal labour might be expected to take as well as encouraging women who are planning to give bir th away from home to stay at home until labour is well established are possibly the two factors which will help most women to achieve a normal birth.

These guidelines may prove to be the turning point for our generation of women in returning to us a real possibility of normal birth for the majority.

Guidelines can be accessed at: www.nice.org.uk/CG55