Thinking outside the box

Stimulating conversation: does cold water wake babies in utero?  
Part 1

We may live in a time and culture in which research evidence is highly valued, but other kinds of knowledge can be just as useful in our lives and work. Indeed, many of the questions relevant to women’s experiences and midwifery practice cannot be answered via formal research methods, and even when we have good quality research findings, other issues still need to be considered. For this and many other reasons, I have long taken the position that we need to value, explore and use other ways of thinking and knowing, and in this article I want to do just that by exploring a practice that is often used but seldom researched.

The cold drink theory

I noticed that the Royal College of Obstetricians and Gynaecologists (RCOG) librarians had considered a question posed to them about whether there was any evidence for the practice of giving a pregnant woman a drink of cold water to encourage fetal movement or improve the reactivity of a cardiotocograph (CTG) trace. Their search highlighted a dearth of research into this common practice, which led me to have a number of conversations with midwives and other practitioners about their experience of this. In the first of two articles on this topic, I explain the theory and describe the range of responses that emerged in these discussions. Overall, the majority of respondents were open to using this practice in certain situations, but they felt it vital that it was used within a framework of providing individualised care and applying common sense.
A range of responses

The respondents include midwives, student midwives, doctors and childbirth educators. I want to acknowledge that I have not used any of the usual means of ensuring that an investigation is sound, reliable and/or that the participants are representative of any particular group, so we should not over-estimate what we can take from the data. An interesting element of using social media to gather data is that it is easy to see when others agree with (or ‘like’) a comment. I think it’s reasonable to suggest that a viewpoint which was ‘liked’ by many people is worth drawing attention to. At the time of writing, the most popular comment was this one:

‘Working in antenatal day unit, [I] saw this work often and very quickly on a daily basis. Cold water and a biscuit normally made a huge difference in a CTG trace. The difference in a CTG could be framed to visualise to pregnant mums the importance of regular meals. Too many mums skip meals or fast, despite evidence that it can affect their baby, too. When cold water and a biscuit didn’t work, it rang alarm bells and reason to look more closely.’ Midwife A

While other people raised some interesting points about which element of this trick is key to its success (which I will discuss next month), the above comment summarises the majority viewpoint. Most respondents have seen some combination of food and/or fluid work well and often in this situation. A few people questioned whether it was coincidental, or the placebo effect, and some noted that individual experience isn’t always reliable. Several also expressed the belief that it is not always necessary to have research evidence in order to offer a low-tech option that is thought to be effective in solving a problem in the real world.

The importance of context

The vast majority of participants didn’t see a problem with the notion of using such a trick to wake a sleepy baby if the circumstances were appropriate, and some very experienced midwives and doctors reported having used this for many years with good results, but a couple of people questioned whether a healthy baby should need to be stimulated in order to persuade it to move. They felt that this practice may be inappropriate, but their response seemed to be limited to one particular context (for instance, advising a woman on the phone who called a hospital to report reduced fetal movements), and so we don’t know whether their view would be the same if the circumstances were different.

As with so many other areas of practice, there is a continuum of ideology and some practitioners begin from the premise that all is probably well until evidence of a problem is found, while others take a more cautious approach and have a lower threshold for seeking technological proof of health and well being. Several people shared their concern that the approach taken within the modern maternity services is increasingly unbalanced. That is, there is a tendency to prioritise finding the occasional unwell baby at the cost of exposing larger numbers of healthy women and babies to further screening and/or intervention. A couple of respondents referred to a ‘worst case scenario’ (such as the woman going on to have an emergency caesarean section, which may lead to criticism of the midwife who gave her food and fluid) as a baseline for decision making, although the majority focused more on the most likely outcome (that all was well and the baby was sleeping) and were concerned about the potential downsides of focusing on the worst possible outcome.

Many respondents either openly or tacitly acknowledged the importance of taking into account the wider context of the woman and baby when deciding whether it was safe to suggest this practice or a different course of action. Midwives wrote about taking into account factors such as the location of the woman (who may be in hospital or at home in a rural community) and her health history, social and emotional situation. My overall sense was that the majority of respondents were open to using this in certain situations and within a framework of providing individualised care amidst the application of common sense.

They had even more to say about whether and how it worked, and in part two I will share more on that and offer a few thoughts about what we might learn from this.

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References


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