



# Royal College of Obstetricians and Gynaecologists

## Consent Advice No. 11

July 2010

### OPERATIVE VAGINAL DELIVERY

This paper provides advice for clinicians in obtaining consent of a woman undergoing operative vaginal delivery. This paper is intended to be appropriate for a number of procedures and combinations and the consent form should be carefully edited under the heading 'Name of proposed procedure or course of treatment' to accurately describe the exact procedure to be performed, after discussion with the woman. The paper follows the structure of Consent Form 1 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland. It should be used in conjunction with RCOG Clinical Governance Advice No.6: *Obtaining Valid Consent*.<sup>1</sup> Please also refer to the RCOG Green-top Guideline No.26: *Operative Vaginal Delivery*.<sup>2</sup>

The aim of this advice is to ensure that all women are given consistent and adequate information for consent; it is intended to be used together with dedicated patient information. After discharge women should have clear direction to obtaining help if there are unforeseen problems.

Clinicians should be prepared to discuss with the women any of the points listed on the following pages.

#### Presenting information on risk

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10000	A person in small town
Very rare	Less than 1/10000	A person in large town

The above descriptors are based on the RCOG Clinical Governance Advice, *Presenting Information on Risk*.<sup>3</sup> They are used throughout this document.

To assist clinicians at a local level, we have included at the end of this document a fully printable page 2 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland, Consent Form 1. This page can be incorporated into local trust documents, subject to local trust governance approval.

## CONSENT FORM

### 1. Name of proposed procedure or course of treatment

Operative vaginal delivery (vacuum-assisted delivery and/or forceps delivery).

### 2. The proposed procedure

Describe the nature of vacuum assisted delivery/forceps delivery. Explain the procedure as described in the patient information. The woman should be aware that an episiotomy may be required, particularly with forceps delivery.

**Note:** If it is a trial of operative delivery such that vaginal delivery is not certain, this must be made clear to the woman and consent obtained for proceeding to caesarean section if necessary.

### 3. Intended benefits

To secure the safest and/or quickest route of delivery in the circumstances present at the time the decision is made, where the anticipated risks to mother and/or baby of operative vaginal delivery outweigh those of an alternative mode of delivery. The benefits may include any or all of the following:

- expedited delivery where fetal compromise is suspected
- relief where the second stage of labour is delayed owing to maternal exhaustion or other reasons
- safer delivery in cases where maternal pushing is not advisable – such as cerebral aneurysm, proliferative retinopathy or cardiac problems.

### 4. Serious and frequently occurring risks<sup>4-10</sup>

It is recommended that clinicians make every effort to separate serious from frequently occurring risks. Higher rates of failure and serious or frequent complications are associated with:

- higher maternal body mass index
- ultrasound-estimated fetal weight greater than 4000 g or clinically large baby
- occipitoposterior position
- mid-cavity delivery or when 1/5 fetal head palpable abdominally.

#### 4.1 Serious risks

Serious risks include:

##### Maternal:

- third- and fourth-degree perineal tear, 1–4 in 100 with vacuum-assisted delivery (common) and 8–12 in 100 with forceps delivery (very common)
- extensive or significant vaginal/vulval tear, 1 in 10 with vacuum 1 and in 5 with forceps.

##### Fetal:

- subgaleal haematoma, 3–6 in 1000 (uncommon)
- intracranial haemorrhage, 5–15 in 10 000 (uncommon)
- facial nerve palsy (rare).

#### 4.2 Frequent risks

Frequent risks include:

##### Maternal:

- postpartum haemorrhage, 1–4 in 10 (very common)
- vaginal tear/abrasion (very common)
- anal sphincter dysfunction/voiding dysfunction.

##### Fetal:

- forceps marks on face (very common)
- chignon/cup marking on the scalp (practically all cases of vacuum-assisted delivery) (very common)
- cephalhaematoma 1–12 in 100 (common)
- facial or scalp lacerations, 1 in 10 (common)
- neonatal jaundice /hyperbilirubinaemia, 5–15 in 100 (common)
- retinal haemorrhage 17–38 in 100 (very common).

## 5. Any extra procedures which may become necessary during the procedure

- Episiotomy (5–6 in 10 for vacuum assisted delivery, 9 in 10 for forceps)
- Manoeuvres for shoulder dystocia
- Caesarean section
- Blood transfusion
- Repair of perineal tear
- Manual rotation prior to forceps or vacuum-assisted delivery.

## 6. What the procedure is likely to involve, the benefits and risks of any available alternative treatments, including no treatment

Delivery of the baby (or babies) vaginally by means of forceps or a vacuum device. A clinical assessment is performed before the instrument is applied. The operator will choose the instrument most appropriate to the clinical circumstances and their competence.

A caesarean section performed when the baby's head is low in the birth canal could be more traumatic for mother and baby than an operative vaginal delivery.

It may be appropriate to explain that a competent pregnant woman may choose the no-treatment option; that is, she may decline operative vaginal delivery, even when this would be detrimental to her own health or the wellbeing of her baby.

## 7. Statement of patient: procedures which should not be carried out without further discussion

If the woman objects to the use of a particular instrument, this should be documented here.

## 8. Preoperative Information<sup>11</sup>

A record should be made of any sources of information (e.g. RCOG or locally produced information leaflets/tapes) given to the woman prior to surgery. Please refer to RCOG Patient Information: *An Assisted Birth (Operative Vaginal Delivery): Information for You*.

