AIMS For a better birth...

Changing Childbirth

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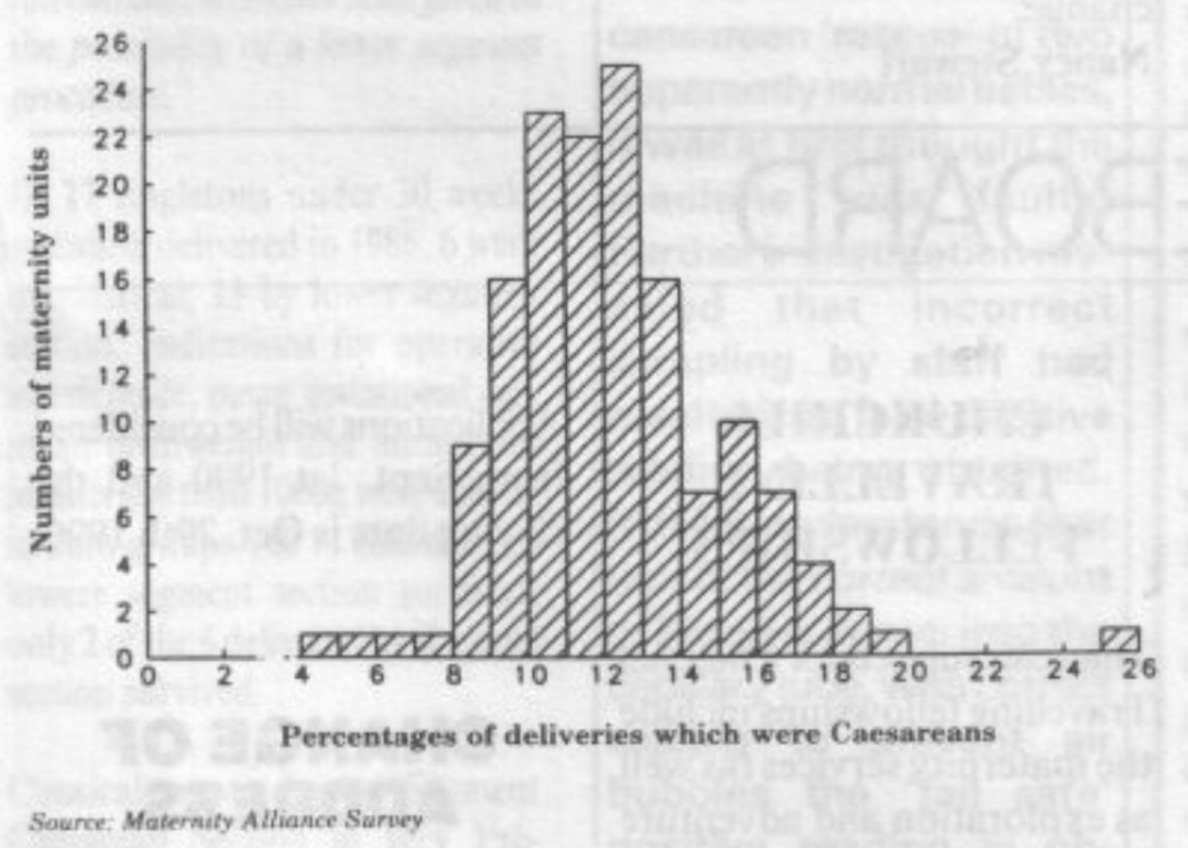
Nancy Stewart

In a new report, "Changing Childbirth: Interventions in labour in England and Wales", the Maternity Alliance has brought the picture up to date since their earlier survey of caesarean trends from 1978 to 1982. Surveys sent to consultant and GP hospitals in all regions show that in the years 1982-1985, for all the concern that has been voiced over the rate of caesarean section, the best that can be said is that the rate continued to rise at a slower rate. In 1982 the caesarean rate was 10.5% of all births, but by 1985 it had reached 11.6%.

