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Response to 'Natural childbirth ideology is endangering women and babies'

David Ellwood & Jeremy Oats

A feature of this debate about 'natural childbirth ideology' is that caesarean section rate (CSR) should not be used as a clinical indicator. The thesis propagated is that by counting caesareans we are likely to do harm. This is an error of interpretation of the utility of clinical indicators. They are not rules to be slavishly followed, but clinical tools, the information from which can guide practice. If an indicator shows a service is an outlier then the action is to understand why, and adjust for factors that might be increasing or decreasing the CSR. It is also important to use a suite of indicators that inform about process as well as outcomes, which need to be both acute and long-term. Such an approach, used by the benchmarking and jurisdictional bodies that analyse perinatal statistics, gives an overall picture that is required to get the best view. Understanding the journey of birth is as important as the outcome, because with every intervention there are risks and benefits.

The statement that 'it is due to the ideology of natural childbirth which demands that CS be a key performance indicator of obstetric services' misses the point. The reason for counting is because a high and a low CSR can cause harm. There are also measurable benefits in vaginal birth for both mother and baby. Optimising the CSR is not ideology, it is evidence-based clinical practice. If there is harm in performing too many then it is not irrational to count the number. Indeed, one can argue that it is unethical not to audit a practice which

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can cause harm. It is interesting that both sides used the same reference in different ways (2). We acknowledged that there are countries in which the CSR is too low to produce optimal perinatal outcomes. But to imply that reducing CSR will increase mortality and morbidity is disingenuous and a misuse of data which suggest that the optimal CSR is around 19%. Indeed, there are examples from around the world where a reduction in CSR is possible without change in perinatal outcomes, but with medium and long-term benefits of a reduced CSR, and we refer to these in our paper.

Finally, we take issue with the argument that the failure of clinical governance which resulted in the Morecambe Bay problems is directly related to a desire to reduce CSR. The disintegration of a collaborative inter-professional culture within a service is a complex mix of issues, as is revealed by careful reading of the report. In the discussion about Morecambe Bay, and the commentary on New Zealand maternity outcomes, the profession of midwifery comes under fire. All maternity care providers should work together to produce optimal outcomes, and this requires nurturing a culture of professional respect. A prominent academic midwife was recently accused of being a prime driver to lower CSR in NSW and blame laid on her for a wide range of adverse outcomes (2). This exemplifies the extremes of passionate ideology rather than rigorous scientific debate. It is only in recent days that we have seen the fall-out from the retrospective cohort study from New Zealand that purports to measure outcomes from two models of care (3). The considered responses to that study from the professional leaders in that country are better examples of how the professions need to work collaboratively for the benefit of women and their babies.

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