Written evidence submitted electivecesarean.com (COM0119)

Executive summary

- In general, the BBC, RCOG, RCM, NCT, NHS Choices and The Lancet are all trusted by the public, but eliminating confirmation (and communication) bias in science remains challenging, and perhaps nowhere more so than in maternity care, where medical science often conflicts with the art of midwifery.

- Scientific developments in reproductive policies, including contraception, IVF, antenatal screening tests, amniocentesis, abortion, ultrasound, foetal surgery and premature NICU are no strangers to controversy, celebration and criticism, but importantly, they are all available on the NHS. A planned caesarean (CS) is considered different, and this is largely because of the dichotomy in maternity care between embracing science and technology, and '*promoting normality*', coupled with misconceptions and misinformation about its cost compared with a planned vaginal delivery (VD).

- In terms of communication, when NICE recommended support for CS delivery on maternal request (CDMR), the (57 page) *NICE* version of CG132 was circulated to the media, but not the (275 page) *FULL* version, which contains the Health Economics of CDMR. The media communicated to the public that a planned CS costs £2,369 and a planned VD costs £1,665 (a difference of £704), yet for CDMR, the comparative medium-term cost (considering urinary incontinence) is estimated at a difference of £84. This information was not communicated to the public and media, but more importantly, to commissioners and CEOs in NHS Trusts, whose misunderstanding has contributed to targets for reducing CS rates generally, and justifying their refusal of CDMR.

- Far more expensive implications of inaccurate perceptions of CS cost can be seen in the UK's litigation bill for obstetrics. A coroner has warned the DH that the NHS is rationing CS births to save money (*Telegraph 15/04/16*) and a solicitor confirmed, "*I come across a large number of obstetricians and midwives in my work as a solicitor and anecdotally they say there is an enormous pressure to save costs and to avoid [CS].*" (*Guardian 15/04/16*). This is a complete false economy, as this submission will show, and all MPs need to understand the staggering litigation bill their constituents' taxes will continue to fund in the future, and why – unless communication and polices urgently change.

- In summary, confirmation bias can exist even within science communication from "*very reputable organisations*" (*see oral evidence*), and while "*undue attention to marginal opinion*" should be avoided, "*Mavericks do sometimes deserve their say*". (*BBC Trust review, 2011*)

Brief introduction

My organisation is a Stakeholder for numerous NICE guidelines and quality standards, and has worked with MBRRACE, charities and other maternity organisations. It campaigns for greater transparency and informed choice in maternity care for all women, and supports women who want a CS but are refused. I have published research and contributed with correspondence in medical journals, and am co-author of '*Choosing Cesarean, A Natural Birth Plan*' (Prometheus Books, 2012).

Reasons for submission

A caesarean (CS) is one of the most established and life-saving reproductive aids in medical science history, but a very serious problem exists in how this area of science is communicated in the NHS, media and public. This matters because – as the Committee Chair rightly points out – "*science underpins so many of the policy decisions we are making*." I am also submitting evidence to the Maternity inquiry, but since its focus is on

the '*National Maternity Review*', a report devoid of any inclusion of the prophylactic benefits of a timely, planned CS, I think a science communication inquiry is just as, if not more, relevant.

Paragraphs

'THE CAESAREAN RATE' IS NOT AN INDICATOR OF QUALITY OF CARE - BUT IS COMMUNICATED AS SUCH WITH NO SCIENTIFIC BASIS.

1. Quality indicators should include stillbirth, perinatal and neonatal mortality, intrapartum death and injury, maternal mortality, morbidity (incl. pelvic floor) and satisfaction*, alongside data on PLANNED and actual mode and place of birth, including spontaneous VD, instrumental delivery (type/s), planned CS (medical or CDMR) and emergency CS, plus patient data (e.g. gestational age and sex; maternal age, parity, height and weight).
*Measures of satisfaction matter because different women plan and perceive birth experiences and outcomes differently. Neither the UK's Birth Trauma Association (BTA) nor Birth Trauma Canada (BTC) have ever been contacted by a woman following a negative CDMR experience.

2. RCOG admits: "*Before we began Each Baby Counts [2015], little evidence was available about the scale or causes of intrapartum harm to babies.*" Yet each year, 500-800 babies died or suffered a severe brain injury at term during labour, a number it wants to reduce by 50% by 2020**.**

3. The UK has been obsessively counting its numbers of CS for decades (e.g. *HES Statistics, CQC red flags*), with awards given for reductions – but without properly monitoring babies' outcomes.

4. However, just like the 2011 Birthplace Study, not 'every' term baby that dies will be counted now. All stillbirths prior to onset of labour are excluded; an omission that allows the 2015 NICE Intrapartum Care CG190 to claim: "*the evidence now shows that midwife-led care is safer than hospital care for women having a straightforward, low risk, pregnancy.*" But what about the high risk babies inside low risk women?[1]

5. 2009: "*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****… Ultimately, what matters most is that all women who need [CS] actually receive them…* ***the optimum rate is unknown****.*" And yet our entire maternity care system is grounded in the CS rate.

