



## New RCOG guidance urges CCGs to increase births without epidurals and reduce caesarean rates to 20%

Embargoed until 00:01 Friday 24<sup>th</sup> August 2012 (GMT)

Published by electivecesarean.com

Controversial guidance contained in a new document published by the Royal College of Obstetricians (RCOG) could result in worse health outcomes for mothers and babies, and greater costs for the NHS, say maternity campaigners and doctors (listed below).

Produced in collaboration with the Royal College of Midwives (RCM) and the National Childbirth Trust (NCT), RCOG's Making sense of commissioning maternity services in England<sup>1</sup> contains guidance for Clinical Commissioning Groups (CCGs) that is directly opposed to maternity care policies advocated by the National Institute for Clinical Excellence (NICE), the National Health Service Litigation Authority (NHSLA), and many charities, campaigners and doctors.

### It advocates:

- Reducing hospital caesarean (CS) rates to 20%
- Increasing rates of 'normal birth' (a definition not used by NICE, which means "without epidurals", and cites "antenatal, delivery or postnatal complications" as normal outcomes)
- Midwifery-led birth units as the 'default option' for pregnant women

Professor Philip Steer, Editor-in-Chief of BJOG says, "To try and achieve increased rates of uncomplicated births by reducing the availability of labour induction, epidural anaesthesia and caesarean section for informed women who request them, reduces choice without any guarantee of an improved outcome (and is likely to increase medicolegal costs substantially)."

Pauline Hull, co-author of Choosing Cesarean, A Natural Birth Plan and editor of electivecesarean says, "If this document had been published by the RCM or NCT alone, it would not be as shocking, but RCOG? I think its contents will raise eyebrows in OBGYN colleges around the world – if not within RCOG itself."

### Guidance shown in bold:

"The NHS Institute has reviewed clinical practice and the organisation of services and has concluded that a 20% rate is achievable and sustainable. Every provider unit should have a clear action plan for increasing its normal birth rate..."

- The DH, NICE and NHSLA have all confirmed that they do not advocate CS rate targets
- The World Health Organization (WHO) stated in 2009 that 'no empirical evidence for an optimum percentage' exists and an 'optimum rate is unknown'
- Obstetricians worldwide have condemned the idea of setting CS rate targets<sup>2</sup>
- The NHS Institute also advocates >80% of women try VBAC

"There is now a good argument to be made for multiparous women being advised to choose a non-obstetric unit birth."

- Significantly, the wording reads "advised to choose" and not "offered the choice". This refers to the 2011 Birthplace study,<sup>3</sup> which has been heavily criticised by statisticians and maternity groups,<sup>4</sup> (e.g. stillbirth is cited as low risk, yet stillbirths prior to onset of labour at gestational weeks when an ultrasound or planned CS could have been discussed or offered, were excluded). It is currently the subject of a charity's formal request for review by the DH.

“...making midwifery-led services the default option for pregnant women.”

- Most women choose to give birth in hospital, where obstetric care is immediately available, and do not want this default option.<sup>5</sup> RCOG president's BMJ response to the Birthplace study noted that up to 45% of first-time mothers required transfer from home or midwifery units.<sup>6</sup> Many centres have closed and with staff shortages, where are the resources for this?

“The consensus statement from the Maternity Care Working Party defines normal birth as “without induction, without the use of instruments, not be caesarean section and without general, spinal or epidural anaesthetic before or during delivery”. It is important to try to increase this rate as well as that of vaginal birth, which includes delivery by forceps and ventouse.”

- NICE says it does not support the use of ‘normal’ as a definition, and some MCWP members criticised the adoption of a phrase originally intended by The Information Centre to measure the process of labour, NOT as a goal or target to be facilitated and achieved.
- The suggestion that CCGs try to increase forceps and ventouse deliveries does not reflect best evidence, and doctors avoid these for their own births.<sup>7</sup> It may reduce CS rates, but it will NOT achieve better outcomes for mothers and babies. Instrumental delivery can have serious adverse outcomes, and for some women, offering a planned CS would be safer.
- It is NOT important for women to experience any type of birth without adequate pain relief; ideological beliefs do not belong in CCG guidance. In 2006, the RCM suggested charging women £500 for “unnecessary epidurals,”<sup>8</sup> which it had to back down on; it still talks about “unnecessary CS”. This does not represent the views of all maternity organisations, who vehemently disagree with denial of access to all legitimate choices as per NICE guidance. Wanted and unwanted are more appropriate values to consider in the context of patient choice, and going forward, RCOG needs to consult with organisations besides the NCT.

“If a trusted GP advises[sic] a low risk woman that her care pathway will be midwife led, or suggests to a woman after a caesarean section that VBAC is a good option to explore, she is likely to be more confident about achieving a normal birth outcome.”

