AIMS For a better birth...

AIMS Commentary: the OASI care bundle debate

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by the AIMS Campaigns Team

The prospect of sustaining perineal trauma during birth remains a topic that has, until recently, been seen as relatively taboo; an issue seldom shared socially, with the consequences of severe perineal trauma rarely discussed. Tears, of course, vary in severity and the subsequent management and treatment for this injury is dependent on accurate clinical identification and recognition, followed by the offer of appropriate treatment. On that basis, the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) have come forward with'an OASI care bundle',[1] with OASI standing for 'obstetric anal sphincter injury'. This article explores some of the controversy surrounding this bundle.

Estimates of the incidence of perineal trauma vary, with an estimated 90% of first-time labouring women and birthing people sustaining some degree of tear, graze or surgical incision (episiotomy)[2], reducing in incidence in subsequent pregnancies. Most of these injuries will not be severe and will heal without long term consequence. These are classified as 1st or 2nd degree tears.

However, some injuries will be identified as a 3rd or 4th degree tear, affecting the tissue around the anus. These are commonly associated with long labours, instrumental birth and prolonged pushing, although they may also occur during spontaneous births. Approximately 3.5 out of 100 tears (6/100 in first time labours, <2/100 in subsequent births) will be classified as a 3rd or 4th degree tear.[3] These Obstetric Anal Sphincter Injuries (OASI) require accurate identification, specialist repair, and post birth support and rehabilitation. This usually includes obstetric follow up appointments and physiotherapy.

Sustaining an OASI can have profound implications for those experiencing them, both from an emotional and physical health perspective, with many women and birthing people reporting chronic and acute pain, sensitivity, faecal and flatus incontinence, bladder and bowel dysfunction, sexual dysfunction, anxiety, depression, post-traumatic stress disorder and tokophobia[4]. Support networks and charities, including AIMS, Birthrights, The Birth Trauma Association and the MASIC foundation, exist to provide specialist support and information to women and birthing people in this regard, as well as to support decision making and to offer practical advice.

Criticism has been levelled against national healthcare policies and guidelines and this continues to gain momentum. Concerns exist around their failure to provide appropriate antenatal education about the

risks and consequences of sustaining not only OASI, but perineal trauma as a whole. There are concerns about the clinical detection of, and the prevention of OASI across maternity systems, and about the provision of suitable support for those having sustained an injury. The stigma associated with the range of consequences of perineal tearing, is also a concern.

Urgent action was therefore needed not only to contribute to reducing OASI across the childbearing population, but also robust information and antenatal support that enables informed decision making. It is for this reason that the OASI care bundle was launched in 16 maternity units between January 2017 and March 2018. The bundle has become a troublesome area of debate across disciplines with regards to not only the evidence upon which it is based, but the way in which the bundle has been introduced and the omission of robustly evidenced interventions such as warm compresses and massage. This has left many clinicians, academics and birth workers scratching their heads as there is evidence that these simple measures reduce the incidence of third- and fourth-degree tears.[5] [6] [7]

Based on a set of interventions brought together and intended to be applied to all women and birthing people, the OASI Bundle includes:

- **Antenatal information about OASI and what can be done to reduce the risk of sustaining an OASI**. This is limited to advising midwives and doctors that the bundle is used, and to explaining its elements. There is no discussion of the risk factors for OASI, for positioning or for the evidence (or lack thereof) for or against manual perineal protection (MPP)[8]. Importantly, there is no reminder about the absolute right of the woman or birthing person to decline the intervention and/or to be supported to give birth in a way that they consider will increase their chance of avoiding an intervention, such as episiotomy, that may in itself increase the risk of OASI.
- **Documented use of manual perineal protection (MPP).** The bundle works on the basis of applying this unless "the woman objects" and in all cases of operative vaginal births. We note that the evidence upon which MPP is founded is limited, a point acknowledged by the authors of the evaluation paper (see footnote 9).
- **Episiotomy when indicated**. The bundle just says it should be used when indicated, so this adds no change to current normal practice. However, the bundle has changed the angle at which this is performed, something that isn't included in the antenatal evidence for the woman or birthing person and lacks robust evidence.
- **Full and thorough examination of the perineum including a rectal examination even if the perineum appears to be intact**. Although this is important in detecting tears and classifying them for appropriate management there remains little evidence of the number of OASI identified by per rectum examination in the presence of an intact perineum.