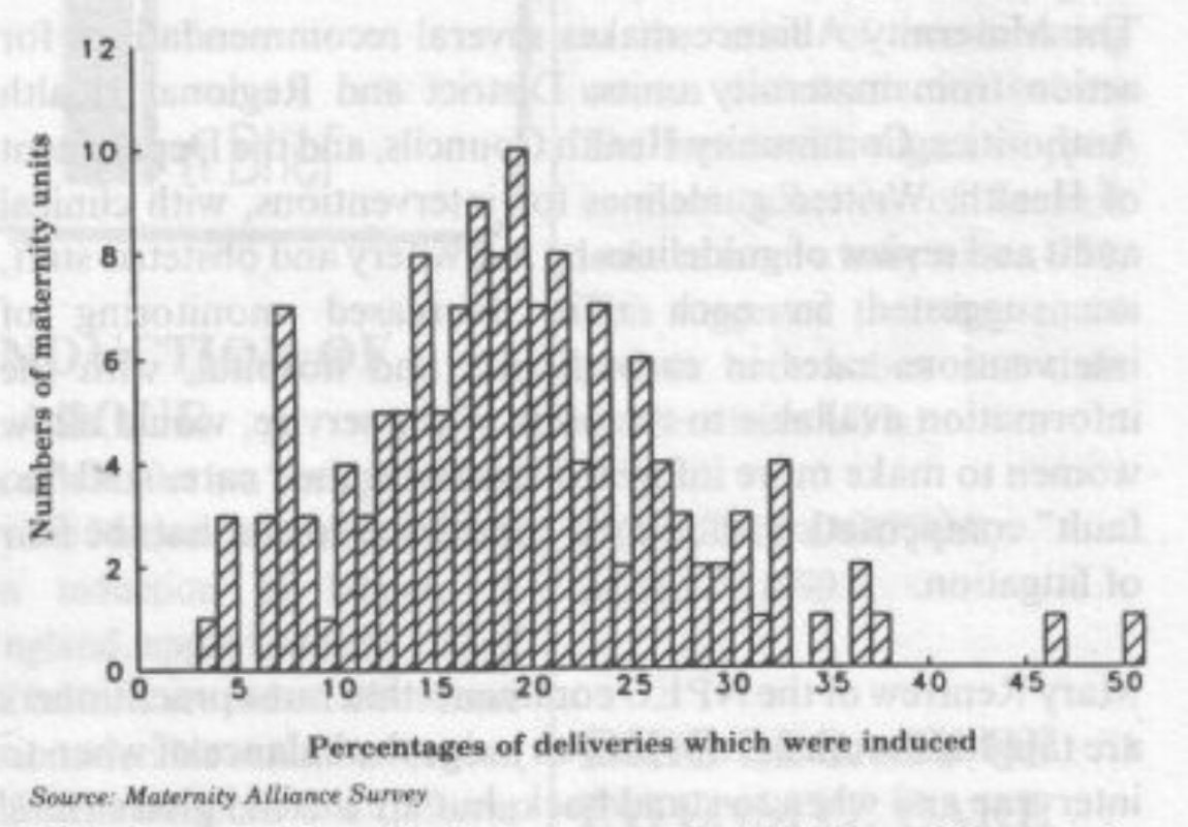
The new report, by Dr. Colin Francome, also looks at instrumental deliveries (forceps and vacuum extraction) and induction of labour. The instrumental delivery rate stayed fairly static over the period, varying from 10.2-11%. The rates for inductions showed an initial drop from 18.8% to 16.4%, followed by a rise to 18.2% in 1985.



These overall rates, however, hide wide variations between hospitals, which were not related to the size of the hospital. For instance, three hospitals surveyed induced over 40% of the labours, and two consultant units had caesarean rates of 25%. As the report points out, these variations show that in many cases interventions are not being reduced anywhere near a clinically defensible level.