- Offering VBAC is acceptable, but care must be taken with advising or pushing VBACs. Research just published in France, where VBACs are promoted, shows the “rate of litigations tripled in a decade [to 2010]. Uterine rupture was the most common cause of complaints.”<sup>9</sup>

“Every potential caesarean section that is enabled to be a normal birth saves £1200 in tariff price alone. [This] saves the NHS money.”

- NICE states that cost comparisons should be of PLANNED mode of birth outcomes, not outcomes alone; it estimates that a planned CS costs £710 more than a planned vaginal birth, but once urinary incontinence costs are factored in, this reduces to just £84.<sup>10</sup> Other downstream costs and litigation (e.g. failure to carry out timely caesareans) are huge, and not considered in this guidance.

“Women must receive consistent, positive information and advice from their health professionals if they are to have confidence in a normal birth.”

- Though not mentioned by RCOG here, the definition of ‘normal delivery’ also includes: “antenatal, delivery or postnatal complications (including for example post partum haemorrhage, perineal tear, repair of perineal trauma, admission to SCBU or NICU)”
- This is vital. These adverse outcomes may be ‘normal’ but they are not ‘positive’ or desirable, and since prophylactic CS and pain relief are possible in the 21<sup>st</sup> century, they should be available to women who actively want to avoid this definition of normal birth.

- Suggested wording: "Women must receive non-biased, factual and evidence-based information, if they are to have a more positive birth experience and safer birth outcomes."

"...make clear that women have a choice about place of birth"

- NICE guidance emphasises choice about mode of birth, not just place of birth. Notably, the cost of homebirth, which involves two midwives per woman for an unknown time period, is not mentioned.

"Women with a BMI over 35 will have fewer choices about their place of birth... As weight increases interventions and PPHs increase, ultrasounds and epidurals become more difficult and women are likely to have larger babies... Clearly it is better for women if they can lose weight before they conceive."

- This section of the document is very important, and correct. However there is no evidence that the rate of overweight and obese women is declining in the UK; in fact the opposite is true. And as long as this trend continues, and as long as women continue to delay motherhood until obstetrically advanced years and heavier birth weights at full term are recorded, the idea that hospitals in England can safely achieve a 20% CS rate is as outdated and unsafe as the WHO's recommendation of a 15% threshold in 1985.

Finally, in a statement provided for csections.org on September 1, 2011, the Department of Health (DH) said that it "did not set a specific target rate for caesarean sections in England, but instead set out policies to promote 'normal' birth... Concentrating on normalising birth results in better quality, safer care for mothers and their babies with an improved experience."

- Evidently, the DH needs to consult with more organisations too. The NCT does not represent the views and preferences of all women.

#### Organisations opposed to guidance

Advocacy for All (AFA)  
Csections.org  
Birth Trauma Association  
Birth Trauma Canada  
Erb's Palsy Group  
Perinatal Illness-UK  
Pyramid Of Antenatal Change

#### Comments on RCOG's guidance:

Maureen Treadwell, The Birth Trauma Association

"We have written to the RCOG Ethics Committee, requesting that it withdraw its support for this document."

Felicity Plaats, Consultant anaesthetist at Queen Charlotte's Hospital, London

"In the 21st century, where the resources are available, it's unacceptable and unethical to withhold effective pain relief from women who require it. Furthermore only the woman in pain can decide whether and what analgesia she needs..."

Mr Charles Cox, Consultant obstetrician and Fellow Director of Baby Lifeline Training

"There is no mention of perineal trauma as a complication of vaginal birth. In our local audit, the rate of third and fourth degree tears is 3-4%, and the highest rate is among VBACs. In most areas of medicine, if

you have a complication rate above 1% it is usual practice to consent the patient accordingly. No mention is made of need for revision of tears, bladder and bowel complication in the short, medium or long term. There is also no mention of long-term risk of prolapse."

Professor Philip Steer, Editor-in-chief of the British Journal of Obstetrics and Gynaecology

"To try and achieve increased rates of uncomplicated births by reducing the availability of labour induction, epidural anaesthesia and caesarean section for informed women who request them, reduces choice without any guarantee of an improved outcome (and is likely to increase medicolegal costs substantially)."

Leigh East, Csections.org

"This is a major step backwards and flies in the face of a substantial body of research which shows that such blanket recommendations are both ill-advised and unwanted by significant groups of women. Once again financial considerations are driving recommendations and cost savings are being put ahead of healthy outcomes and a mother's right to choose. Such targets and 'advice' remove the possibility of informed choice and ignore the findings of the 2011 NICE recommendation on caesarean birth and informed choice."

