

## OBITUARY

**Richard Johanson**

**11th January 1957 - 21st February 2002**  
**Consultant Obstetrician and Gynaecologist,**  
**North Staffordshire Hospitals NHS Trust**

I first came to know of Richard Johanson from his published research work, notably his Cochrane Reviews relating to instrumental vaginal delivery, repair of perineal trauma, and his interest in external cephalic version of breech babies. I subsequently had the privilege of meeting him, a sensitive, reasoned, listening obstetrician, who believed in establishing the best evidence and putting it into practice. His contributions to ASQUAM (Achieving Sustainable Quality in Maternity), and to the first two caesarean conferences will be long remembered.

The NCT has lost a good friend, and the obstetrical world has become a lot poorer with his premature demise. In his, all too brief, life he achieved so much of permanent and enduring value for women. My deepest condolences, particularly to his wife and children, but also to all who are affected by his early death.

Cynthia Clarkson,  
 UK Trustee



From the first time I met Richard, I knew that here was an obstetrician who approached birth from a similar perspective to the one that we in the NCT do; believing that birth is a normal physiological process and a profound emotional and social experience for woman and family, rather than approaching it from the perspective of managing a potentially risky pathological process. Everything he did with and for women was done with inimitable enthusiasm and a passion for change, which was truly empowering. Over the years he was supportive of every NCT campaign.

On a personal note, I was thrilled when he asked me to join the Labour Ward Management Working Group at the RCOG that he was chairing. The remit of this group is to look at special-skills training for senior obstetric registrars on their way to becoming consultant obstetricians and for labour ward lead clinicians. Richard was very keen to have the ethos of normality as a central tenet of this group. Sadly his sudden illness and subsequent death prevented him from seeing the work through, but I will do everything I can to ensure that his aspirations for that group are fulfilled.

We in the NCT have lost a most supportive champion of women's rights who will be sadly missed in the world of obstetrics. Our sincere condolences go to his loving family, who have lost so much more.

Gillian Fletcher  
 NCT President



It was Richard's enthusiasm, sparkle, friendliness and real commitment for women-centred care that was so striking. He involved users throughout his work and was always interested to listen to new suggestions and ideas, and he treated everyone with thoughtfulness and respect. He truly believed that midwives were the guardians of normal pregnancy and birth, and that evidence-based care should be

provided around the needs of women and their families. I will always remember him saying during a conference presentation that stand-alone midwifery units were essential in order to provide the right care and support for women who were unlikely to need obstetric interventions. He believed that in integrated midwifery units, the ethos of intervention could easily "seep under the doors" from the high-tech side. We know he will be sorely missed by his family and friends, and we must do our part to keep his enthusiasm and drive alive.

Gill Gyte

Cochrane Collaboration Consumer Rep, formerly Chair of  
 NCT Research and Information Group



I first made the acquaintance of Richard at an ASQUAM (Attaining Sustainable Quality in Maternity) conference in Crewe. I was impressed by his enormous enthusiasm and dedication to his subject, and to his whole-hearted encouragement of consumer involvement. I subsequently heard him speak on a number of occasions and learnt also of his very human side. This was no ivory tower scientist!

My most enduring memory, however, is of him agreeing to attend a Region 6 day in Market Drayton, not far from where he lived. He arrived slightly late and apologising profusely as he had been operating that morning and obviously things had not gone as planned. He then proceeded to talk with enthusiasm and wit to the relatively small number of NCT members attending the day, illustrating his talk on caesarean section with some very real examples of the dilemmas confronting a consultant obstetrician. I was delighted and amazed that this very busy man was prepared to give up his Saturday afternoon to talk to only around 30 - 40 NCT members, and yet took the time to explain his work and beliefs about his work so clearly and enthusiastically. Richard had asked me, as a representative of the NCT, to collaborate with him on a research project to investigate the use of nicotine replacement therapy (gum or patches) in pregnant women, a highly necessary piece of work in view of the number of women who continue to smoke during pregnancy. I very much hope that this work will still take place, whether or not the NCT is involved.

