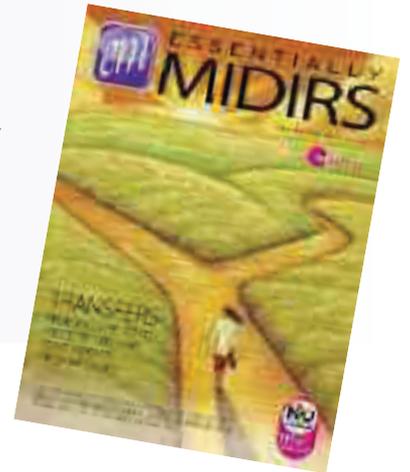




Editorial comment on issues addressed in this month's Essentially MIDIRS...

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Comment by
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Carbon monoxide testing: what choice?

The issue of smoking in pregnancy has been in the news rather a lot over the past few weeks, mainly because of the National Institute for Health and Clinical Excellence (NICE) having taken the position that pregnant women should be tested for carbon monoxide at booking in order to determine whether they smoke, and be given advice or counselling as appropriate (NICE 2010). Although NICE claimed that this was about helping smokers to quit rather than about penalising them, this idea has been greeted as a very unhelpful step by many of those involved in maternity care, who are concerned that it will have a negative impact upon women's experiences as well as on their relationships with those caring for them. As Sue MacDonald, RCM education and research manager said of the guidance:

'There appears to be an emphasis on pregnant women, which is appropriate given the evidence. However the key issue here for NICE is their emphasis on the CO2 monitor. It is crucial that health practitioners, including midwives, focus on being supportive rather than making women feeling guilty, or as though they may not be truthful. Use of the CO2 monitor has the potential to make women feel guilty and not engaged. We need to look at a range of individualised interventions for women that meet their needs and aspirations.'

'There is also the cost implication of all midwives carrying monitors, and issues such as safety and infection control, and whether this is the best use of funds to address smoking cessation.' (O'Malley 2010)

Unfortunately, we don't have good evidence that any of the interventions currently

employed really work or that this IS the best use of precious funds. Smoking is complex; it is not merely a physical action and neither can it be easily pigeonholed into boxes labelled 'addiction' or 'habit'.

People smoke in different ways, at different times and for different reasons. The fact that so many people still do smoke, despite several decades of increasingly intrusive health warnings at every turn, reinforces just how complex this issue really is. In fact, research into smoking could give us an opportunity to learn more about people and what motivates them on different levels, but probably only if individuals and organisations can remain open-minded rather than automatically labelling people as 'bad' because, for whatever reason and despite all the warnings, they continue to smoke.



Women, information and choice

Routine carbon monoxide testing is already in place in some UK Trusts, and the (perhaps isolated) experience of one pregnant woman who I talked to while writing this editorial gives me further cause for concern. She was tested during her booking appointment but was told that it was being done to check that she was not exposed to carbon monoxide either in her home or at work. Smoking was not mentioned, and she was quite shocked when she later realised that she had been unwittingly tested to see if she was a smoker.

It is my understanding that women have the right to be given full and frank information about any screening test offered to them, along with a discussion about the implications of the test and its results. Moore *et al's* (2002) study showed lower rates of smoking cessation when this was validated by measuring cotinine levels than when reported by individual women, yet this is a very complex area and one that we are nowhere near to understanding. It may be that the differences between the self-reported and validated rates are linked with the fact that women already feel guilty. It is also possible that women have a desire to believe that they are smoking less than they really are, but even if these things are true, then they are unlikely to be the only factors and this certainly doesn't justify our being less than fully honest about the testing ourselves in order to police women's possible cigarette intake. This is so far away from both the traditional understanding of what midwifery is supposed to be about and the modern codes and rules that set the standard for our practice, that it is difficult to reconcile the two.

I now know of other non-smoking women who are reluctant to undergo this test, not because they have anything to hide, but because they simply do not want to accept being policed in this way by the maternity services. One woman who I was talking to as this hit the news quipped that it may only be a matter of time before the NHS introduces compulsory handbag searches at the door of the antenatal clinic to detect contraband. I have also seen online comments about whether the health service will start using full body scanners such as those being brought into some airports in order to detect lighters. This is surely not conducive to the kind of relationships that midwives are striving to create with the woman they attend? People do not tend to develop trusting and open relationships with customs or security officers, so how can we expect them to do so with midwives who are having to take on elements of these roles?

None of this is intended to downplay the risks of smoking, but there are lots of other things that can affect women's well-being

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and yet we are not seeing nearly as much attention paid to how we can detect and try to reverse the harms caused to pregnant women by factors such as poverty, domestic violence or lack of social support. When Emma Tominey (2007) published her analysis of smoking in pregnancy, showing that the impact of smoking on birth weight was far greater for women with lower educational levels, she received harsh criticism from some quarters, yet the evidence does show that these issues are complex and intertwined and universal policies do little to target the women with real need. It would be so useful if some of the resources that are being put towards producing universal guidance on these big issues could be used to look at ways in which we can further explore this complexity rather than continuing the reductionist approach of investigating individual issues and bringing in yet more universal screening tests without proven benefit and at high economic and personal cost.



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