Deborah Morgan, Specialist Perinatal Psychotherapist, Perinatal Illness-UK

"The physical and mental health of women and the lives of babies are now being compartmentalised to 'fit' a system which is not really in their interests, and instead, is all about saving money – bottom line. Under the guise of 'choice', women are being covertly pushed into accepting a (supposedly) cheap option. We are shocked at the RCOG for suggesting and supporting such a document. The safety and health of mothers and babies is paramount. If this document is implemented, the rate of perinatal mental health issues and litigation for trauma will no doubt increase."

Felicity Reynolds, Emeritus Professor of Obstetric Anaesthesia

"Emphasising pregnancy and birth as essentially normal tends to gloss over the bad outcome of 'natural childbirth' as practised by default in the third world. The difference between the two environments is the availability of intervention, which is therefore on balance therapeutic, not otherwise. Also, the demonization of epidural analgesia overlooks the situation in France for example, where to have epidural analgesia in labour is the norm, and outcomes (caesarean section rates etc.) are not worse than ours; if anything, better. Finally, primiparous women are more likely than multiparous to ask for advice about place of birth, and the general advice offered throughout the publication overlooks the differences. First-time mothers need to be warned that home birth is a less safe option for their babies than hospital birth."

W Benson Harer MD, Former president of the American College of Obstetricians and Gynecologists

"The only meaningful data for either costs or outcomes must come from comparing the two different intentions to treat. One, let the pregnancy take its course hoping for a good birth or two, elective prophylactic cesarean delivery at 39 weeks."

Robert Devine, Pyramid Of Antenatal Change

"If they don't look, they can't find. POAC urges the public to voice their opinion by writing to the RCM and RCOG. We believe these proposals will be massive step backwards in maternity care, leading to higher mortality." Registered Scottish charity supported by world leading obstetrical and fetal medicine specialists; presented at RCOG (London) in September 2010.

Penny Christensen, Birth Trauma Canada

"Canadian women struggle with the same outdated bias against planned cesareans and effective pain relief that is held by some in the UK. That these medical advancements are denigrated in 2012 is disheartening and not supported by good science. It is planned vaginal births that cause the most physical

and psychological damage in childbearing women and it is long past time that this fact be acknowledged by those professing to be obstetrical experts."

References:

1. Making sense of commissioning Maternity Services in England – some issues for Clinical Commissioning Groups to consider. Published by: Naomi Weston 14/08/2012
2. (U.S.) "Attempts to define, or enforce, an 'ideal' cesarean section rate are futile, and should be abandoned." Myth of the ideal cesarean section rate: Commentary and historic perspective, Ronald MC, 2005  
(Australia) "There are no scientific grounds for identifying an 'appropriate' level for cesarean rates." Will there ever be an end to the Caesarean section rate debate? Dietz & Michael, 2004  
(France) "...the concept of CS rate limitation has become obsolete."  
Evaluation of cesarean rate: a necessary progress in modern obstetrics, Rozenberg P, 2004  
(UK) "Maternal satisfaction has now become one of the most significant outcome factors after childbirth and must be taken into consideration when implementing any changes in childbirth...  
Cesarean rates should no longer be thought of as being too high or too low, but rather whether they are appropriate or not, after taking into consideration all the relevant information."  
2001 Can we reduce the caesarean rate? Robson MS
3. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. BMJ2011;343:d7400
4. Where's best to give birth? Easy question, tough to answer. Nigel Hawkes, Straight Statistics. May 1, 2012.  
Rapid Responses to BMJ2011;343:d7400 (above) and Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study. BMJ2012;344:e2292 (e.g. Concerned that flawed analysis may be used to restrict birth choices. P.M.Hull. 30 April 2012)
5. Rapid Response to BMJ2011;342:d1495 by Pauline Hull; Midwife led care is not appropriate for all low risk women, and its cost-effectiveness is not proven. 2 April 2011
6. Rapid response to BMJ2011;343:d7400 by Tony Falconer , RCOG President. 1 December 2011
7. Al-Mufti et al. Survey of obstetricians' personal preference and discretionary practice. Acta Obstetrica Et Gynecologica Scandinavica 83, no.3 (March 2004): 262-6.  
Farrell et al. The choice of elective cesarean delivery in obstetrics: a voluntary survey of Canadian health care professionals. International Urogynecology Journal and Pelvic Floor Dysfunction 16, no. 5 (October 2005): 378-383.
8. Midwives call for epidurals fee, BBC News. 23 February 2006
9. Shojai et al. Litigation in obstetrics and gynaecology: Experience of a university hospital in France. J Gynecol Obstet Biol Reprod (Paris). 2012 Jun 26.
10. NICE. CG132 Caesarean section. November 2011

Contact information:

Pauline M Hull

Editor, electivecesarean.com

Co-author, Choosing Cesarean, A Natural Birth Plan (Prometheus Books, New York 2012)

Email: [info@electivecesarean.com](mailto:info@electivecesarean.com)

Telephone: 07780 308455

-----  
ENDS