

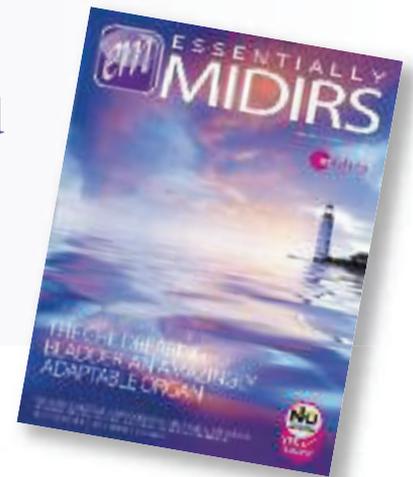
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Writes



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

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Comment by

Sara Wickham Editor

The importance of illumination

Over the years, I have become increasingly aware of just how many of the tenets of the medical approach to childbirth are based not on research evidence or sound reasoning, but on accidents of history, seemingly arbitrary choices or quirks of numerical fate. I am often asked why the cut-off limit for the administration of postnatal anti-D is 72 hours. The answer — at least as I understand it — has nothing to do with there having been research studies that tested a variety of limits which discovered that this was the cut-off point before which anti-D provided the most effective coverage. It is, instead, because this was the time

frame used in some of the early research studies, which used prisoners as subjects, rendering timing of access a key issue. In the Focus article in this issue of *Essentially MIDIRS* (pages 17-23), Penny Champion draws our attention to another example of an area in which the values seem arbitrary — the assessment of urination in women who have recently given birth.

As Penny highlights, the values that are used in this assessment are arbitrary in at least two ways, the first being that the numbers change from study to study and between areas of service provision. This is probably because, secondly, each time someone needs to define a numerical value in order to

develop their own research study protocol or practice guideline, they have no option but to either choose someone else's arbitrarily-arrived-at number or merrily add their own guesswork into the mix.

Let's look at this in another way. One might think that things we consider problematic are deemed to be because, well, they have caused problems. With that in mind, was the volume of urine used to determine covert retention found to be problematic in a study exploring the experiences of postnatal women who had difficulty passing urine?

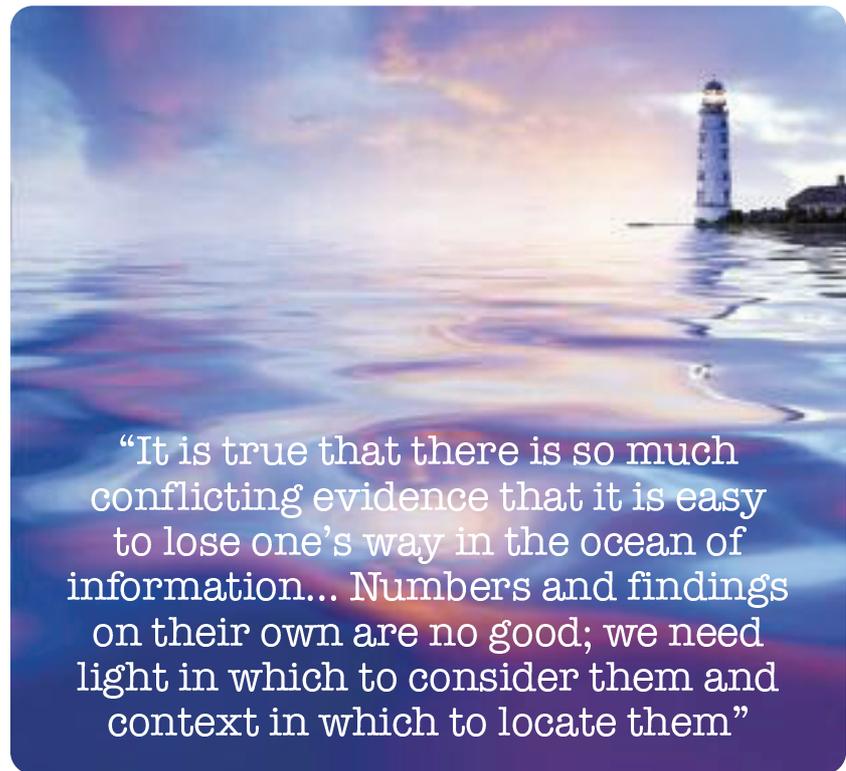
No.

Oh. OK then, was the volume of urine that is considered normal (and has thus become the target at which women aim when filling their measuring jugs) carefully chosen from the results of a study that looked at the amount of urine postnatal women normally passed after birth?

Still no.

There are several other possibilities that could have formed a logical base on which to build the aforementioned practices, but which did not, but I imagine that you have taken my point by now and they are covered very well in Penny's article. I was particularly struck when I read that the definitions of postnatal urinary retention have been extrapolated from a pathological situation which likely differs in several key areas from that in which postnatal women's bladders find themselves (Yip *et al* 2004). This is very worrying to me, because I first became interested in what was happening in relation to the notion of covert urinary retention in the postnatal period when approached by some midwives who were concerned that there were moves afoot to begin screening all women in their area for this with the use of ultrasound. When one looks at the evidence, as Penny has done, it is hard to see that there is even a problem, let alone justify such an invasive, expensive and potentially pointless screening programme in order to find it.

We could have filled the entire journal with a discussion of the myriad examples of situations where the values that determine what happens to women and babies have been determined in an arbitrary fashion, debating questions such as, who decides and on what basis such decision are made. But we haven't, because the issue of alleged covert urinary retention is concerning enough in itself and the problem can be boiled down really easily to the one issue that really matters: the fact that the underpinning facts are anything but factual. There is no long and noble literature detailing how the



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number of millilitres of urine that denotes covert urinary retention in women who have recently given birth was arrived at. There has — to my knowledge, but please write in if you know differently — been no consensus conference in which the great and the good pooled their clinical experience while drinking wine in a hot tub. Instead, the numbers used appear to have been extrapolated from an area that is related in some ways but absolutely irrelevant in others, and then repeated and published enough to help them on their way to becoming such a part of the literary furniture that we will soon forget that there was no real basis for their use in the first place. As has happened in the case of those myriad other examples that we aren't going to discuss this month but will almost certainly be returning to soon.

It is fascinating (and also alarming) to dig deeper and discover just how many of the ideas that underpin the way in which we approach childbirth arose in a relatively arbitrary fashion, often with incredibly good intentions. I am not suggesting for a moment that anyone is setting out

solely to naff off women or midwives by the proffering of plastic jugs. This is a genuine attempt to solve what is perceived to be a real potential problem. Yet the first step in such an endeavour must surely be to determine whether a problem actually exists, with an emphasis on ensuring that this is the case before we set up arbitrary targets at which we then make women's bodies aim. It is true that there is so much conflicting evidence that it is easy to lose one's way in the ocean of information now available on almost any topic. But evidence is not necessarily the key in this case. Surely it is the careful application of thought, intelligence and — dare I say it — common sense that is paramount? Numbers and findings on their own are no good; we need light in which to consider them and context in which to locate them. This kind of illumination, I would suggest, is gained only by carefully thinking about what we think we know.

References

Yip SK, Sahota D, Pang MW *et al* (2004). Postpartum urinary retention. *Acta Obstetrica et Gynecologica Scandinavica* 83(10):881-91.