October 3, 2010

Response to the Government White Paper 'Equality and Excellence: liberating the NHS', from the organisation 'electivecesarean.com'

electivecesarean.com hopes that this government will listen to and act on the views of a diverse range of maternity support groups in response to this White Paper, and understands (as it appears to, in a most welcome goal of 'extending choice') that women are not homogeneous creatures, and that they (and their babies) are not best served by a blanket 'one size fits all' approach to maternity care. Choice about how they give birth (e.g. planned caesarean versus trial of labour) is as important as where they birth (e.g. at hospital or home), and with whom (e.g. consultant versus midwifery-led care).

Furthermore, ***electivecesarean.com*** wishes to highlight grave concerns about current drives to reduce 'low risk' planned caesareans, and indeed to reduce caesarean rates according to percentage targets that have no basis in evidence. Choice aside, the lives of women and babies are being put at risk in many hospitals where the emphasis is on 'normal/spontaneous delivery at all costs'. The delay and/or failure to carry out necessary caesarean deliveries are not placing the health and wellbeing of families first, but moreover, are an entirely misdirected and misinformed effort to reduce NHS costs.

The fact is that unsuccessful planned vaginal deliveries – not planned caesarean deliveries – are costing the NHS billions of pounds in litigation costs. Yet these huge sums of money are never attributed to the relevant birth plan. And neither are the short- and long-term costs associated with the healthcare (physical and psychological) of women and babies who are injured during actual and attempted vaginal deliveries. Some women for example go on to have numerous operations to repair the damage caused during these births. ***electivecesarean.com*** proposes that all future allocating and accounting for NHS maternity resources should factor in these realities of cost. They should no longer be ignored or avoided.

Electivecesarean.com does not propose that planned surgery be presented to women as risk-free (no birth plan is), but rather, that it is presented as a legitimate birth plan for informed and educated women following an individualized consultation. That said, as the White Paper states, 'not all choices will be appropriate or safe for all women', which is entirely true, but for those whom it is appropriate and safe, it should not be refused – and most certainly not on grounds of fiscal policy or rate-driven targets (since both of these arguments against planned caesarean delivery are fundamentally flawed).

Finally, in support of this White Paper response, the information below is included for your review please. It is part of an original submission by ***electivecesarean.com*** to NICE during its Scope consultation earlier this year for the Caesarean Section (Update). It contains a number of important study references and articles that support the statements by ***electivecesarean.com*** above, and can be read in full via the pdf link provided. Please note that since the time of this submission, NICE has confirmed that 'maternal request' will now be included in its review of the Caesarean Guideline.

Thank you for accepting my response and I look forward to future positive developments in NHS maternity care, where the physical and psychological health outcomes of families are placed ahead of any single birth plan ideology, and where genuine autonomy – not arbitrary targets – are what count.

ADDITIONAL INFORMATION IN SUPPORT OF THIS RESPONSE

As seen in the National Institute for Health and Clinical Excellence - Caesarean Section (Update) Scope Consultation Table (24 February - 24 March 2010) - http://www.nice.org.uk/nicemedia/live/12156/49682/49682.pdf

Electivecesarean.com stated:

(**On Cost**)

Appendix C of the 2004 NICE guideline reads: 'The estimated cost of maternal request can change depending on the cost value entered in the model... If the lowest vaginal birth costs reported in the review and highest caesarean cost reported in the view are used, the additional cost for accepting 8,747 maternal requests for caesarean is around £21.2m. [But] since the highest cost for vaginal birth in the review is higher than the lowest cost for caesarean, if these values were entered into the model, the model would show that increasing planned caesarean due to maternal request would lead to savings, which is not a realistic conclusion.' This is an incredible admission in the compilation of caesarean cost statistics - that we can only accept the conclusion if it is the conclusion we expect or endorse. Again, this area of the guideline in relation to maternal request and cost is in urgent need of review.

On the subject of cost, I can provide other quotes and studies, but as one example, in 2008, an ACOG Committee Opinion concluded that it 'is not clear whether widespread implementation of elective cesarean birth would increase or decrease resources required to provide delivery services.' (http://www.acog.org/from_home/publications/ethics/co395.pdf)

Finally, it is important to note that current cost comparisons are flawed in terms of maternal request, as they contain medical and/or emergency surgical costs, but more crucially, vaginal delivery costs repeatedly fail to include the financial impact of:
1. all planned vaginal delivery outcomes, including spontaneous, instrumental and emergency caesareans.
2. short and long-term perineal and pelvic floor repair (e.g. prolapse) and counselling when trauma occurs.
3. huge litigation bills when vaginal delivery goes wrong and a baby/mother is injured or dies. For NICE to discount the cost of litigation to the NHS when it comes to evaluating the cost of maternal request versus trial of labour is a colossal error of judgement, and I would urge a reconsideration of this issue.

