AIMS For a better birth...

Managing the Third Stage

By Jean Robinson

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AIMS' Research Officer Jean Robinson summarises the pitfalls and problems of research into third stage management.

Work at AIMS means listening - listening in a way "which means you are prepared to be changed by what you hear". We never tire of hearing parents' stories of birth; each brings a new dimension. We are also enriched by listening to midwives and doctors telling us about their hands-on experience. As we read the latest Confidential Enquiry or randomised study, we hear the background music of these voices.

For the third stage of labour, the 'raw' consumer material is less plentiful than the feedback we get from parents on management of the first and second stages. Giving birth, and seeing and holding the new baby, are so overwhelming that for most mothers delivery of the placenta fades into the background unless something goes wrong.

Cutting the cord may be most vividly spoken of by fathers, who are now often involved, and we had a deeply felt complaint from a father who was prevented from doing so. Most criticisms we receive about care shortly after delivery concentrate on handling of the baby and particularly on any separation from the mother, or exclusion of the father.

However, there are individual families, and especially those from certain cultures, for whom handling and disposal of the placenta is important, and lack of understanding or respect of their choices can be damaging. Anyone who wants to learn about the consequences of cultural mismatch in medical care should read Anne Fadiman's brilliant and devastating account of a Hmong family in the USA - which includes their belief that the placenta should be buried under their hut - impossible to do in a city high rise apartment (Fadiman, 1997).

However, expectant parents often tell us that one of their concerns is the cord not being cut too soon - though we have no idea how common knowledge or anxiety about this is. Whether of not the baby is getting all the blood it should have for the best start in life is a simple enough question for parents to understand. This is a prime example of an issue parents will not question if they do not know about it, since they assume professionals know best. But once they have information, they immediately grasp its importance, whatever their level of education.

We continue to receive a steady trickle of complaints about retained parts of placenta not being detected

before mothers are sent home, and the subsequent problems they have. Sometimes diagnosis or treatment of infection are delayed, and women may have prolonged ill health. This is nothing to do with active or physiological management, but basic quality of care in inspecting the placenta after delivery to ensure that it is complete.

There are also women who were traumatised or upset by manual removal of the placenta. One vividly described floating above her body and could describe what was done and said in theatre, and could describe a doctor she had never met, even though she was under general anaesthetic at the time. She suffered severe post-traumatic stress disorder.

Unlike the widespread outcry on induction and augmentation of labour, and fetal heart monitoring, consumer challenge to routine third stage management has come almost entirely from those who have more background and knowledge - the organised maternity groups like AIMS and the NCT, but we were not alone. We were allied with many midwives, and some doctors, who were asking similar questions. Would there have been a randomised trial of physiological versus active management of the third stage without consumer pressure? Throughout the discussions there has been a continual to-ing and fro-ing and sharing ideas between ourselves and professionals.

It simply became a natural extension of the questions we had learned to ask from the 70s when induction rates soared. Why interfere with Nature routinely when you can do more harm that good? What outcomes are you measuring? For whose good are you intervening - the good of the mother, the baby, the staff or the institution? Do these research studies actually prove the benefits they claim, and who defines them as benefits? Were adverse effects effectively sought and measured?

The primary justification for third stage intervention, of course, is prevention of post-partum haemorrhage. Fortunately there were only five maternal deaths from PPH in three years covering the latest Confidential Enquiry into Maternal Deaths 1994-6 (Department of Health, 1998). Four of them followed caesarean section and the remaining one happened after vacuum extraction. There were no deaths following normal delivery. However for other causes of haemorrhage - placenta praevia (three deaths, two of them associated with embedded placentas with a previous uterine scar) and placental abruption (four deaths) - risks are increased if the mother has a previous caesarean section.

So is the risk of haemorrhage from placenta accreta (embedded placenta) increased when manual removal is attempted, or at a later caesarean? (Zaki, 1998; Hemminki, 1996). The current high rate of caesareans is creating a population of mothers at future risk of antenatal and postnatal haemorrhage, as well as rupture of the uterus. Unfortunately when deaths associated with a previous uterine scar occur, the Confidential Enquiry do not investigate how necessary the earlier caesarean was when they are judging the avoidability of death.

