Author's response to reviews

Title: Diverse definitions of prolonged labour and its consequences with sometimes subsequent inappropriate treatment

Authors:

Astrid Nystedt (astrid.nystedt@miun.se)
Ingegerd Hildingsson (ingegeerd.hildingsson@miun.se)

Version: 5 Date: 9 July 2014

Author's response to reviews: see over
Dear Editor

Thank you for your valuable comments on our paper MS: 2887050101098130 Diverse definitions of prolonged labour and its consequences with sometimes subsequent inappropriate treatment, Research article. We have revised the manuscript based on suggestions made by the referee. The following revisions have been made to answer the comments.

Comments to Susan McDonald

In the recruitment section- Sample size. Can you please clarify how many questionnaires were distributed in total? Providing this information would provide a response rate percentage for your study and therefore an indication of the generalisability of your results.

More information about the study design has been inserted on Page 5 under heading Method Setting, third sentence: Women who were recruited were asked to complete a total of four questionnaires: the first during mid-pregnancy (week 17–19), the next in late pregnancy (week 32–34), the third, 2 months after birth, and the last questionnaire was given 1 year after birth. For this study we used the questionnaire which was given 2 months after birth together with socio-demographic background data collected in mid-pregnancy.

Page 6 under heading Recruitment second paragraph: The number of women who in mid-pregnancy consented to participate was 1506 and 1212 (80%) returned the first questionnaire, the second was completed by 1042 (70%). Two months after birth, 1242 women were sent the third questionnaire and 936 returned the questionnaire. The sample corresponds to 62% of those who originally consented to participate in the longitudinal survey and 75% of those who received the third questionnaire. For the purpose of this study, women with induction of labour and planned Caesarean section were excluded.

I am still unclear as to why the prolonged labour rate (21.7% overall) was so high.

This question was raised by one of the other referees and our response was:
We have only presented the prevalence of dystocia according to the numbers of women who were identified either by a code and inspection of partogram or only by inspection of partogram (fig 1) according to international classification for diseases (ICD10). We also refer to other studies that present higher prevalence than we do in this study (Kjaergard, 2009; Selin, 2009).

if the reasons for the 7% who were diagnosed with prolonged labour had reason recorded.
Page 8 in last paragraph, the following sentence has been inserted.
In both groups of prolonged labor and among those who did not receive oxytocin, there was no information recorded on the reason why they did not receive treatment.

While you have described women's responses to pain to be significant if they had a prolonged labour and/or if they did not have a prolonged labour but the labour was augmented with oxytocin. You have not offered any explanation or view as to why that might be or to have asked the women to expand on that sensation. Is it possible that the women, as has been described anecdotally, experience the onset and intensity of labour pain as greater as the body is not afforded the same timeframe to accommodate the normal process of progressive increase in length and strength and intensity of the pain accompanying contractions?

We do agree with your opinion about responses to pain and augmentation with oxytocin. But still all of the women included in the study had a spontaneous onset of labour. We think that the study design does not permit us to explain answers or to draw conclusions about issues that could be explored by more qualitative data. For example it would be interesting to interview women about their experience of labour pain in relation to progress of labour or the use of oxytocin augmentation.

I feel there needs to be a better qualification of what you mean by (page 11) the comment that in the post hoc analysis, that women used an epidural to a high extent also in the normal groups suggest that women within the the group of normal labour are exposed to unnecessary interventions and treatments. How so? Are women not given the option of epidural as an acceptable pain management strategy of choice? Are your results able to show that the women would have had a different or better outcome without the use of epidural?

Page 11, in the last paragraph two new sentences and a new reference have been inserted
Generally women used an epidural to a high extent in both the prolonged and normal groups. A post hoc analysis, showed that women used an epidural to a high extent also in the normal groups. These findings suggest that the high use of epidural within the group of normal labour could be a consequence of being exposed to unnecessary interventions and treatments of oxytocin augmentation, to speed up the progress of labour. However the benefit for the woman is being relived from pain, but the use of epidural is also associated with an increased risk for instrumental delivery and emergency cesarean section [38]. (Dahlen HG, Tracy S, Tracy M, Bisits A, Brown C, Thornton C: Rates of obstetric intervention among low-risk women giving birth in private and public hospitals in NSW: a population-based descriptive study. BMJ open 2012, 2(5).)
I feel you should still be cautious in your interpretation of augmentation without a diagnosis of prolonged labour as abuse or misuse unless you have clear data that shows that the oxytocin augmentation was implemented for no other reason.

On Page 7 we clarify two ways of identification of prolonged labour and we inform that only records which indicated use for augmentation of labour were included. We argue that we have data that included only the use of oxytocin augmentation for prolonged labour and that the use of oxytocin augmentation for other reasons were excluded.

The data of this study was collected with the intention of classifying labours if they were prolonged or not and of recording the use of oxytocin augmentation. The numbers of prolonged with and without codes and the use of oxytocin augmentation are the result of the study. We think that the statistical analyses we have used are appropriate for this data collection because of its descriptive and comparative quality. We have showed that the experiences differ between and within the group of prolonged labour compared with and within the group of normal labour. And that mode of delivery, the length of labour and pain experience differs between women with and one without diagnosis of prolonged labour and between women with normal labour with and without oxytocin augmentation. The result showed significant differences between women with normal labour, with and without oxytocin augmentation. We also present the factors and feelings that contributed most strongly to a negative birth experience both in women with prolonged and normal labour.

I think you need to be cautious with the interpretation of your questionnaire responses. In reviewing the way in which your questions were structured, 8 of the 12 questions were structured negatively. I would suggest that a recommendation for future research may be that a more balanced approach to the questionnaire structure could be considered so that it may allow women to expand on their views and perhaps give more depth to their experiences in their responses.

When it comes to the experience issues, we do specify this as a limitation and we have noticed on page 13 first sentence in the discussion section that one weakness of this study is that some of the significant factors associated with a negative birth experience among women with a prolonged labour gave an odds ratio with wide confidence intervals. The wide values of the confidence intervals are a cause for concern and should be interpreted with caution.

Your conclusion paragraph is quite good. Just one suggestion for consideration would be to replace the wording ... avoid mistreatment... with ... promote best care.

Thank you for your suggestion but we want to clarify our statement to keep normal births normal and avoid mistreatment.

In our paper we present the prevalence of the use oxytocin augmentation among women with both prolonged and normal labour. The result showed that some of
the women within the groups of both prolonged and normal labour were not correctly treated. Especially in the group of normal birth, where about one in three women (28%) received oxytocin augmentation, despite having no evidence of prolonged labour. In our study, we refer to two articles in which the concept of misuse or abuse of oxytocin augmentation has been discussed (Selin et al. 2009) and (Johnson 2008). Both authors discuss in their papers the consequences of this misuse of oxytocin. Therefore, we argue that we can use the concept “avoid mistreatment” because in this context, it refers only to normal birth. We also highlight in the last sentence of the conclusion that it is important to improve care for all women regardless of whether they experience prolonged labour or not.