Richard will be much missed by very many of us, and even more so by his wife and family, to whom I send my sincerest condolences. His memorial service was attended by hundreds of people, many of whom had to stand throughout as there was no more room. A fitting tribute to an amazing man.

Sue Maguire

Chair, Research Networkers Panel



One of the last things Richard worked on before he died was the first draft of an article: "Has the medicalisation of childbirth gone too far?" Mary Newburn and Alison Macfarlane completed the article in March which was published in the *British Medical Journal* on 13th April.

## NCT EVIDENCE BASED BRIEFING

### Epidural

#### Background:

An epidural is the most effective form of pain relief available to women in labour. Like all medical treatments, the procedure involves some side effects and risks. Having an epidural involves an injection into the epidural space of local anaesthetic, sometimes combined with an opiate drug. An intravenous line to administer fluid is also set up to counteract the effect the epidural has in reducing the blood pressure. Compared with a "traditional" epidural, the so called, "mobile" epidural, introduced during the last ten years, enables a woman to retain sensation in her legs, move around a little, and usually empty her bladder without a catheter. A lower dose of local anaesthetic is used, sometimes preceded by, or in combination with an opiate drug, such as fentanyl or pethidine.

The National Sentinel Caesarean Section Audit (2001) found that 96% of obstetric units in England, Wales, Northern Ireland, the Channel Isles and the Isle of Man offered a 24-hour epidural service and 49% offered "mobile" epidurals. The average epidural rate was 24.5%.

#### Research:

Research on pain relief poses particular methodological and ethical challenges. Relatively few randomised controlled trials have been carried out, to evaluate the short and long-term effects of epidurals on women and babies. Much of the published work is based on observational rather than randomised controlled studies.

A Cochrane systematic review of RCTs conducted by Howell (2000) assessed epidurals in terms of pain relief and adverse effects during labour. The results suggested that epidurals provide greater pain relief than non-epidural methods and are associated with:

- longer first and second stages of labour;
- an increase in the incidence of malposition of the presenting part of the baby;
- an increase in the use of oxytocin (overall, oxytocin augmentation was twice as likely in epidural groups);
- an increase in ventouse and forceps deliveries when the block is maintained beyond the first stage of labour;
- an increase in maternal fever.

One small early study found increased hypoglycaemia in the baby in the days after birth but more recent research reported no increase in admissions to special care.

There was no evidence of a causal relationship between epidural analgesia and an increased caesarean section rate.

A review of the literature which included both RCTs and observational studies (Zhang *et al* 1999) found epidural use was associated with a two fold increase of oxytocin augmentation in both types of study. In addition, it showed that while clinical trials did not find a significant increase in the caesarean section rate associated with epidural use, in the observational studies there was a four-fold increase in caesarean section and instrumental delivery in the epidural group.

The current evidence on the incidence of long-term backache suggests that there is no additional risk for women who have had an epidural (Howell *et al*, 2001). The chance of a dural tap occurring during the setting up of an epidural, which can cause a severe headache, varies in UK hospitals. An audit for 1991-95 found rates of 0.19-3.6%. Hospitals carrying out greater numbers of epidurals had better results (Gleeson and Reynolds, 1998). More serious complications are rare (see MIDIRS, 1999).

A trial randomising women to either a traditional epidural, or to one of two kinds of mobile-like epidural, a "low-dose combined spinal epidural", or "low-dose infusion epidural" found that forceps and ventouse deliveries were reduced in both the latter groups. High level resuscitation of the baby was more frequent in the low dose infusion group but not in the combined spinal epidural group (COMET Study Group UK 2001).

Opiates such as fentanyl and pethidine are known to cross to the baby at the doses used in low dose epidurals (Fernando *et al* 1997). A retrospective cohort study found that the babies of mothers who had had a mobile epidural with pethidine had significantly more feeding difficulties than those whose mothers had had no drugs (Smith 1997).

