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VEs - Essential Diagnostic Tool?

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Debbie Chippington Derrick looks at the contentious issue of vaginal examinations with specific reference to the NICE Intrapartum Care Guideline

Vaginal examinations are extremely unpopular among pregnant and labouring women but seem to be considered a normal part of routine care by most health professionals; what does the NICE Intrapartum Care (IPC) Guideline actually recommend about their use?

The Guideline is confusing and contradictory, stating repeatedly that vaginal examinations are intrusive and should be avoided unless necessary, then elsewhere making recommendations based on information gained from carrying out vaginal examinations. The Guideline fails to consider any possible alternative methods of assessing whether or not labour is progressing normally.

In the summary of the Guideline it reminds health professionals to consider whether the examination is necessary, and to remember how difficult women may find the procedure, saying:

Healthcare professionals who conduct vaginal examinations should:

- be sure that the vaginal examination is really necessary and will add important information to the decision-making process
- be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, vaginal examinations can be very distressing
- ensure the woman's consent, privacy, dignity and comfort
- explain the reason for the examination and what will be involved, and
- explain the findings and their impact sensitively to the woman.
  (*NICE IPC Guideline*, page 17, summary)

The summary above encapsulates the problem: that they are difficult for women and should only be done if absolutely necessary, but that they are deemed necessary as they are the only easily documented measurement of progress in a system where more descriptive assessment of labour is not accepted.

Nowhere in the Guideline are there clear indications about when vaginal examinations might be considered essential, when they might be considered a low priority option, or how monitoring of labour should be carried out when women do not consent to these examinations.

> *'The first thing they wanted to do was an internal, and they were quite insistent about that ... and that was horrible, it was quite horrible ... I was in quite strong labour by then, and it was just interfering, there didn't seem to be any need for it'*

- Edwards 2005

Being 'aware that for many women ... vaginal examinations can be very distressing' is all very well, but the day-to-day reality on labour wards is that if a health professional has already made up his or her mind that a vaginal examination is necessary then consent will be assumed and a vaginal examination carried out. Women may have said yes to the examination and this is accepted as consent, despite the fact that they may have actually felt they had no option but to agree.

> One woman commented that she was unaware that her primary midwife would want to do a vaginal examination in order to decide when to call the second midwife. She reluctantly agreed, *'I just thought, oh, right, that's what we have to do. Whereas afterwards you think, well, did we need to do that?' I did find it a horrible part of it - and painful, and not really part of the process of getting [baby] out necessarily. I don't think I really trusted the midwife after that'*- Edwards 2005

The prevailing attitude seems to be that women should expect to leave their dignity at the door and put up with the management of labour and all it entails, for some unproven assumption of safety for their baby.

In chapter 7, **Normal labour: first stage**, the first recommendation is that 'Clinical interventions should not be offered or advised where labour is progressing normally and the woman and baby are well.' The problem with this statement is that unless a vaginal examination is carried out, most health professionals will be unable to assess whether labour is progressing normally. Nowhere in the Guideline are alternative methods for such assessment discussed.

Vaginal examinations are considered in sections 7.4 **Observations on presentation in suspected labour**, and 7.6 **Observations during the established first stage of labour**.

This separation itself is interesting as these two different states are often categorised by cervical dilation of greater or less than 4cm. The Guideline seems to omit the issue of how this categorisation should be made and why.

Most health practitioners would assume a vaginal examination should be done to establish this.

In 7.4 there is an excellent introduction which highlights many issues of concern to women, but still fails to allow for the possibility that vaginal examination will not be done:

The intimate nature of any vaginal examination should never be forgotten and, as with any procedure, consent obtained. While they may be useful in assessing progress in labour, to many women who may already be in pain, frightened and in an unfamiliar environment, they can be very distressing. The adverse effect on the woman may be reduced by having due regard for the woman's privacy, dignity and comfort. Good communication, as in all aspects of care, is vital and caregivers should explain the reason for the examination and what will be involved. Caregivers should also be sure that the vaginal examination is

really necessary and will add important information to the decision-making process. The findings, and their impact, should also be explained sensitively to the woman - using the word 'only' when referring to the amount of dilation may not be a good start and could easily dishearten or even frighten her. (*NICE IPC Guideline*, page 142, section 7.4.6)

