AIMS For a better birth...

What happens when a woman needs a caesarean?

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Two recent research papers suggest that women who need caesarean sections often fail to get them quickly enough. AIMS research officer Jean Robinson comments on a disturbing trend.

If the baby is in trouble and the mother needs a caesarean section in a hurry, how long does it take? The "standard" hospitals are now supposed to meet, is to deliver a baby within 30 minutes of the decision being made that a section is urgently needed. How was that half hour standard arrived at, and where is the evidence that it is the right time? No one knows. There is no real evidence - only an early animal study and small collection of different studies giving fairly crude measurements on conditions of groups of babies.

As in so many studies, these group measurements do not tell us whether for any individual baby, faster or slower delivery would have made a difference. And why are they measuring only by plus or minus 30 minutes and not 25 or 35? Well, it's a nice round figure and it seems potentially achievable. And, of course, these studies suffer from another defect we are only too well aware of: they rely on what is on the case notes, with all their inaccuracies and omissions. Parents are never asked for their version of what happened. We know that some of them turn to litigation out of frustration, simply to get their story heard.

Once a standard has been set, it might be used in complaints and legal cases, where parents have a brain-damaged baby and may claim that the caesarean should have been done sooner. "The 30 minute yardstick is in danger of becoming a rod for our backs" says a recent leader in the British Medical Journal. (1) "The implication is that caesarean section for fetal distress that takes longer than 30 minutes represents suboptimal or even negligent care." Yet surely the author, as a professor of fetomaternal medicine (at Nottingham) should be more worried about the health of the baby than whether doctors get sued.

This leader merely confirms what has been obvious to watchers from the consumer side for years. Obstetricians have been reluctant to discuss the issue, reluctant to establish a firm standard, reluctant to have guidelines, reluctant to audit this most crucial of measurements of quality of care, precisely because it did give potential ammunition to parents who believed they had an avoidably dead or brain damaged child.

It is not an easy area to research, and we still do not have adequate evidence as to what makes a difference. The obstetricians can only go by the simple standard: if they think the baby seems to be in real

trouble, get it out quickly.

Despite years of research on fetal heart monitors, scalp monitors, infra-red monitors, there is no perfect measure saying which baby is in trouble, how seriously, and how rapid delivery has to be to make a difference.

Analysis of the statistics is made more difficult because "emergency" can have a wide range of meanings. Classifications as to what is an "emergency" section and what is not, varies from hospital to hospital. It includes women and babies with a wide variety of problems - women with pre-eclampsia, eclampsia or haemorrhage, prolapsed cords, abrupted placentas and babies who are showing signs of "distress" of various degrees.

Women have been corralled into a smaller and smaller number of larger and larger maternity units, even if they were very low risk, because "if it came to an emergency everything was at hand". They and their babies were "safer".

Yet AIMS case files tell a different story. Even units which we know to have sky-high section rates are not always doing them in time on the women who really needed them - even when they were in known high risk groups. And although decision-to-delivery time is studied, no one is talking about the many delays when no one is taking the decision, despite mounting evidence, because there are not enough midwives (especially more expensive higher grade ones), junior doctors know too little and are inadequately supervised, and care is fragmented.

The stories of women who come to AIMS with complaints after emergency sections usually have one of four themes, though there may be a combination of two, or all four.

1. Interference reduced the woman's chance of normal delivery e.g. The section would not have been needed if they had not unnecessarily induced/speeded up my labour, and/or kept me lying down strapped to a monitor, and/or caused stress by their behaviour or pattern of care/ if they had allowed me to labour in peace in my own time. It was the oxytocin or misoprostol which caused the intense contractions which caused the fetal distress.
2. Failure to detect problems soon enough e.g. "My baby is dead/brain damaged because they did not do a section soon enough, although I kept telling them I was in trouble. No one took any notice. I was getting intermittent care from junior people who did not know what they were doing."
3. Depression and post traumatic stress disorder after emergency sections e.g. "I am having nightmares and flashbacks after they finally rushed me off for a section. It was panic stations."
4. Delays because of blocked resources. e.g. "I was told I needed a section but they did not have a theatre vacant." (This begs the question: how necessary were the caesareans that were using precious theatre space?)

Checking the quality of care is much more complex than auditing how many women get an "emergency" section in half an hour - and it is now clear that even half an hour is difficult to achieve in practice. Simply

measuring outcomes from decision-to-delivery time leaves out the crucial problem of quality of care before the decision was taken. That should be part of the audit.

However, for the time being the 30-minute guideline is at least a start. Despite its inadequacies, it is the only standard we have, and every unit should be auditing, and publishing the results - and every Maternity Services Liaison Committee and Community Health Council should be watching their local statistics.

References

1. James J, Caesarean section for fetal distress, BMJ, 2001; 322: 2001.