AIMS For a better birth...

RCOG Caught on the Net - Clinical Guidelines on Waterbirth are Pretty Wet

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You find the must extraordinary things on the Internet. While 'surfing the Net' I discovered that the Royal College of Obstetricians and Gynaecologists had taken it upon themselves to produce draft RCOG Clinical Guidelines on Birth in Water. I was intrigued, as the past experience has shown me that the RCOG's knowledge of this subject is sorely lacking.

These Guidelines were produced under the direction of the 'Scientific Advisory Committee' Very impressive, until one discovers that the members of this Committee have little or no experience of helping women give birth in water. But why let a little matter of ignorance inhibit one from pontificating on a subject of which they have no knowledge or experience.

The introduction states, "The use of warm water for relaxation and pain relief during early labour bas been in practice for many decades, but usually only for brief periods of 20-30 minutes." No evidence was given to support this statement and as AIMS members have known of midwives who have used water for pain relief for decades and know of none who only use it for 'brief periods of 20-30 minutes" one wonders why they feel the need to suggest this restriction.

A large section of this questionable document addresses "Strategies which may reduce potential problems associated with birth in water". Note the use of the word "potential". Instead of addressing real, everyday problems associated with birth in water (like obstetricians who issue dictats, not based on any scientific evidence, with which midwives are then required to comply) the College chooses to focus on theoretical "potential" problems.

It begins by stating that "In the national surveillance study of morbidity and mortality among babies delivered in water the perinatal mortality was not different to that associated with conventional birth". It then highlights the British paediatric Surveillance Unit's survey of babies who had been admitted to special care baby units or who died following delivery in water between April 1994 and March 1996 and goes on to state that "There were five perinatal deaths among the 4,032 babies born in water in England and Wales, giving a perinatal mortality of 1.2/1000 live births... This compares with a perinatal mortality of 1.4 for a comparable group of low risk women having a conventional birth".

The Guidelines omit to mention that this study concluded that "no deaths were directly attributable to

delivery in water, but 2 admissions (to the Special Care Baby Unit) were for water aspiration".

The document goes on: 'Temperature of the water needs ro be carefully controlled". Having hypothesised about the effects of warm water it states that "Body temperatupe (37 deg) is the 'ideal temperature". No comment is made about the range of temperature which experts in birth in water have observed women using and which vary from 28' - 38' C2! with no reported ill-effects.

In the next section the guidelines state: "During a normal delivery, as soon as the chest is no longer compressed, air is sucked into the lungs". The Scientific Committee appears unaware of Dr Paul Johnson's research which clearly demonstrates how a normal healthy baby has a physiological mechanism which prevents it inhaling while it is immersed in water1!

While acknowledging that "Although the risk to the baby of serious infection appears to be low, minimising contamination of the water by strict adheænce to procedures for cleaning pools should help minimise any of infection". No mention is made of the significant risk of infection women run when having a standard delivery in our maternity units. It would have been helpful to compare the infection rates between birth on a bed and birth in water. There are many of us who suspect the risks of from birth on a bed are far higher, and often under-reported.

The Guidelines move on to make one of its more bizarre suggestions: "lowering the level of water prior to delivery may avoid cord traction and reduce snapping of the umbilical cord". Clearly, the Scientific Committee has little knowledge of water pools. Many pools have powered drainage systems and if the woman remained in the pool when the pump was turned on she may well find herself sucked towards the drainage hole! Furthermore, no mention is made of cords snapping because midwives pull on them.

"The newborn baby should be exposed to an adequate cold stimulus to optimise the breathing reflex before oxygen supply from the placenta ceases, which means removing the baby from the water". No responsible practitioner would leave a baby in the water until the oxygen supply from the placenta ceased. Adequate stimulus to breathe is provided by ensuring that the baby is brought to the surface, face up, immediately.

"It is suggested that until further evidence becomes available, it would be prudent to advise women to leave the pool for the third stage". We suggest this advice is based on the old chestnut that "the combination of vasodilatation and increased hydrostatic pressure produces the theoretical risk of water embolism". They even go so far as to stress "Again, this is a theoretical risk". There is a theoretical risk that we might be hit by a meteor, do we issue guidelines warning people about walking in open spaces?

"It is important that women are properly informed about the possibility that they may be advised to leave the birthing pool, as it may be impossible to manage the situation tn the water. Emergency interventions may be delayed if it is difficult to get the woman out of the bath. Injuries may occur when trying to get out of the bath as quickly as possible". Another theoretical risk, details about actual risks would have been more helpful.

The Guidelines conclude "The use of a birthing pool for labour and/or delivery is an option is now widely offered within maternity units in the UK, and is also available for home births".

This is news to us. The reality is that almost half the maternity units in the UK, in a rush of enthusiasm, installed birth ools (many were merely glorified large baths and not ideal by any means). However, in the face of persistent and ill informed adverse publicity and comments from the RCOG, including injunctions from obstetricians banning women from giving birth in water, and the reluctance of many obstetric nurses to encourage this option, most maternity units severely restrict the use of the pools. My local unit does not even have a sign on the door advertising the existence of the pool room.

Even if women manage to fight their way into the water, the staff in many units appear to do everything they can to get them out again. A woman at Chelsea and Westminster who wanted a water birth and thought they would support her wishes found that the staff did everything they could to stop her getting into the water. She eventually had a completely avoidable and unnecessary caesarean section for a birth which was "failing to progress'.

Throughout this document the RCOG has classified the level of evidence these Guidelines are based on. It will come as no surprise to discover that every single statement (bar the first) is based on "Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities". Respected by whom?

Experts in water birth, such as Diane Garland, Cass Nightingale, Yehudi Gordon, Faith Haddad, Roger Lichy were not consulted. There is a huge amount of midwifery and lay literature on water birth, all of which has been ignored by the College, In 1995 I organised together with Janet Balaskas, Jayn Ingrey, and Sheila Kitzinger the First International Water Birth Conference to which we invited respected water birth practitioners from all over the world. 1,500 midwives, doctors and mothers gathered to hear of their experiences and the proceedings of that conference "Water Birth Unplugged" was published by Books for Midwives Press. At the very least the RCOG could have read the book.

It is fascinating how determined obstetricians are to stop women using water for pain relief or birth. They constantly talk about "theoretical" risks, and vigorously oppose women who choose this method Of pain relief.

Why is it that obstetricians champion women's right to choose a caesarean section, but if a woman chooses a water birth they find every excuse under the sun to prevent that choice? It is perhaps some comfort that after years of water birth use and thousands of births in water the best the Obstetricians can come up with is "theoretical" risk because one can be absolutely certain that if they could have found a real risk they would have been shouting from the rooftops. And while they are focusing on the "theoretical' risks of water birth, no-one is paying much attention to the real risks of medicalised birth in our large, centralised. obstetric units.

"Towards Safer Childbirth" a document drawn up by the RCOG and RCM requires consultants to

develop and implement standards of obstetric practice. Anyone wanting a water birth is required to fit into the "normal" category and they will be cared for by experts in normality, namely midwives. Water birth is, therefore, outside the obstetricians' remit. They are experts in abnormality and know little or nothing about normal birth. If guidelines are needed on water birth they should be drawn up by the Royal College of Midwives.

AIMS has written to the RCOG suggesting that as they should now withdraw this document.

Editors Note: The RCOG have recently announced this document has now been withdrawn.

References

Muscat J. A thousand water births; [s]election criteria and outcome, in Water Birth Unplugged, Proceedings of the First International Water Birth Conference, Ed. B A Lawrence Beech, Books for Midwives Press, UK.
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