> A woman called back after her first baby was born to tell her story. She had been anxious about birth and had worked hard to prepare herself and increase her confidence and finally approached birth feeling much more confident.
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> She went into hospital in strong labour and a lovely, young midwife supported her, did a VE and said she was 7cms dilated. The midwife told her how well she was doing and everyone was delighted. She then told the woman that because she was newly qualified she would need to get a senior midwife to check the VE.
>
> The senior midwife checked and said that she was only 4cms if that. The woman said she 'crumbled' and started to cry. She was then offered pethidine which she took because she felt so deflated, and shortly after the baby was born. She described the labour as traumatic. - a call to AIMS

This is followed in the introduction in 7.6.6 by the statement, 'A vaginal examination during labour often raises anxiety and interrupts the woman's focus in labour.'

> '*...if she'd examined me, I could really picture myself just getting closed up, thinking of someone touching me inside*' - Edwards 2005

Then in the review of the evidence in 7.6.6 the lack of evidence of the benefit of vaginal examinations is acknowledged. NICE was only able to find one study to provide this evidence and concludes:

There is low-quality evidence on the frequency of vaginal examinations during labour, with some evidence that the number of digital vaginal examinations is associated with neonatal and maternal sepsis, where the membranes rupture prior to the onset of labour.

However, despite this apparent conservative approach to the use of vaginal examinations, the Guideline remains confusing: sections on monitoring progress of labour and delay in the progress of labour are based mainly upon changes in cervical dilation, information that will not be available without vaginal examinations having been carried out.

It would be interesting to know how many women are really making informed decisions about having vaginal examinations and giving proper consent for them. How many women are informed about how little is known about the risks and benefits of vaginal examination? From our knowledge of women's experiences, we know that many women are actually coerced into giving uninformed consent, by staff leading them to believe that vaginal examinations are necessary for the safety of themselves or their

baby and that therefore to refuse would be unthinkable. Even when women are well informed and have decided against vaginal examination, they often find their decision is not respected.

> '*it was straight away into a VE. Like I just want to give you a VE, okay? I felt, oh God, this is happening straight away. I felt, the power's being taken and they were going to start taking control. But I was really relieved when [main midwife] said, no, we've already discussed it and she's not going to have one. That kind of came at the very beginning when they arrived and it really mattered then to know that I could trust her with something like that. I felt I could trust her further, because she was taking my side above her colleague's really*.' Edwards 2005

At the beginning of section 7.4 **Observations on presentation in suspected labour** there is acknowledgement that many practices in monitoring labour are carried out because it is 'traditional' to do so:

It is traditional to carry out a number of routine observations of the woman and the baby. These are aimed at assessing maternal and fetal health, determining the stage and progress of labour, evaluating the woman's needs, determining whether admission to her chosen place of birth is required, and, if not, what follow-up observation and advice is required. (*NICE IPC Guideline*, page 141, section 7.4)

Such tradition will affect the way that interventions are viewed and offered, and how well accepted it may be for a woman to decline the offer of a vaginal examination or for a midwife really not to carry them out when in her professional experience they were unnecessary, especially if she felt her professional opinion was at conflict with the practices of others.

This confusion about the routine and conservative use of vaginal examination is highlighted in the **Recommendations on initial observations** (page 144), saying, *If the woman appears to be in established labour, a vaginal examination should be offered*', *but then going on to say in the following paragraph that healthcare professionals should 'be sure that the vaginal examination is really necessary and will add important information to the decision-making process.*

This confusion is carried through to the IPC quick reference guide, with the first box warning 'Ensure exam is really necessary,' then the following box, which is on initial assessment, saying 'Offer vaginal exam' which apparently covers all women and not just those who appear to be in established labour.