Taking the interesting approach of asking midwifery managers and consultants directly what they thought contributed to the intervention rates in their units, some useful insights emerged. For instance, midwives felt that a reduction in inductions was possible and desirable, and thought it could best be achieved by establishing specific criteria for induction; this should particularly reduce inductions for postmaturity and social reasons. It was suggested that clinical audit should ensure that specific criteria are met. In the case of postmaturity, this would mean careful monitoring of individual pregnancies to determine which might be at risk, rather than induction by dates alone.

Surprisingly, though midwives called for a reduction in inductions for social reasons, there was no direct question of how such a procedure could ever be clinically justified.



Midwives also identified what many in AIMS would see as the crux of the matter - the dominance of obstetrics over midwifery in determining the standards of good practice. They felt the intervention rates would currently only be changed as consultant policy changed, and that the guidelines of practice were handed down from above by consultants to midwives, and to junior doctors who often were too quick to intervene.

Consultant obstetricians who replied to the survey listed as reasons for a higher caesarean rate that indications had changed (more acceptance of breech and pre-term births as being automatic indications for a caesarean); fear of litigation; avoidance of long and difficult labours; and increased use of fetal monitoring (which has repeatedly been shown to result in higher caesarean rates without improvements in outcome). It was stated that society had come to expect a 'perfect child' from each pregnancy, and since the public is generally unaware of the risks of caesareans, it may be felt that a doctor has not done everything possible if a baby is damaged and a caesarean has not been done.

The idea that fear of litigation constitutes a valid justification for high caesarean rates is admirably refuted in commentaries following the Maternity Alliance report. Beverley Beech points out that deciding on medical interventions on this basis is unethical, since clinical considerations alone should determine interventions. Arnold Simanowitz, executive director of Action for Victims of Medical Accidents, argues that in fact fear of litigation has a small if any real influence. Rates have risen everywhere in the world regardless of litigation rates, including Sweden where no-fault compensation is already in effect. Doctors are being misled, he says, because having done a ceasarean section is NOT a protection against suits of negligence, particularly since the operation carries significant risk. Rather, any doctor who bases his or her treatment on that which is clinically justified is not at risk of litigation, because this cannot be negligence.

It also emerged from the consultants' comments that whether forceps or vacuum extraction with the ventouse are used depends on the experience and preference of junior staff, who perform most instrumental deliveries, rather than any rational clinical choice.

The Maternity Alliance makes several recommendations for action from maternity units, District and Regional Health Authorities, Community Health Councils, and the Department of Health. Written guidelines for interventions, with clinical audit and review of guidelines by midwifery and obstetric staff, are suggested in each unit. Increased monitoring of interventions rates in each district and hospital, with the information available to the users of the service, would allow women to make more informed choices in their care. And "no fault" compensation should be considered to combat the fear of litigation.

Mary Renfrew ofthe NPEU comments that most practitioners are taught as students not how to judge the balance of when to intervene and when to stand back, but are instead given 'rules' such as second stage should not last longer than one hour in primips. "This approach could be likened to using a sledgehammer to open the most delicate of containers, with little understanding of the normal range of healthy labour," she writes. It reminds me of a similar metaphor I have seen elsewhere, and mentally

applied to the practice of modern obstetrics: "If your only tool is a hammer, you are likely to see every problem as a nail. "

This report offers some insight into the thinking of those who provide maternity care, and a few suggestions that may increase awareness of the use in interventions in labour. Yet it does not address the basic paradigm of childbirth as a function which is so potentially hazardous that a certain set of tools are issued to practitioners. As Wendy Savage comments, she is far below the national average rate of caesareans, and the rate within her own hospital, with just over 7%. Yet she wonders if her views have been distorted by her training, when she considers the statistics from the Farm midwives in Tennessee who over 15 years have had a caesarean rate of 1.5%. Have we set up a system, she asks, which in itself creates anxiety, and then translates to fetal distress which calls for the intervention rates we accept as the norm?

The final impression from this report on "Changing Childbirth" is that so far it has not been changing very much. If we consider it more in the active sense of instigating change, doubtful whether the recommendations, leaving intact as they do both the prevailing system of care and the established paradigm, will produce much more than slight, cosmetic change.