AIMS For a better birth...

Lip service and red tape

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Susan Merrick asks if RCM practice guidance makes any difference in maternity care

As interventions in labour and birth become more and more traditional and routine (medicalisation of childbirth) so have protocols, policies and fear of litigation. The Royal College of Midwives (RCM) guidance was originally developed and exists to underpin midwifery practice and also to 'achieve practice change' within midwifery. This guidance was, and still is, necessary due to the nature of maternity care in the UK.

Previously the practice of obstetricians and gynaecologists was unevaluated and this impacted heavily on midwifery. The response to this was to begin to use systematic reviews such as Cochrane reviews, which were already being successfully used elsewhere. The aim of such reviews is to collect research, and in this guidance the RCM aims to use the reviews to provide midwives with evidence-based information with which to challenge routine practice that interferes with the normal birth process.

As a mother, doula and birth campaigner, I wanted to see how student and experienced midwives are guided on paper, what focus women have within this and how these guidelines compare with hospital policy and practice as we see it on the ground.

I want to briefly explore the positive elements of these guidelines and the conflicting elements within them, as well as the dilemma midwives may face when working with these guidelines alongside NICE and other policy documents. I also want to look at the language used, especially in relation to women.

The guidance is split into 20 chapters:

- Introduction
- Birth environment
- Latent phase
- Supporting women in labour
- Supporting and involving women's birth companions
- Immersion in water for labour and birth
- Understanding pharmacological pain relief
- Intermittent auscultation
- Assessing progress in labour
- Rupturing membranes
- Positions for labour and birth

- Persistent lateral and posterior fetal positions at the onset of labour
- Nutrition in labour
- Second stage of labour
- Third stage of labour
- Care of the perineum
- Suturing the perineum
- Immediate care of the newborn
- Early breastfeeding
- Guideline development manual 2012

The guidelines offer a comprehensive discussion about supporting women in normal labour and birth, using evidence that is current and that introduces some much-needed debate about current practices within maternity care. The valuable emphasis that I noted through many of the chapters was that of individual, continuous support by a named midwife and the importance of listening to the woman.

Wonderful examples of what can be done to improve normality are given, such as providing home visits in early labour, avoiding the subjective and problematic 'diagnosing' of active labour, focusing on women not measures, avoiding negative terms and avoiding interventions such as opiates, continuous monitoring, vaginal examinations (VEs) and augmentation. The guidelines also state that offering support to women often comes low down on the list of priorities in favour of technical aspects of care and that this should not be so.

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'Frequent vaginal examinations in the second stage may also "reinforce cultural messages about women's powerlessness" and imply that "the woman's body cannot be trusted to work right."'

And it was found that:

'Midwives have sometimes responded to the embarrassment of this situation [VEs] by adopting ritualistic semi-sterile procedures, and by using language which infantilises the woman.'

The guidance recognises that such attitudes and use of language can cause much damage within labour and birth and to the woman who is supported.

These recommendations and practice guidance star t to paint a picture of a great maternity service. However, it is one that falls far from many women's experience. So why is that?

If the evidence is promoting this good practice and also promoting the abandonment of some harmful practice, how does this transfer to the community or to the midwives practising in hospitals and birth centres?

Whilst encouraging midwives to take an individual approach to care and giving them good evidence to question habitual practice and procedures, the guidance also reminds them to document and justify ALL departures from evidence-based practice and policy. So, what about when the evidence and policies are multiple or conflicting? What happens, for example, when NICE guidance asks for arbitrary VEs to check progress or senior professionals are pushing for augmentation or intervention when a labour stalls or slows? Which guidance falls to the wayside?

What happens when the habitual or unresearched practices that are mentioned within these guidelines are policies within an NHS trust? How can a midwife challenge this safely?

Also, are women aware that this good practice is what they should be expecting? Are they aware that they should be offered this level of care? I would argue not. I would also argue that there are some midwives who do not have the time, skill or confidence to work in this way. Within busy labour wards some midwives are still being taught to manage the machinery, watch the monitors, concentrate on the paperwork and the best they can do is try to keep the woman out of the labour ward until she is at the magical 3/4cm and can be classed as in 'active labour' so as to try to avoid interventions that will come into discussion at certain arbitrary times. So I suggest that too often this is what midwives learn, instead of being able to practise autonomously, giving the individual care and support that each woman needs and that is recommended as best practice.

What can be of real help to midwives here is the women themselves. It does seem to be forgotten within the realms of policy, procedure and recommendations that ultimately these are the choices of the woman. It is up to her to give informed consent to every single one of these procedures and practices. The woman must consent for you to support her, she must consent to you being present and to you touching her. If a woman does not consent to something, then the midwife has the justification she requires for her documents.

However, this requires women being informed and being aware of their rights in maternity.

A phrase that stands out for me in the guidance introduction and several other places is that women are to 'be involved in decisions'. To be involved is not suggesting, as it should, that women are the decisionmakers. They are only consulted. This type of language can detract from any other good practice that is recommended. If midwives are not taught, and constantly reminded, that women are the centre of maternity, that they make ALL the decisions about their bodies and their care, then midwives will continue to practise without this in mind. The midwives and professionals involved may give the

information and guidance but they should not be making the decisions. An example of this can be found in chapter 17 when the midwives are guided to 'explain to the woman what they plan to do and why'. This does not remotely suggest that they should ask for permission.

A consistency of language is important within such influential guidance. Many of the chapters do speak clearly about the woman being the decision-maker, but this varies in other chapters and can minimise the role of the woman.

The philosophy underlying these guidelines is one of good practice to promote positive normal labour and birth for women. Where midwives have the time, autonomy, experience, skill and confidence to listen fully to women, know the women and provide individualised care, these guidelines can be considered extremely beneficial. Where midwives have less autonomy, confidence, experience and medicalised training and where protocols, time restrictions, busy shifts and fear prevails I ask if it really possible for these practice guidelines to be implemented.

I would like to see more women having access to this information themselves, to gain more of an idea as to what they should expect from their care, with normal birth as described in these guidelines truly becoming the normal practice and experience rather than the exception.

'In all situations, it is important that women understand who has responsibility for their care and that they remain informed and involved in decisions about themselves and their babies.'

And again, I remind those reading that the ultimate responsibility lies with the woman herself.

If the practice recommended in this guidance is what evidence shows is best, what midwives want to achieve and what women want for themselves, then please, please let's find a way to use it to truly implement good care.

The RCM practice guidelines 2012 are available at www.rcm.org.uk/college/policy-practice/evidence-basedguidelines/