In August 2020, a quantitative evaluation of the bundle was published[9] to complement the publication of clinicians' perspectives on the bundle[10]. This showed a decrease in OASI rate from 3.3% to 3.0% after implementation of the bundle. Whilst acknowledged as a small effect, the paper's authors suggest that the pre-bundle figure of 3.3% may have been an underestimation of the incidence of severe perineal trauma (with perineums previously not checked as thoroughly), and that therefore, the reduction in

trauma brought about by using the bundle, may be bigger than it appears. However, there is no evidence to support this.

This again sparked discussion and debate across disciplines around the true impact of the interventions, challenging the evidence upon which the bundle was based as well as the interpretation of data collected as part of the bundle, and the evidence gaps that remain.[11] [12] [13]

It was not until January this year, in the International Urogynecology Journal[14], that the qualitative data of the views of the women was published. This provided an evaluation of women's experiences of the bundle. Sadly, it did not seem to answer the anticipated questions surrounding the acceptability of the bundle in a way that truly represented the wider population upon which the bundle was imposed. 19 women out of a prospective 55,060 (accepting that qualitative research is neither representative of an entire population nor aims to capture everyone's perspective), responded to questions that seemed neither to capture the elements of the bundle, nor to reflect the available evidence.

It is clear that the implementation of the bundle comes from a place of good intentions. No-one would deny that there would be huge benefit in being able to reduce the incidence of OASI.**However, the history of maternity care is littered with the implementation of seemingly well-intentioned innovation and interventions that later have been found to be problematic, ineffective and/or harmful.**Care bundles, themselves, are intended to draw together a variety of evidence-based interventions, in order to achieve improvements in outcomes, that are greater as a sum of the parts, than individually.[15]

It is important that scrutiny should therefore be applied to all care bundles and interventions, no matter how well intentioned, before they are implemented and during implementation, as once embedded into clinical practice, it can be hard if not impossible to de-implement.

There continues to exist professional disagreement in relation to the bundle, and it is these same issues that lead AIMS to continue to be concerned:

Lacking a physiologically informed approach - The bundle aims to standardise practice in relation to reducing OASI with a focus on the application of the invasive intervention MPP across a whole birthing population but without consideration of the physiological variations of women and birthing people or of the mode or place of birth, and is therefore lacking a physiologically informed approach to reducing serious tears.

Place of Birth - Evidence already exists around the preventative effect of out of hospital birth on perineal tearing.

Position in Labour and Birth - The authors of the bundle's original paper explored risk factors for OASI and identified instrumental birth as a 'key determinant' in increased risk of severe perineal tears.[16] And Bidwell's evaluation of clinicians views of the bundle[17] and its unintended consequences found, amongst other things, that the position the birthing person needed to adopt in order for someone to apply manual pressure to the perineum, may in itself be a cause of OASI.

One size fits all - The application of the bundle takes a one size fits all approach rather than offering individualised care, possibly for fear of being drawn into a blame culture should any serious trauma occur. The homogenised approach once again reflects the mechanised, pathologised and defective view of women's birthing bodies[18] [19], failing not only to acknowledge individual uniqueness, but reinforcing the belief that every birth must be medically managed in order to 'save the mother and baby'. This is perhaps illustrated in the failure to fully acknowledge the dehumanising effects of rectal examination in the absence of evidence and visually identified trauma, and the psychosocial effects of labial tears, which increase when using MPP.[20] Whilst labial tears have less long-term implications compared to OASI, this does not negate the personal effects of this type of injury.

