To: The Department of Health

Presented by: Jeremy Hunt MP
South West Surrey Constituency

On Behalf Of: Pauline M Hull
Editor, electivecesarean.com & Co-author, Choosing Cesarean, A Natural Birth Plan

Open Letter:
Concern Over Caesarean Rate Targets in England

The Department of Health, August 2011:

"There is no target for the rate of caesarean sections in England."
"Concentrating on normalising birth results in better quality, safer care for mothers and their babies with an improved experience."

The World Health Organization, August 2009:

"Both very low and very high rates of caesarean section can be dangerous, but the optimum rate is unknown. Pending further research, users of this handbook might want to continue to use a range of 5–15 percent or set their own standards. Although WHO has recommended since 1985 that the rate not exceed 10–15%, there is no empirical evidence for an optimum percentage or range of percentages…"

MY QUESTIONS:

1. What action, if any (given the DoH confirmation above that there is "*no target*" for caesarean rates in England), does the DoH propose taking in light of the target setting practice described in this letter?

2. Does the DoH recognize that by "*concentrating on normalizing birth*" it is simultaneously supporting a culture in which medical intervention (including planned and emergency caesareans) is not always appropriately utilized when needed or indeed wanted?

3. What/where is the clinical evidence for the DoH statement above concerning "*concentrating on normalizing birth*" outcomes (which is different to hindsight evidence on actual spontaneous birth outcomes*)?

(**I am aware of evidence demonstrating better outcomes with spontaneous vaginal birth versus other modes of delivery , but would appreciate links to evidence that demonstrates this with "intention to treat" or "planned" birth outcomes please - especially given many of the planned vaginal birth experiences that are cited on websites such as The Birth Trauma Association.*)

CESAREAN RATE TARGETS

The Department of Health states that there is no target rate for caesarean sections in England, and yet targets ***are*** reported to be in place throughout the country's hospitals (incl. direct and indirect targets). For example:

- Some PCTs have set caesarean rate targets of 23%.
- Some PCTs have set annual caesarean rate reduction targets of 1%.
- Some PCTs will not financially reimburse hospitals for caesareans where the rate is greater than 23%.
- As per the 2011/12 NHS Operating Framework and NHS Outcomes Framework, all NHS hospitals are accountable to the Care Quality Commission, and the CQC assessment awards points according to a hospital's cesarean rates.(1)
- In 2009, the NHS Institute for Innovation and Improvement introduced a "Toolkit for Reducing Caesarean Section Rates".(2)

THE PROBLEM WITH THESE TARGETS

Arbitrary targets that are not evidence-based (*see the 2009 WHO quote, above*), put lives (and quality of lives) at risk.

They do not prioritize reducing the most dangerous surgeries (i.e. emergency), and in fact risk *increasing* emergency cesareans as a direct result of concerted efforts to reduce planned surgeries (which are much safer) and encourage trials of labour first and foremost.

For example:

- In NHS hospitals in England (2009-10) there were 14.8% emergency and 10% elective cesareans. I recently had it confirmed by one Primary Care Trust that it has a target caesarean rate of 23% overall and specifically, 13% emergency cesareans and 10% elective cesareans. Not 10% emergency and 13% elective (for example), which would likely result in better outcomes for babies and mothers – but rather, an arbitrary split of the 23% target.

- Emergency cesareans are associated with some of the greatest birth risks and result in some of the lowest birth satisfaction rates for women. In terms of intrapartum care, they are the most expensive birth outcome in the NHS. Yet when they are carried out too late or not carried out at all (and should have been), there is the additional, considerable financial cost of litigation for the NHS – not to mention the physical and psychological cost to families.

- I have received correspondence from numerous women about their birth experiences in the hands of hospital 'targets', and present just three examples here:

    1. <u>Clinical decisions are not based on best outcomes but target rates</u>

    A GP, a midwife and a counselor all agreed that ***Mother A*** had such a severe fear of birth (tokophobia) that an elective cesarean would be the safest and best birth plan - but her consultant steadfastly refused. Eventually, following considerable pressure from the GP and counselor, he conceded, and "*apologized for bullying me and stated that he is the least strict consultant on allowing elective cesareans. He also said that he had been extra hard on me as his hospital was desperately trying to reduce the cesarean rate.*"

    2. <u>Risks associated with late gestation (e.g. stillbirth and macrosomia), likelihood of pelvic floor damage, and respect for maternal request, are all ignored - even when the risk factors have shifted (e.g. an</u>

induction of labour at late gestation versus planned surgery risk/benefit analysis differs from that of spontaneous onset of labour at term versus planned surgery).