(**On caesarean rates and targets**)

It needs to be recognised that rising caesarean rates are no longer inherently viewed as a 'bad' thing; it is not the rate that is important, but rather, positive birth outcomes for mothers and babies. Also, any attempt to reduce rates should focus on those that are 'unwanted' and not those that are 'wanted'.

It is vital to note that the WHO recommendation of 1985 (that caesarean rates should be limited to 10-15%) has been updated as of its 2009 Handbook (which was not publicised and very few people seem to be aware of it). The WHO now admits that there is no empirical evidence for its 25-years-old recommended figure, and that there is in fact no known optimum rate. More info can be found here: http://www.medicalnewstoday.com/articles/169058.php

(**On informed choice**)

There is also an issue of morbidity tolerance for women; some will prefer abdominal morbidity in preference to perineal or pelvic floor morbidity – for example, the 2003 U.S. Healthgrades nationwide survey of hospitals uncovered significantly higher than expected vaginal complication rates in hospitals with lower than expected caesarean rates, and lower than expected vaginal complication rates in hospitals with higher than expected caesarean rates, 'suggestive of, but not definitive of, inappropriate under-utilisation of preplanned first time caesarean deliveries.'

Re: Maternal Request Caesarean will not be updated. Since the 2004 NICE Guideline, there has been an unprecedented publication of research studies, surveys and medical opinions on the issue of maternal request. This surely constitutes 'changes to the evidence base' and means that it should be included in this review.

To begin with, there was the March 2006 NIH State-of-the-Science Conference Statement: "Cesarean Delivery on Maternal Request":
http://consensus.nih.gov/2006/CesareanStatement_Final053106.pdf
While the panel concluded that there 'is insufficient evidence to evaluate fully the benefits and risks of cesarean delivery on maternal request as compared to planned vaginal delivery, and more research is needed', this is largely because there had been no effective clinical trials to compare the two at that time. However, the panel was able to conclude that 'any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical principles.'
[*note* In 2003, an ACOG ethics committee stated that it is risks from vaginal delivery:
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=20658]
The panel also concluded that due to the fact that 'the risks of placenta previa and accreta rise with each cesarean delivery, cesarean delivery on maternal request is not recommended for women desiring several children.' [*note* The fertility rate in the UK is less than 2, and the vast majority of women requesting a caesarean are only planning 1 or 2 children; therefore, their maternal request is legitimate within these guidelines.]
The panel also concluded that 'cesarean delivery on maternal request should not be performed prior to 39 weeks of gestation or without verification of lung maturity, because of the significant danger of neonatal respiratory complications.' [*note* Again, if a woman stays within this guideline, and does not deliver prior to 39 weeks, she should be allowed to have a caesarean. Furthermore, studies that demonstrate poor outcomes for babies born via planned casearean delivery prior to this gestational age should not be used as evidence against maternal request at 39 weeks.]
[NIH background: The National Institutes of Health (NIH) consensus and state-of-the-science statements are prepared by independent panels of health professionals and public representatives on the basis of 1) the results of a systematic literature review prepared under contract with the Agency for Healthcare Research and Quality (AHRQ), 2) presentations by investigators working in areas relevant to the conference questions during a 2-day public session, 3) questions and statements from conference attendees during open discussion periods that are part of the public session, and 4) closed deliberations by the panel during the remainder of the second day and the morning of the third.]

Secondly, there are a large number of studies that point to better health outcomes for babies born via elective caesarean delivery at 39 weeks, so why not allow women the opportunity to choose the safest birth for their baby if that's their informed conclusion? For example (note: PCD = planned caesarean delivery):

*Canadian study of almost 40,000 term deliveries, 1994-2002 comparing outcomes of PCD for breech presentation with spontaneous labour with anticipated vaginal delivery (i.e. PVD) at term in pregnancies with a cephalic-presenting singleton. Life-threatening maternal morbidity was similar in each group. Life-threatening neonatal morbidity was decreased in the CS group. It concluded that 'elective pre-labour Caesarean section...at full term decreased the risk of life-threatening neonatal morbidity compared with spontaneous labour with anticipated vaginal delivery.' (Dahlgren et al, 2009)

*Californian study of almost 2m babies born 1999-2003 excl. EGA <38w0d, or >42w6d. [In the knowledge that CDMR is recommended at 39 weeks EGA:] Infants born beyond 41w0d EGA have greater neonatal mortality relative to term infants born between 38w0d and 40w6d. (Bruckner et al, 2008)

