Electronic Encyclopaedia of Perinatal Data (EEPD)
Volume I. Discussion Documents
B. EPRs

Current paper based definitions do not make sense when using a flow-patterned computerised systems. Suggested Solution.

Original Versions: 16th February 1999 (Updated 28 July 2010)

B08.“Method of Birth”

Major Problem areas
with current-paper based Maternity Data Set Definitions.

See also similar discussions concerning “Place of Birth” and “Anaesthesia / Analgesia”

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Any Comments, Criticisms, Corrections or Suggestions for Improvement very welcome

“Method.pdf” is based on EEPDSOURCE/01-ESSAYS/E-EPRS/B08/Method-15.pages (27 Jul 2010)

Previous and Current Paper and Electronic Definitions

National Maternity Services Dataset Initiative

Method of Delivery

Spontaneous Vertex
Spontaneous Other Cephalic
Vacuum Extraction
Vacuum Extraction after Failed Forceps
Forceps after failed vacuum
Forceps (low cavity)
Forceps (mid cavity or with rotation)
Spontaneous Breech
Assisted Breech
Breech Extraction
Elective caesarean
Emergency caesarean
Emergency caesarean after failed instrumental delivery
Other (including destructive)

Korner Maternity

Method of Delivery

0. Spontaneous Vertex
1. Spontaneous, Other cephalic
2. Low Forceps, not Breech
3. Other Forceps, not Breech
4. Ventouse
5. Breech
6. Breech Extraction
7. Elective Caesarean Section
8. Other (non-elective Caesarean Section

RCOG

Annual Return

i SVD
ii. Vaginal Breech Deliveries
iii. Breech by Caesarean Section
    of which
    a) Emergency
    b) Elective
iv. Forceps Deliveries
v. Ventouse Deliveries
vi. Total Instrumental Deliveries (iv and v)
vii. Total Caesarean Sections (NB Singleton pregnancies)
    of which
    a) Emergency
    b) Elective

English National Board

Now abolished but ideas for data potentially required by any similar organisation are still just as relevant

Total Women Delivered
Total delivered in the hospital
Deliveries in Midwifery-Led Centres

HOME BIRTHS
Total Deliveries (Confinements) in the Home

MIDWIFERY LED CARE
Total Bookings for Midwife-Led care
Total Number of deliveries undertaken by midwives (of all the above)
Women delivered by a midwife known to them
Delivered by midwives in private practice

OBSTETRIC INTERVENTIONS
Number of planned inductions
Number of accelerated labours
Number of episiotomies
Number of epidurals with vaginal births
Number of epidurals/spinals with caesarean section
Number of planned caesarean sections
Number of emergency caesarean sections
Number of forceps deliveries
Total ventouse deliveries
Ventouse deliveries by Midwives
Number of Vaginal Breech Deliveries

Unfortunately neither the RCOG nor the ENB requirements can be answered from any of the current paper definitions, so all current computer systems often have to ask the same question twice using different answer options!

EEPD "Logical Priority" Proposals

Default Answers underlined

A draft standard of *Flow patterned Questions and all allowable answer options is proposed as follows*:

A. Route of Birth? 1. Vaginal
2. Caesarean
3. Abdominal
4. Unknown (Free Text)

IF VAGINAL
If answer to question A = 1. Vaginal

A1. Time and Date of Start of Labour?
A2. Time and Date of Start of Second Stage?
(allows computer to calculate Duration of First & Second Stages)
A3. Presentaion at Birth? 1. Cephalic
2. Breech
9. Other (free text)

IF VAGINAL AND CEPHALIC
If answer to question A3 = 1. (Cephalic)

A3/1/1 1. No operative assistance
2. Ventouse
3. Mid Cavity or Outlet Forceps
4. Kjellands Rotation
5. Other Forceps (free text)
8. Unknown (free text)
9. Other (free text)

A3/1/2 1. No shoulder problems
2. Problems with Shoulders (inc Shoulder Dystocia) (free text)

A3/1/3
Probably needs to be diagniosed as "Shoulder Dystocia"
1. No
2. Yes

It may be argued that the question should be "Shoulder Dyustocia?" "Yes" or "No" but it would seem better to encorage front line staff to record their immediate impression that there was a problem with the shoulders; and only afterwards try to calculate if what actually happened falls withing the strict diagnostic definition of "Shoulder Dystocia"

If answer to question A3/1/1 = 2 or 3 (“Forceps”) then

A3/1/1/1 Previous failed Ventouse?