At ten days overdue, ***Mother B*** (who had received treatment for fear of birth and been counseled to give birth naturally) requested a cesarean birth but was "*point blank refused*". Six days later, she was induced. This lasted 18 hours with no progress. Eventually a macrosomic baby was born via forceps delivery resulting in a 3rd degree tear, massive blood loss, a hospital stay of 5 days, and a traumatized mother who's been advised she may be doubly incontinent.

3. Clinical decisions are not always made in the best interests of the mother and baby, and the significant differences in risk between planned and emergency surgery are ignored.

Mother C is currently pregnant and in addition to her own maternal request informed choice, she also has a medical reason that tips the risk-benefit ratio in favour of a planned cesarean. Her midwife agrees that surgery is best but her consultant refuses to schedule this. Worse still, during her consultation, the doctor conceded that ***Mother C*** is at high risk for ending up with an emergency cesarean by telling her, 'You will most likely "end up getting the birth you want anyway".'

- Hospitals in some American states recently implemented an institutional policy to limit 'unnecessary' elective cesareans prior to 39 weeks' gestation, in order to reduce infant morbidity. The outcomes of this policy at one large community-based academic center have just been published (3), and reveal that while the policy succeeded in achieving a "small reduction in NICU admissions; however, macrosomia [11% increased odds] and stillbirth increased [from 2.5 to 9.1 per 10,000]." This country would do well to learn from this example.

The British government and the British tax-payer can no longer afford maternity policies that set out to 'normalise birth' at all cost. The cost is simply too great – both for the mothers and babies whose lives are affected, and the financial burden of paying out millions of pounds (in medical treatments and in litigation) when mistakes are inevitably made.

THE HEALTH SECRETARY'S PROMISE

In June 2010, while setting out his ambition for patient-centred care, the Health Secretary, Andrew Lansley, stated:

"*Mothers-to-be should have information about the different aspects of maternity care including choices of location, but also issues like pain-relief, choice of providers as well as risk assessments – because not all choices will be appropriate or safe for all women.*"

And he continued:

"*Reform has stalled. Targets have trumped quality. On too many key areas our health outcomes lag behind our European neighbours." We need change. We need to set the service free to deliver high-quality care, based on evidence of what works. Accountable for results. Answerable to informed and engaged patients. Focused on what matters most to those patients – safe, reliable, effective care. The best care for each patient and the best outcomes for all patients.*"

My suggestion would be that the DoH does indeed look to our neighbours – specifically The Netherlands, – and question why NHS maternity policies continue to lean towards a model of care that has resulted in one of the worst perinatal mortality rates in Europe.(4)(5)

The National Institute for Clinical Excellence (in its 2011 draft Caesarean section update) has taken the country's first major step towards recognizing what many doctors throughout the world have been saying for a number of years now – that the balance of risks and benefits (and indeed costs, when you look beyond the intrapartum period) between a *planned* natural birth and a *planned* caesarean are now so close that neither "normalizing birth" nor "reducing caesarean section rates" can be held up as the safest or most cost-effective maternity care model.

Thank you very much for reading my concerns, and I look forward to a response to my questions above at your soonest convenience.

Yours faithfully,
Pauline M Hull
Editor, electivecesarean.com
Co-author, Choosing Cesarean: A Natural Birth Plan

REFERENCES

(1) Healthcare Commission - Inspecting Informing Improving 2007
(2) "Toolkit for Reducing Caesarean Section Rates," NHS Institute for Innovation and Improvement, November 27, 2009, http://www.library.nhs.uk/qipp/ViewResource.aspx?resID=330743
(3) Neonatal outcomes after implementation of guidelines limiting elective delivery before 39 weeks of gestation. Ehrenthal DB, Hoffman MK, Jiang X, Ostrum G. Obstet Gynecol. 2011 Nov;118(5):1047-55.
(4) Meagan Zimbeck, Ashna Mohangoo, and Jennifer Zeitlin, "The European Perinatal Health Report: Delivering Comparable Data for Examining Differences in Maternal and Infant Health," European Journal of Obstetrics, Gynecology, and Reproductive Biology 146, no. 2 (October 2009): 149–51.
(5) Annemieke C. C. Evers et al., "Perinatal Mortality and Severe Morbidity in low and High Risk Term Pregnancies in the Netherlands: Prospective Cohort Study," British Medical Journal 341, no. 5639 (November 2, 2010).