#### Women's Views:

An early study of epidural use found that women were less satisfied with their labours despite finding the pain relief more effective. The author, a consultant anaesthetist, concluded that satisfaction with the pain relief was counteracted by increased length of labour and more operative births. (Morgan 1982). While women may worry about possible relatively uncommon side effects of epidural such as chronic backache and headache, there is evidence that they are not often informed of possible effects on the labour itself.

Other more recent studies have also concluded that there is no correlation between the level of pain women report and their satisfaction with labour. For example, Kannan and colleagues (2001) suggest that among women who wanted to have a natural birth, those who had an epidural for pain relief during labour reported that pain was significantly reduced, but so was their satisfaction with their childbirth experience. Suggested reasons for reduced satisfaction were effects of epidural on the baby, a gap between expectation and experience in terms of greater than anticipated labour pain, feeling a failure for requesting an epidural, and longer duration of labour.

A study from America, where the use of epidurals is much higher than in the UK (Goldberg *et al*, 1999), found that women expecting their first baby who planned to have an epidural were much more likely to have one than first-time mothers who wished to avoid one (91% vs. 57%); and they had their epidurals administered earlier. A Canadian study (Pattee *et al*, 1997) questioned the extent to which women give informed consent before administration of an epidural, finding that women wanted to be informed of all possible complications. The MIDIRS informed choice leaflets should be offered to all pregnant women when discussing birth plans (1999).

**Key Points:**

Epidurals are a very effective form of pain relief which involve some side effects and risks. The NICE guideline on electronic fetal monitoring (EFM) recommends continuous EFM when epidural analgesia is used. Labour is inclined to be longer, and there is an increased likelihood of forceps or ventouse, and possibly caesarean delivery. There have been no studies of the effects for babies of epidural analgesia compared with no pharmacological pain relief. Most studies compare use of epidurals with use of pethidine. Opiates on either form of pain relief may make babies more sleepy, which can affect their feeding. Further work is needed on women's experiences of epidural analgesia, including their antenatal preferences and expectations, satisfaction with labour and the postnatal effects for them and their baby.

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25th March 2002

**DEVELOPMENTS IN THE POSTNATAL WORLD**

In the interests of new parents and more "joined up" services and to better use the skills of our trained workers the NCT is proposing to introduce an easier route to accreditation as a postnatal leader for antenatal teachers and breastfeeding counsellors. In the past such workers, who were keen to run postnatal groups, were expected to have completed a postnatal conversion course before registration. We now propose to substitute two additional skill development study days and appropriate written assignments.

The first postnatal skills study days will be held in October and November 2002. Attendees will then receive postnatal mailings, recommended reading lists and continuing professional development, supported by the tutors involved in the project. The second, final update study days, will be run in April and May 2003. Successful attendees will then be registered as postnatal leaders. They will be accredited to run

postnatal groups and will come under the remit of Postnatal Panel. We are inviting antenatal teachers and breastfeeding counsellors who are currently working with parents postnatally and who are interested in becoming postnatal leaders to express an interest in participating in the new programme. A successful programme will enhance NCT's capability and profile in the postnatal field and help us to reach more parents. Please complete and return the tear off slip below to register your interest, which will be followed up by a personal approach from a postnatal project tutor. There will be opportunities at the annual conference and at local open days before the summer holidays to meet with postnatal project tutors to find out more about our plans and to discuss your own involvement in meeting the needs of new parents. Watch your local newsletter, read your e-group or contact Bernadette at UK office to keep abreast of further developments.

**Step one - Share what you're doing. Step two - Go on a study day.**

Juliet Goddard (postnatal tutor), Cynthia Masters-Waage (antenatal tutor) and Jenny Gavin (breastfeeding counselling tutor).

**Step-by-step plan to NCT postnatal accreditation for antenatal teachers and breastfeeding counsellors**

Name:.....ANT/BFC  
(Delete as appropriate)

Address:.....

Tel No:.....

Email Address:.....