## 9. Anaesthesia

Where possible, the woman must be aware of the form of anaesthesia planned and be given an opportunity to discuss this in detail with the anaesthetist before surgery. It should be noted that, with obesity, there are increased risks, both surgical and anaesthetic.

## References

1. Royal College of Obstetricians and Gynaecologists. *Obtaining Valid Consent*. Clinical Governance Advice No. 6. London: RCOG; 2008 [www.rcog.org.uk/womens-health/clinical-guidance/obtaining-valid-consent].
2. Royal College of Obstetricians and Gynaecologists. *Operative Vaginal Delivery*. Green-top Guideline No. 26. London: RCOG; 2005 [www.rcog.org.uk/womens-health/clinical-guidance/operative-vaginal-delivery-green-top-26].
3. Royal College of Obstetricians and Gynaecologists. *Presenting Information on Risk*. Clinical Governance Advice No. 7. London: RCOG; 2008 [www.rcog.org.uk/womens-health/clinical-guidance/presenting-information-risk].
4. Murphy DJ, Liebling RE, Verity L, Swingler R, Patel R. Early maternal and neonatal morbidity associated with operative delivery in second stage of labour: a cohort study. *Lancet* 2001;358:1203–7.
5. Johnson JH, Figueroa R, Garry D, Elimian A, Maulik D. Immediate maternal and neonatal effects of forceps and vacuum-assisted deliveries. *Obstet Gynecol* 2004;103:513–18.
6. de Parades V, Etienney I, Thabot D, Beaulieu S, Tawk M, Assemekang B, et al. Anal sphincter injury after forceps delivery: myth or reality? A prospective ultrasound study of 93 females. *Dis Colon Rectum* 2004;47:24–34.
7. Doumouchtsis SK, Arulkumaran S. Head injuries after instrumental vaginal deliveries. *Curr Opin Obstet Gynecol* 2006;18:129–34.
8. Holden R, Morsman DG, Davidek GM, O'Connor GM, Coles EC, Dawson AJ. External ocular trauma in instrumental and normal deliveries. *Br J Obstet Gynaecol* 1992;99:132–4.
9. Pretlove SJ, Thompson PJ, Toozs-Hobson PM, Radley S, Khan KS. Does the mode of delivery predispose women to anal incontinence in the first year postpartum? A comparative systematic review. *BJOG* 2008;115:421–34.
10. Murphy DJ, Macleod M, Bahl R, Goyder K, Howarth L, Strachan B. A randomised controlled trial of routine versus restrictive use of episiotomy at operative vaginal delivery: a multicentre pilot study. *BJOG* 2008;115:1695–702.
11. Royal College of Obstetricians and Gynaecologists. *An Assisted Birth (Operative Vaginal Delivery): Information for You*. London; RCOG; 2007 [www.rcog.org.uk/womens-health/clinical-guidance/assisted-birth-operative-vaginal-delivery].

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The final version is the responsibility of the Consent Group of the RCOG.

**Consent Advice review process will commence in  
2013 unless otherwise indicated**

#### DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces consent advice as an aid to good clinical practice. The ultimate implementation of a particular clinical procedure or treatment plan must be made by the doctor or other attendant after the valid consent of the patient in the light of clinical data and the diagnostic and treatment options available. The responsibility for clinical management rests with the practitioner and their employing authority and should satisfy local clinical governance probity.

**Patient identifier/label**

**Name of proposed procedure or course of treatment**

(include brief explanation if medical term not clear) *OPERATIVE VAGINAL DELIVERY: forceps and/or vacuum assisted delivery (ventouse).*

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient, in particular, I have explained:

The intended benefits:

- *Safe and speedy delivery when there is concern about your baby's wellbeing*
- *Safe delivery where the second stage of labour is delayed*
- *Make delivery safer for you by avoiding pushing if you have a medical condition in which pushing is not recommended*

Serious risks:

To the mother:

- *Vaginal tear extending to the anus (third- and fourth-degree perineal tear), 1–12 in 100 (common)*
- *Other serious vaginal tears, possibly with accumulation of blood around the tear (haematoma), 1–2 in 10 (very common)*

To the baby:

- *Significant bleeding in the baby's head, 5–60 in 10 000 (uncommon)*
- *Facial nerve injury from forceps (rare).*

Frequent risks:

- *Very common – swelling/cup marking on the scalp ('Chignon' – practically all cases of vacuum-assisted delivery); forceps marks on face; vaginal tear/bruise; problems with anal/urinary function; substantial bleeding from the womb after delivery (postpartum haemorrhage; ten times more common than in normal delivery)*
- *Common – skin cuts (face or scalp); jaundice in the newborn; minor bleeding within the baby's eyes; bleeding between the baby's skull and the scalp, the type which usually resolves without problems (cephalhaematoma), 1–12 in 100*

Any extra procedures which may become necessary during the procedure

Cut to facilitate delivery (episiotomy); manoeuvres to deliver trapped shoulder; caesarean section; blood transfusion; repair of tears

other procedure (please specify)

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided: *Please see RCOG Patient Information: An Assisted Birth (Operative Vaginal Delivery): Information for You*

This procedure will involve:

general and/or regional anaesthesia       local anaesthesia       sedation

Signed ..... Date .....

Name (PRINT)..... Job title.....

**Contact details** (if patient wishes to discuss options later)

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand

Signed ..... Date .....

Name (PRINT).....

**Top copy accepted by patient: yes/no** (please ring)