Birth Practices - More work is needed, not only to inform clinicians and birthing women and people around which birth practices are associated with intact perineum or severe tears, but to reach a consensus and to resolve clinical issues. The ongoing debate and conflict serves only to underline the dysfunctional nature of the current system which will benefit very few in the long term.

Antenatal Information - It goes without saying that women and birthing people have an absolute right to clear, unambiguous and evidence-based information antenatally to enable informed decision making regarding their care, and this includes the OASI care bundle. Currently the bundle information pack provision extends to advising the content of the bundle rather than the evidence around prevention of tears, and any other options for care. More must therefore be done in terms of the provision of appropriately tailored antenatal education and discussion of perineal tearing including risk factors that extend beyond the individual including mode and place of birth, as well as discussing acceptability of interventions including MPP, rectal examination etc.

AIMS would like to remind all clinicians that the birthing person's wholehearted and fully informed consent is needed for any examination or procedure and they must be aware of all their options before agreeing to any part of the OASI care bundle.

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[1] OASI Care Bundle Project Team. (2018) Implementation guide for maternity sites in the roll-out phase 2017-2018. RCOG London. www.rcog.org.uk/globalassets/documents/guidelines/research--audit/oasi-care-bundle/oasi-care-bundle-guide-final-_-050118.pdf

[2] RCOG (2019) Perineal tears during childbirth. Available at: www.rcog.org.uk/en/patients/patient-

leaflets/perineal-tears-during-childbirth

[3] RCOG (2021) Third- and fourth-degree tears (OASI). Available at: www.rcog.org.uk/en/patients/tears/third-fourth

[4] Editor's note: Tokophobia is a morbid fear of childbirth and/or of the experience and consequences of medicalised birth care.

[5] Magoga, G., Saccone, G., Al-Kouatly, H.B., et al., 2019. Warm perineal compresses during the second stage of labor for reducing perineal trauma: a meta-analysis. Eur. J. Obstet. Gynecol. Reprod. Biol. 240, 93–98. doi:10.1016/j.ejogrb.2019.06.011

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[7] Pierce-Williams R. A. M., Saccone G. and Berghella V. (2019): Hands-on versus hands-off techniques for the prevention of perineal trauma during vaginaldelivery: a systematic review and meta-analysis of randomized controlled trials, The Journal of Maternal-Fetal & Neonatal Medicine, www.iris.unina.it/retrieve/handle/11588/804108/333468/199%20Hands%20on%20-%20JMFNM%20-%20Pierce%20Williams.pdf

[8] Editor's note: Manual protection of the perineum (MPP) is a practice that has been used for a very long time, but one that's use remains debatable. The findings of the HOOP (Hands On Or Poised) trial of 1998 challenged the practice, but the study was considered flawed by proponents of the 'hands-on' method of care. However, there is little evidence that 'hands-on' reduces trauma, and very few studies think to ask the women themselves. A 2017 Cochrane review of the evidence for different techniques for reducing perineal trauma concluded that, "massage and warm compresses may reduce serious perineal trauma (third- and fourth-degree tears). Hands-off techniques may reduce the number of episiotomies but it was not clear that these techniques had a beneficial effect on other perineal trauma. There remains uncertainty about the value of other techniques (*i.e. manual protection*) to reduce damage to the perineum during childbirth".

[9] Gurol‐Urganci I, Bidwell P, Sevdalis N *et al* (2020). Impact of a quality improvement project to reduce the rate of obstetric anal sphincter injury: a multicentre study with a stepped‐wedge design. BJOG doi:10.1111/1471-0528.16396.

[10] Bidwell, P. *et al.* (2020) 'Exploring clinicians' perspectives on the "Obstetric Anal Sphincter Injury Care Bundle" national quality improvement programme: a qualitative study',*BMJ Open*, 10(9), p.

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