Branch:.....

**Please return to: Kate Williams, Parent Services Manager, NCT, Alexandra House, Oldham Terrace, Acton, London W3 6NH.**

I have the following experience of working with parents postnatally:.....

I am interested in possible participation in the above programme for the following reasons:.....



**BANK ACCOUNTS FOR SPECIALIST WORKERS**

**Dear teachers/breastfeeding counsellors/postnatal discussion leaders, including tutors and trainees,**

My original letter clarifying how income from NCT classes should be accounted for and explaining where this income should be collected was in the August 2001 edition of *New Digest*. Since then, it has become apparent that it did not fully address the related issue of class expenditure. I have, therefore updated my letter to cover this remaining area of uncertainty.

**Income from National Childbirth Trust classes - are you clear about how to account for it?**

Last year it became apparent that there was some confusion over how money for National Childbirth Trust classes should be paid and what accounts should be used for the money. At that time this confusion was probably because some specialist workers were unaware of the bank account requirements. Some also may have believed it is necessary to receive cheques from a number of different sources in order to maintain your self-employed tax status. As a result, some class attendees were asked to make cheques for class fees payable to the specialist worker concerned resulting in personal bank accounts being used to hold National Childbirth Trust income.

I hope that all are now aware that all money collected on behalf of the National Childbirth Trust, i.e. for National Childbirth Trust classes, must be paid into a Lloyds TSB, NCT registered (i.e. registered with the UK office) bank account. This of course means that any cheques collected for classes must be made payable to the National Childbirth Trust (branch or teaching group).

The Trust must have properly set up accounts to comply with the law. Having properly set up accounts also protects the individual from any suggestion of improperly collecting National Childbirth Trust money.

At the time, some specialist workers were worried that this would affect their self employed status. We can reassure that this does not affect your self-employed status. You are deemed self-employed for tax and national insurance purposes. This is a tax status granted especially to you as a National Childbirth Trust specialist worker and will not be lost through having the payments for the classes in the name of the NCT branch or teaching group, instead of payable to you personally. If you do have any problems with your local tax office when you register as self-employed or subsequently, then you should inform the UK office (Finance department) so that we can resolve the matter on your behalf.

**Expenditure for NCT Classes:**

In the same way as income must be collected into an NCT registered account, expenditure must be made from an NCT registered account. The class fees and the reimbursement of any expenditure incurred by the specialist worker on the classes, e.g. on refreshments or telephone calls, should be paid to the specialist worker with a cheque raised by the branch or teaching group treasurer from the NCT registered bank account. The worker will need to complete an expense claim form and attach receipts or invoices. The payment of the capitation to the UK office is the responsibility of the branch or teaching group treasurer, with the cheques being raised from the NCT registered branch or teaching group account. Payment to the teacher of fees for work done should also be made from this account.

**Why should I use National Childbirth Trust registered Lloyds TSB accounts?**

Charity law requires us to account for all the income and expenditure of the National Childbirth Trust. Money must be in National Childbirth Trust registered Lloyds TSB bank accounts. We must supply accounts for all our income and expenditure, including that of all National Childbirth Trust classes, to our auditors so they can sign the National Childbirth Trust Accounts as a true record.

It is the legal duty of the Trustees and senior staff to ensure the charity complies with Charity Law.

**What do I need to do now?**

**Check account being used for the depositing of class fees:**

- If income from your clients paying for classes goes into a National Childbirth Trust Lloyds TSB account, where that account has been registered with the UK office, then you do not need to change the account you are using. Where accounts are set up properly, you will obviously need to ask clients to make cheques payable to The National Childbirth Trust (branch or teaching group).
- If you are not sure if you have the correct account which is registered with the UK office with your accounts being provided you should check with your treasurer, and if in any doubt at all please contact Denise Bosschaert on 0870 770 3236 or email [d\\_bosschaert@national-childbirth-trust.co.uk](mailto:d_bosschaert@national-childbirth-trust.co.uk)