*U.S. analysis of Ovid Medline over the past 10 years incl. intrauterine fetal demise: 'Copper reported that the rate of stillbirth is consistent from 23 to 40 weeks EGA with about 5% of all stillbirths occurring at each week of gestation. Yudkin reported a rate of 0.6 stillbirths per 1000 live births from 33 to 39 weeks EGA. After 39 weeks EGA, a significant increase in the stillbirth rate was reported (1.9 per 1000 live births). Fretts reported on fetal deaths per 1000 live births from 37 to 41 weeks of gestational age, showing that the rate progressively increased from 1.3 to 4.6 with each week of gestation. It can be estimated that delivery at 39 weeks EGA would prevent 2 fetal deaths per 1000 living fetuses. This would translate into the prevention of as many as 6000 intrauterine fetal demises in the U.S. annually-an impact that far exceeds any other strategy implemented for
stillbirth reduction thus far.' (Hankins et al, 2006)

*UK study of 37 of the 873 cases of intrapartum-related deaths reported in the 1994-1995 national enquiry. 'When cranial traumatic injury was observed, it was almost always associated with physical difficulty at [VD] delivery and the use of instruments. The use of ventouse as the primary or only instrument did not prevent this outcome. Some injuries occurred apparently without evidence of unreasonable force, but poorly judged persistence with attempts at VD in the presence of failure to progress or signs of fetal compromise were the main contributory factor regardless of which instruments were used.' (O'Mahony et al, 2005)

*U.S. study of 97 infants (65 VD, 23 CD) found a 26% prevalence of intracranial hemorrhage in asymptomatic neonates with VD; "ICH was significantly associated with vaginal birth." (Looney et al, 2007)

*Canadian study of 305,391 VDs found vacuum extraction may 'increase risk of cephalhematoma and certain types of intracranial hemorrhage (e.g., subarachnoid hemorrhage)'. (Wen et al, 2001)

*Californian study of 583,340 infants born to nulliparous women, 1992-1994. The rate of intracranial hemorrhage is higher among infants delivered by vacuum extraction, forceps, or CD during labor... the rate among infants delivered by CD before labor is not higher, suggesting that the common risk factor for hemorrhage is abnormal labor. (Towner et al, 1999)

*U.S. analysis of Ovid Medline over the past 10 years found that 'Overall, the frequency of significant fetal injury is significantly greater with VD, especially operative VD, than with CD for the nonlaboring woman at 39 weeks EGA or near term when early labor has been established... infants born to nonlaboring women delivered by CD had an 83% reduction in the occurrence of moderate or severe encephalopathy' and brachial plexus palsy with VD ranges from 0.047% to 0.6% compared with CD

0.0042% to 0.095%. "It is reasonable to inform the pregnant woman of the risk of each of the above categories, in addition to counseling her regarding the potential risks of a cesarean section for the current and any subsequent pregnancies. The clinician's role should be to provide the best evidence-based counseling possible to the pregnant woman and to respect her autonomy and decision- making capabilities when considering route of delivery." (Hankins et al, 2006)

*England's 2007-08 NHS Maternity Statistics report that birth injury to scalp occurs in 09% of births (est. as 5,400 babies in 2004-05, and confirmed that: 'none related to elective CD.' This breakdown has not been made available for 2009) (HESonline, 2009)

There is also evidence of better outcomes for mothers with elective caesarean delivery; again, maternal request allows women to decide which birth morbidity they find most tolerable – planned vaginal or planned caesarean:

*Australian retrospective review of 2,212 singleton CDs 2004-5 found that 14 women (0.63%) required a blood transfusion, and while the 'risk of blood transfusion for elective and emergency CD are 3.9 per 1000 and 9.8 per 1000', in 'the absence of risk factors identified in this study, no women (of a total of 1,293 elective CD) required blood transfusion.' (Chua et al, 2009)

*UK study of more than 2m women (CEMACH) >24 weeks EGA found fewer deaths occurred with PCD (n7; 0.31 per 10,000) than any other delivery type. (Treadwell M, BTA, 2008)

*U.S. study in Massachusetts 1995-2003; risk of maternal death with primary ECD is less than that associated with VD; also, death directly due to surgery itself is extremely rare (Berger M and Sachs BP, 2006)

*Protection of the pelvic floor:
http://www.prlog.org/10462391-planned-cesarean-delivery-offers-protection-against-pelvic-floor-disorders.html

*Greater satisfaction and psychological wellbeing:

*Australian anonymous postal survey of 78 women who had maternal-request primary CDs in eastern states private maternity hospitals. Most common reason for CDMR was 'concerned about risks to the baby' (46%) and on a scale from 1 (totally unsatisfied) to 10 (completely satisfied), the mean satisfaction rating reported was 9.25/10. 'Respondents were highly satisfied with their delivery'. (Robson et al, 2008)

*Swedish study of CD 'in the absence of medical indication' compared 2 groups from 357 healthy primiparas: CDMR (n.91) and PVD controls (n.266) with 3 self-assessment questionnaires in late pregnancy, 2 days after delivery and 3 months after birth. 'After PCD, women reported a better birth experience compared to PVD women. They were breastfeeding to a lesser extent 3 months after birth [but] there were no differences in signs of postpartum depression between the groups 3 months after birth. (Wiklund et al, 2007)

