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Original Research – Qualitative

A critical analysis of Australian policies and guidelines for water immersion during labour and birth

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ABSTRACT

Background: Accessibility of water immersion for labour and/or birth is often dependent on the care provider and also the policies/guidelines that underpin practice. With little high quality research about the safety and practicality of water immersion, particularly for birth, policies/guidelines informing the practice may lack the evidence necessary to ensure practitioner confidence surrounding the option thereby limiting accessibility and women's autonomy.
Aim: The aims of the study were to determine how water immersion policies and/or guidelines are informed, who interprets the evidence to inform policies/guidelines and to what extent the policy/guideline facilitates the option for labour and birth.
Method: Phase one of a three-phase mixed-methods study critically analysed 25 Australian water immersion policies/guidelines using critical discourse analysis.
Findings: Policies/guidelines pertaining to the practice of water immersion reflect subjective opinions and views of the current literature base in favour of the risk-focused obstetric and biomedical discursive practices. Written with hegemonic influence, policies and guidelines impact on the autonomy of both women and practitioners.
Conclusion: Policies and guidelines pertaining to water immersion, particularly for birth reflect opinion and varied interpretations of the current literature base. A degree of hegemonic influence was noted prompting recommendations for future maternity care policy and guidelines'.
Ethical considerations: The Human Research Ethics Committee of the University of South Australia approved the research.

Statement of significance

Problem

Water immersion policies and clinical practice guidelines (CPGs) are in existence despite what is argued to be a less than sufficient evidence base.

What is already known

Water immersion has many benefits during labour and birth including reductions in sensation of pain and increased feelings of satisfaction and control. However, safety of the practice continues to be challenged against the lack of high quality evidence.

What this paper adds

This paper highlights that water immersion policies and guidelines are informed by authoritative opinion and less by the current evidence base.

1. Introduction

Warm water provides a welcome environment for many women during labour and birth. Not only does the buoyancy of water assist in mobility and facilitation of an upright position, it is known that warm water immersion reduces the sensation of pain and allows women a sense of control over their labour and birth experience.[1,2] However, water immersion in the context of

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maternity care, whilst not new, continues to be challenged against concerns of safety and potential associated risks, which may be related in part to a paucity of evidence particularly surrounding its use during birth. Such challenges include the risk of neonatal aspiration, possible drowning, umbilical cord avulsion and potentially increased rates of maternal and neonatal infections.[3] Despite the concerns raised, research has not definitely demonstrated that these adverse events are significantly increased during water immersion compared to other modes of birth.[4]

Water immersion for labour and birth is often used as a means of facilitating a normal, physiological birth given the benefits it provides. Therefore, the practice is most commonly associated with the role of a midwife. Philosophical underpinnings of midwifery support and promote the journey through pregnancy, childbirth and beyond as a normal life event where women are not a patient in need of treatment and management but instead, are healthy and in need of empowerment and support. Midwives not only provide education but advocate for and support women to be autonomous beings with the ability to exercise choice and decision making power. This relationship of advocacy alongside of the philosophical belief that birth is a normal process sees midwives supporting women in alternatives to practices that sway from the biomedical framework and illness model. This often includes the use of alternative pain relief options including water immersion.

The movement towards woman-centred care has not only been a frequent topic of debate but also of research. With this, recognition of greater satisfaction and better outcomes has been realised as women are increasingly supported in self-determination and autonomy of choice. Midwives, are often gatekeepers in the sense that they are in the frontline of facilitating and supporting a woman's right to self-determination.[5] However, despite midwifery having been built on the foundation of being 'with woman'[5,6] and facilitating as much as possible, the ideal of woman-centred care,[5,6] supporting choice and working within the realms of policies and clinical practice guidelines (CPGs) is not always as easy as it may first seem. The difficulty of finding balance between obligations as the woman's advocate and the constraints of policies and regulations mean there is the potential for women's right to choose where and how she gives birth to go unacknowledged and unaccounted for in care facilitation.[5] At times midwives are forced to make compromises in order to work in line with poorly informed policies/CPGs that lack the recognition and importance of the woman-midwife relationship and all that it embodies.[7]