1. No
2. Yes (free text)

IF VAGINAL AND BREECH

If answer to question A3 = 2. (Breech)

A3/2/1
1. Simple Assisted Breech
2. Breech with Forceps to the Aftercoming head
3. Breech Extraction
8. Unknown (free text
9. Other (free text)

A3/2/2 Timing of Diagnosis of Breech

1. Before Labour
2. In First Stage
3. Second Stage
8. Unknown (free text
9. Other (free text)

IF CAESAREAN

If answer to question A = 2. (Caesarean)

A2/1. Presentation just before birth

1. Cephalic
2. Breech
3. Transverse or Oblique
8. Unknown
9. Other (Specify)

Essential question to avoid confusion if a Cephalic Presentation Caesarean is delivered as a Breech Extraction

Urgency of Caesarean

The distinction between the different levels of urgency of a Caesarean ("Emergency", "Planned' et. is not just yet another "Paralysis by Analysis" essential since the computer default list for the Indications for a "Planned Caesarean" is the same as for a "Planned Caesarean needed doing early", and not the same as for an "Emergency Caesarean"

A2/2
1. Immediate (Crash Section): (Within 20 mins?),
2. Urgent: (Within 30 mins?)
3. Scheduled: (Within 2 hrs?)
4. Planned (= Elective)
5. Planned done as an emergency
6. Peri-mortem (Caesarean at the time of a Maternal Death)
8. Other (free text
9. Unknown (free Text)

Although the term "Crash Section" is currently 'out of fashion' it is, in real life, far more likely to galvanise everyone involved into the urgency required. Too often in my experience as a labour ward consultant locum in 30 different hospitals over the past 8 years I have, for example, waited while a senior midwife carefully checks that every labouring mother has 'one to one' care, while a fetal brain is, by the second, getting more and more damaged from for example an abruptio placentae emergency.
'Immediate Caesar' does not in practice ring such powerful alarm bells as 'Crash'

and although more worrying to the expectant mother if, by chance, she overhears that risk seems worth taking for the sake of the baby

A2/3 1. In Labour? Yes/ No

If Yes. 1. Time and Date of Start of Labour

2. In Second Stage Yes / No

If Yes, Start of 2nd Stage?

1. Time and Date

Failed Forceps or Ventouse?

1. No
2. Yes

Allows computer to calculate Duration of First & Second Stages whenever relevant

The 14 different “Methods of Birth”

Using the above, a maximum of three questions are all that is needed for the “Method of Delivery of each Fetus to be classified under one of the following 14 options

VAGINAL CEPHALIC
(All with or without Shoulder problems/Shoulder Dystocia)

1. Vaginal - Cephalic - Unassisted
   (Also known as Spontaneous Vertex Delivery)
2. Vaginal - Cephalic - Ventouse
3. Vaginal - Cephalic - Midcavity or Outlet Forceps
4. Vaginal - Cephalic - Kjellands Rotation Forceps (free text)
5. Vaginal - Cephalic - Other Forceps (free text)
6. Vaginal - Other (free text)

VAGINAL BREECH

6. Simple Assisted Vaginal Breech
7. Vaginal Breech with Forceps to the Aftercoming head
8. Vaginal Breech Extraction
9. Vaginal Breech- Assistance Unknown
10. Vaginal Breech Other (free text)

CAESAREANS

11. Caesarean - Cephalic
12. Caesarean - Breech
13. Caesarean - Transverse or Oblique
14 Caesarean - Presentation Unknown (free text)

This may seem excessive but it is the only way in which to allow a computer to answer in a simple way the data requests of the RCOG, the ENB and others. Other options (especially Korner) require many more questions or a great deal of complex and unneccesary computer programming.

The above questions will also allow a calculation of the Duration of the First and Second Stages whenever appropriate, and will also identify all vaginal deliveries with shoulder delivery problems.