*Swedish study of women via questionnaires, incl. 124 emergency CD, 70 ECD, 89 instrumental VD and 96 normal VD. 'The women reported more post-traumatic stress reactions following EmCS as well as after instrumental VD, than after elective CD or normal VD...The psychological well-being of mothers is

generally not so favourable after emergency CD and instrumental VD, than after elective CD and normal VD. (Ryding EL, 1998)

*UK observational study at University College Hospital, London of 102 consecutive women undergoing CD. 'Women undergoing CD were well informed and took a considerable part in the decision-making process... High levels of satisfaction with both the decision and the procedure itself indicate that CD is an acceptable method of delivery, particularly when an elective procedure. (Mould et al, 1996)

Tokophobia as an indication for caesarean delivery can often fall between two stools, and these women are particularly vulnerable when being forced to have a vaginal delivery. Some doctors view tokophobia as a medical indication, and permit the 'maternal request' on those grounds while others view it as 'irrational' state of mind, controllable with counselling and/or adequate pain relief during a trial of labour. This 2000 study should be noted and recognised in the discussion on maternal request:

*Queen Elizabeth Psychiatric Hospital in Birmingham, England, interviews with 26 women 'noted to have an unreasoning dread of childbirth'. 'Pregnant women with tokophobia who were refused their choice of delivery method suffered higher rates of psychological morbidity than those who achieved their desired delivery method...Close liaison between the obstetrician and the psychiatrist in order to assess the balance between surgical and psychiatric 2000)
I would add that I am aware of two women for whom a refusal of maternal request caesarean delivery resulted in their termination of viable and much-wanted pregnancies.

The maternal request statement in the 2004 NICE guideline, as it stands, is wholly inadequate and open to different interpretations. I am contacted by numerous women who say that their request is being denied – including those that have asked for a second referral. I have also spoken with a number of NHS doctors about this subject, and they confirm that this is happening – especially in hospitals outside the South East of England. I have also been told that some doctors do not even write down 'maternal request' as an indication for a caesarean because they fear the repercussions from their NHS Trust; instead, they write down non-existent medical indications in order to support women that they believe are making a perfectly legitimate decision. The situation is a mess, and it is not being helped by the current 2004 maternal request statement.

Finally on this point, some doctors are speaking out about maternal request, including the very high profile Dr Mark Porter:
http://www.timesonline.co.uk/tol/life_and_style/health/expert_advice/article6897399.ece
Please note what I have written in the 'Comments' section below the main article, and more importantly, Dr Porter's positive reaction to what I've said.

(**On the challenges faced in establishing the true facts**)

When reviewing caesarean evidence, it is important to be aware of a bias that exists in some research and reporting on the subject of maternal request. For example, the recent the recent publication of a survey by The World Health Organization contained a seriously flawed and unsubstantiated conclusion in relation to caesarean delivery 'with no indication', and yet was published in The Lancet and subsequently received mass media coverage. This is what Nigel Hawkes, director of the pressure group Straight Statistics wrote about it:
Nigel Hawkes: A bad case of bias against Caesareans

http://www.independent.co.uk/life-style/health-and-families/health-news/nigel-hawkes-a-bad-case-of-bias-against-caesareans-1883667.html
Funny Figures from WHO on Caesareans:
http://www.straightstatistics.org/article/funny-figures-who-caesareans
When compiling tables of data, this latest development is of great importance:

The Department of Health has stopped publishing the table of birth data that links infant birth injuries with delivery type, which makes comparative assessment of infant risk extremely difficult. I noticed this while I was responding to a journalist's request for information on the incidence of scalp injuries with planned delivery. I knew that the 2007-08 data (births that occurred in 2004-05) showed that not a single case occurred with planned elective caesarean sections - and yet scalp injury as a risk is frequently cited as a serious risk for women who choose maternal request caesareans. As of 2008-09, this data is no longer available. Women deserve to know what risks their babies face with different delivery types, and given the research on babies' health outcomes cited above, again, I would reiterate that this is cause to review the 2004 statement on maternal request.

Table 3.1a on page 22 of the 2004 NICE guideline is in urgent need of review, and cannot be allowed to stand as it is. There are a number of out-of-date inaccuracies within the table – most notably that a woman is 5 times more likely to die with a caesarean. Also, the table would be of far more value for women planning their births, if it separated risks into each birth plan's potential OUTCOME. The overwhelming majority of emergency caesareans are outcomes of planned vaginal deliveries, and yet this table mixes these negative surgical outcomes with planned caesarean deliveries – of which an emergency caesarean is a comparably rare outcome. At the very least, elective caesareans should command their own column alongside emergency caesareans and vaginal deliveries.