ESMiE confidential enquiry: Broader view besides focus on errors by birth-attendants.

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Letter to the Editor, BJOG

Title: ESMiE confidential enquiry: Broader view besides focus on errors by birth-attendants.

Re: Rowe R, Draper ES, Kenyon S, Bevan C, Dickens J, Forrester M, Scanlan R, Tuffnell D, Kurinczuk JJ. Intrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry. BJOG 2020;127:1665–1675.

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Dear Editor,

The important ESMiE study[1] highlights many well-known issues. Its conclusions bolster a view that birth-attendants are not learning from mistakes perpetuating preventable serious events. ESMiE[1] is highly important but methodologically equivalent to a retrospective uncontrolled unblinded study, hence caution required regarding the weight of conclusions. Therefore, the conspicuous shortcomings especially the prevalence of

logistical errors (common in normal-outcome-group as well) may not be the uppermost underlying reasons. Does validity/weakness of science of intermittent auscultation (IA) and cardiotocography (CTG) need a mention? With imperfect science, limited resources, ever-higher standards and non-eradicable human factors; would similar proportion (50 -75%) of adverse events may often/always appear 'avoidable' in retrospect, but not necessarily prevented in practice?[2]

The messiness of CTG is well-known.[2] This letter focuses on IA, especially relevant to ESMiE[1] which criticises non-compliance (61%) to national guideline.[3] It does not critique science or guidelines but only clinical practice. It illustrates a case having IA despite a risk-factor. But why didn't the IA diagnose the likely progressively abnormal fetal heart rate (FHR) pattern? An optimal scientific IA should hedge risk-stratification-errors because it should detect occurrence of abnormal FHR even in "low-risk" cases (some call the "new high-risk"). ESMiE[1] recommends auditing frequency of IA despite no logical/scientific rationale for IA every 15 minutes[3] (unnecessary arduous burden / recipe for non-compliance), against 15-30 minutes recommended by most developed countries.[4] Contrastingly, it is the recommendation of "1 minute auscultation"[3] that has been shown to miss seriously abnormal FHR patterns.[4] Moreover, NICE[3] took a retrogressive step enforcing that the FHR read-outs on Doppler-device be ignored and the audible FHR tones be counted over a minute documenting as a single figure (presumably the baseline FHR). Notwithstanding, the observation of Doppler-device read-outs (not counting) reveals reliable instantaneous FHR, allows better recognition of baseline and important FHR variations.[4] Contrarily, in the presence of acceleration/deceleration, the actual counting over 1 minute gives a meaningless random number (not the true baseline) thereby misleading judgement of decelerations.[4] The culprit is not midwives mentioning baseline FHR as a narrow range (which it actually is).[1,4] More importantly, the unwarranted effort of actually counting to 120 -160 over 1 minute compromises attention span and also precludes flexible/longer extension of auscultation which is crucial for fetal safety.[4]

Thus, it is important to recognise that flawed regimes and unscientific FHR pattern-recognitions enforced on grassroots birth-attendants[2,4] account for perinatal adverse events whether risk-categorisation etc. was optimal or not. ESMiE[1] enquiry suggests solutions as shared commitment to agreed plan, openness, mutual respect and development of yet another new standardised risk assessment tool[1] (to be fully exercised at every patient-interaction?) which cannot compensate for bad science.[2] The proportion of avoidable factors seems to have increased from 47% in 2015 to 75% despite similar measures.[1] Ever-escalating logistical/organisational standards are resource-intensive and can even be distracting.[2] Recruiting more staff who then spend increasing time on bureaucracy and lesser time individually on actual clinical exposure may create its own problems. A broader perspective correcting flawed science seems crucial together with reverberation of old solutions.

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