In the Guideline all discussion of the progress of labour is in terms of cervical dilation. Chapter 14, which covers delay in the first stage of labour, says in the introduction:

Delay in the first stage of labour has been defined in a number of ways and there is no universal consensus. It has been traditional to define delay largely by the rate of cervical progress without taking into account either maternal uterine activity or descent or rotation of the fetal head during labour. Although it is acknowledged that the duration of labour is dependent on parity, clinical practice and local labour guidelines rarely make that distinction.

Again this makes it clear that monitoring cervical dilation is such a 'tradition' that there is no consideration of how any delay in labour would be diagnosed without that information, despite the clear and repeated cautions against the use of vaginal examinations.

Suspected delay is given as less than 2cm dilation in four hours, but no other measures are suggested.

> *'I was assured that they would only do them [vaginal examinations] out of necessity, but I still don't understand why they're necessary. Somehow I have the feeling that they can't observe women and feel that things are alright without having to use physical monitors all the time. That is what I find slows me down, interferes with me.'* - Edwards 2005

There are recommendations on the use of partograms to monitor the progress of labour and these are carried over from the NICE Caesarean Guideline. It is NICE policy to carry relevant recommendations over from other guidelines to avoid conflict between guidelines. The recommendation says 'A partogram with a 4-hour action line should be used to monitor the progress of labour of women in spontaneous labour with an uncomplicated singleton pregnancy at term, because it reduces the likelihood of CS.' This recommendation is based solely on the rate of caesarean section and not on any other outcomes for mother and baby.

There is a failure to acknowledge that completing a partogram requires a vaginal examination to be carried out and the potential adverse effects of this, nor is consideration given to the issue of obtaining consent. A further concern is that the research this is based upon made comparisons only between partograms with different action lines and does not compare the use and non-use of partograms. There is acknowledgement of this aspect in the IPC Guideline in the research recommendation:

Studies looking at the efficacy of the use of the partogram, and the comparison of a partogram with an action line and one without, should be carried out.

It is unclear why this recommendation did not extend to appealing for research that considered whether the use of partograms is of benefit to women and babies at all.

This raises another concern: the research on partograms did not provide information on outcomes other than the caesarean section rates and in the evidence review of the Caesarean Guideline there is acknowledgement that 'No study has evaluated tests based on maternal and fetal outcomes,' so this recommendation is being made without knowing the effects, positive or negative, that partograms may have on mothers or babies.

The IPC Guideline does acknowledge well the potential negative effects of vaginal examinations, and does urge caution in their use. However, so much else in the Guideline requires information about cervical dilation that it can do nothing but leave those caring for women in a quandary about which advice they should be following.

This Guideline fails to draw on midwifery skills that allow labours to be monitored without this intrusive procedure or recognise that such knowledge even exists.

Further reading on VEs

- Bergstrom, L., Roberts, J., Skillman, L., and Seidel, J. (1992) 'You'll feel me touching you sweetie: Vaginal examinations during the second stage of labor', Birth, 19(1), 10-18.
- Warren, Chris (1999a) 'Invaders of privacy', Midwifery Matters, 81, 8-9.
- Warren, Chris (1999b) 'Why should I do vaginal examinations?', The Practising Midwife, 2(6), 12-13.

References

- NICE Guideline. Intrapartum care: care of healthy women and their babies during childbirth, September 2007 www.nice.org.uk/CG55
- Edwards, Nadine Pilley (2005) Birthing Autonomy: Women's Experiences of Planning Home Births, Routledge, London, New York.
- Edwards, Nadine Pilley (2001) 'Women's Experiences of Planning Home Births in Scotland: Birthing Autonomy', Unpublished PhD Thesis, University of Sheffield, UK.

All-Wales clinical pathway for normal labour

The All-Wales clinical pathway for normal labour (published just before the NICE IPC Guideline in 2003) differs, in that it relies heavily on the use of VEs for assessing the progress of labour: Under Expected progress in labour - first stage of labour:

- A vaginal examination within four hours of receiving 1:1 midwifery care.
- Re-examine vaginally four hours later in the absence of signs of full dilation and if there is progress of at least 2cm then re-examine four hours later, if not, but there is at least 1cm then two hours later in the absence of signs of full dilation. If less than one then exit the pathway.

Full dilation is defined by VE or by a visible vertex at the perineum.