However what AIMS hears about most is delayed diagnosis of heavy blood loss, and late or inadequate treatment, and prolonged low physical and emotional health afterwards. It is interesting that almost all of these cases involve haemorrhage from trauma - from unsuspected injury, from episiotomy or tears.

Is it possible that the midwife's confidence in routine Syntometrine reduces awareness and watchfulness? Even more worrying are the occasional stories we get about an almost deliberate refusal to diagnose or record heavy blood loss which seem similar to staff refusals to admit that women have had serious postnatal sepsis. "If we don't see it and record it, it didn't happen" seems to be the philosophy.

Quantity of blood loss, the accuracy of estimations, and what constitutes a "haemorrhage" rather than "normal" loss - these are still unsettled questions. One doctor routinely estimated "499 mls" - presumably to keep within the common British definition that more than 500 mls constituted a haemorrhage (Logue, 1990). If he had been in Holland, where the definition is apparently 1000 ml, he could have gone up to 999 mls!

As we explain these problems to parents, many of them are astonished at how inaccurate and unscientific expert maternity care can be. But they talk about the soaked mattress, the pools of blood on the floor, and no-one listening to them and how long mothers took to recover from the birth. The danger here comes not from lack of active management, which they received, but from staff who were not caring and paying attention.

No-one mentions how the behaviour of individual accouchers can affect risk. Margaret Logue's important, but little known, study showed that some obstetricians caused twelve times the haemorrhage rate of others - related to their personality - and that midwives too have varying rates (Logue, 1990). Does this mean that Syntometrine needs to be used when some staff are on duty but not others? If her study at one hospital showed such a marked effect, we wonder what analysis of outcomes at other hospitals would show.

What is clear from mothers' comments is that doctors and midwives who cause physical blood loss are also likely to cause emotional damage, and women are just as vulnerable to psychiatric trauma during the third stage as at other stages of labour.

When randomised trials report on outcome from any extra intervention, they do not mention the additional risks each one brings. With every drug comes a risk that it will be given to the wrong person in the wrong dose or at the wrong time. And drugs given by injection are riskier than those given orally, since their diverse effects are likely to be more severe, and they can be injected into the wrong place as well as the wrong person. For additional procedures, each new intake of staff has to practise and learn on someone - like the mother whose cord was broken when the medical student was told to practise controlled cord traction.

Those of us who often dip into medical literature, soon realise that adverse effects of intervention often surface only when a different treatment becomes available for comparison. Proponents or producers of

the new drug or treatment will then happily write about the disadvantages of the old, in order to convert colleagues to the new. This is also true of different oxytocic drugs used to reduce haemorrhage risk in the third stage.

There are still many unanswered questions. One midwife told us that Syntometrine may reduce immediate blood loss, but that loss may simply come later, when it does not count as PPH. Another suggests that pharmaceutical use of oxytocin may reduce mothers' own ability to produce natural oxytocin in subsequent deliveries. These are interesting, but unresearched issues.

In debates on the third stage once again we are involved in argument about time in labour. Who defines "normal" time for natural processes and who controls it? This is illustrated in a social study of midwifery: "Even Syntometrine was said to be used in the third stage of labour 'to shorten the third stage' as if there was some urgency to end this undesirable condition." (Hunt and Symonds, 1995). Later the authors refer to the speed with which women are "washed and warded" after delivery: "The staff have been very efficient but perhaps they were not effective. The urgency to complete the process had overtaken everything else."

In this booklet, Nadine Edwards, AIMS' Vice Chair, summarises what we know and do not know about research on the third stage and highlights some of the issues of concern to parents and professionals alike.

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Editor's Note:
After a great deal of intensive work our new and fully revised ***Delivering Your Placenta: The Third Stage*** *is available. This article forms the introduction to the booklet which is 68 pages and contains the most up to date research on the third stage currently available. Copies are available from AIMS publications*