Clinical Practice Guidelines (CPGs) first came about in the late 1970s and the trend continued through the 1980s. However, it was the focus on evidence-based practice in the 1990s that gave rise to the increasing use of CPGs in all areas of health care.[8] Evidence-based medicine (EBM) in particular, brought about a growth in scientific knowledge, which arguably allowed for safer care facilitation and better outcomes for both practitioners and most importantly, those they cared for. Although this is ultimately what has been achieved in terms of perinatal and neonatal morbidity and mortality in the maternity care setting, improvements appear to have been overshadowed by increasing rates of intervention including induction of labour and caesarean section. Newnham[9] suggests that this is largely a result of the pathological view of pregnancy and childbirth, the greater focus on risk and the need to control all aspects of the childbearing experience. Bryers and Van Teijlingen[10] further suggest that the litigious nature of maternity care and the resulting 'blame game' if things go wrong ensures all parties involved in the birth process are accountable, to some extent, for what transpires. Often it follows that the onus rests on the health care provider to uphold evidence-based practice and follow CPGs and policies, which has ultimately meant that directives are important as a means of regulation and maintaining practitioner accountability.

Fervers et al.[11] define CPGs as "propositions developed methodically to help the physician and the patient in their decisions concerning the appropriateness of care in a given clinical setting." Such documents provide end-users or practitioners with guidance underpinned by high-quality literature with the purpose of informing decision making around the provision of care or the undertaking of a procedure. However, up until the 1990s, CPGs relied heavily on authoritative opinion and therefore, there has been a conscious effort to ensure that there is both rigour and systematic review of the literature to inform content. Silberstein[12] suggests that one of the conditions of a robust CPGs/policy is that there is sufficient high quality evidence on which to base decisions in order to minimise the influence of expert opinion. This is particularly important in ensuring that there is no bias within the document that allows for domination of one particular group over another.

Though the terms policy and CPGs are often used interchangeably, there are distinct differences between them. The World Health Organisation (WHO)[13] defines health policy as 'decisions, plans, and actions that are undertaken to achieve specific health care goals within a society' whilst the Centers of Disease Control and Prevention (CDC)[14] in the United States suggests that policy is "law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institution". Policies are in use across the Australian health system to direct care provision however, unlike CPGs, are often prescriptive and mandatory and therefore must be followed by those who use them. For example, the South Australian First Stage Labour and Birth in Water Policy states that "Compliance is mandatory"[15] reflecting the sometimes marked differences between policies and CPGs.

Documents that provide clinical governance and guidance such as CPGs and policy are known to improve the quality of care by decreasing practitioner variation and bias.[8] Further to this, CPGs and policies also allow for timely advances in practice, which would otherwise present as a challenge if literature was not systematically reviewed and combined. However, despite the many benefits of CPGs and policy in providing care providers with readily available, evidence-based documents, there are a number of limitations. For example, Burgers and van Everdingen[16] suggest that the development of CPGs can be time-consuming particularly given that informants may interpret research differently. Furthermore, they make it clear that there are often 'gaps' in knowledge that makes translation of research difficult. This is further complicated by the reality that evidence is evolving and therefore CPGs need frequent and timely update, not always possible for time poor clinicians. In addition, available resources, entrenched practices and institutional variations may affect the development of policies and CPGs. For example, Cameron et al.[17] highlighted: time and staffing, fear and resistance to change and differences in service venue, as difficulties in the development and implementation of a postpartum haemorrhage policy. The evidence base underpinning policies and guidelines also appears to be a limitation in many instances. This was shown by Grimmer et al.[18] who found that the overall quality of 16 South African CPGs using the International Centre for Allied Health Evidence (iCAHE) CPG appraisal instrument and Appraisal of Guideline Research and Evaluation (AGREE II) was poor. The authors therefore suggested that focus needed to be placed on the development of quality CPGs informed by a rigorous evidence base with the purpose of increasing end-user confidence and compliance.

To date, there has been limited analysis of maternity care CPGs and policies and their subsequent influence on practice. Whilst the