6. 2008: WHO Director of Making Pregnancy Safer, "*A woman should have the right to decide… It should be an informed decision; the doctor needs to give the woman all the information she needs, and then the woman should decide whether she wants a CS or she doesn't want a CS.*" (*2008*)

7. 2011: WHO Press Medical Officer, "*The WHO doesn't know what the optimum CS rate for countries is, but it does know that a very low rate means that the population is not receiving optimum care, and with upper rates, a rate of 60% or 70% is likely to mean a problem…*" [On 15% citations:] "*They're quoting the 1985 rate. Things have moved on since then… Goal posts are shifting. It used to be that a cesarean was only done to save the life of mother… But now more caesareans are done for the sake of the baby… Also, expectations are changing and indications have been changing. As technology got better, CS rates started changing.*"

8. 2015 WHO statement on CS: "*there is no evidence showing the benefits of CS delivery for women or infants who do not require the procedure".* Except its "*systematic review of the ecologic studies available in the scientific literature*" ignored pelvic floor outcomes and had insufficient data to determine stillbirth association.
The WHO's view of CS is the most oft-quoted 'expert' consensus communicated.

9. RCM: CDMR in NICE CG132 "*seems to be simply encouraging CS. Many of our members have commented on this as very unhelpful in their* ***quest to reduce CS rate***". (*comments 23/11/2011*)

10. 2010 Health Secretary, Andrew Lansley: "*Targets have trumped quality".*

RECOMMENDATIONS FOR THE GOVERNMENT WHEN COMMUNICATING POLICY–LED SCIENTIFIC ISSUES TO THE PUBLIC AND DEVELOPING NHS.

11. In answer to Carol Monaghan MP's question (Q101) on health, the government has a responsibility to listen to *ALL* engaged Stakeholder organisations and patient representatives, in order to ensure the full spectrum of maternity art and science is better understood, and a less adversarial way forward is achieved. I have personally met with and emailed both the Health Secretary and the former *All-Party Parliamentary Group on Maternity* (APPGM) chair, and written letters to the DH. I have explained how the *Maternity Care Working Party* (MCWP) stipulated that members must be in full support of its purpose, "*to promote normality in childbirth…"* (and how some members, including the BTA, resigned), and I repeatedly requested to speak at an APPGM meeting (secretariat provided by NCT), to ensure balance in communication to MPs, but to no avail.

12. Checks need to be made to ensure the GOV.UK '*NHS Choices*' website reflects science and NICE evidence correctly, and is balanced in its communication to the public. In 2015, CDMR information was updated only after my organisation highlighted important inaccuracies about NICE CG132 (published >3 years earlier). Unfortunately, NHS Choices refused to add links to *electivecesarean.com* and *c-sections.org* (both NICE CG132 Stakeholders) because they "*campaign*" and have books. It does however link to the NCT and AIMS (who fundraise, campaign and sell books) for their CS information.

13. The DH needs to fully understand and communicate maternity costs more accurately. A recent BBC news report included DH figures on 'average' VD costs (£1,985) and CS (planned and emergency) £3,781. NICE CG132 (2011) makes it clear that combining CS like this is unhelpful.

14. The government should avoid giving into pressure from international league tables without a thorough examination of all the facts. For example, in 2008, Greece's stillbirth rate was at a historic low (3.31/1000) but with one of the highest CS rates in the world, a public 'CS epidemic' campaign began on reducing CS and increasing VBACs. By 2010, its stillbirth rate had increased 32% to 4.36/1000. The economic crisis also occurred at this time, which may be factor, but years later, when other mortality measures started to improve again, stillbirth rates didn't (*The Lancet, 2014*). In 2013, a U.N. *"Committee urged Greece to reduce the number of CS performed for no good medical reason and to introduce strict controls on medical indications for CS, in order to bring percentages in line with the WHO recommendation. The Greek Government agreed to advise the WHO committee by 1 May 2015 of the measures implemented…" (Parliament MEP*, *2015*). The pressure to reduce CS rates to unscientific levels is huge, but governments need to closely monitor mortality and morbidity outcomes if they comply, since "*reducing the rate of CS delivery may lead to higher costs and more complications for mothers and their babies. The reason is that two of the strategies proposed to reduce the CS delivery rate, increasing the number of VDs among women who have had CS deliveries and increasing the number of operative VDs, are associated with uterine ruptures and neonatal trauma, respectively.*" (*N Engl J Med. 1999*)

15. Follow through on promises. In 2012, on BBC Radio 4, Health Secretary Jeremy Hunt reportedly said, "*I believe that my decisions as health secretary should be based on science and should be evidence-based and driven by evidence. In everything I do* ***I will follow the scientific advice.***"
1) In November 2015, he pledged to "*reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030.*" A recommendation for the government is to read the stillbirth research papers and Dr. Collins' book *SILENT RISK,* cited in #s 38-50 below.

2) On April 29, 2016, DH published '*The NHS Choice Framework: what choices are available to me in the NHS?'* but section 6, *Choosing maternity services*, does not include CDMR. Another recommendation is for the government to communicate CDMR more effectively to ***all*** women, so that it is not only the most educated and affluent women who have knowledge and access to this scientifically supported choice.

16. Follow the unprecedented stillbirth inquest taking place in Northern Ireland right now – where the alleged errors cited are all too familiar: w*rongly categorizing…as "low-risk*" VBAC; inadequate counselling on mode of delivery; induction without discussing risks; incorrect recording of baby's heart rate; delaying emergency CS. The baby's cord was wrapped around her neck and her mother "*recalled repeatedly requesting a planned CS*" but was refused. (*Irish Times, 30/08/2016*)
Also read about the SNP MP Patricia Gibson's devastating personal experience of stillbirth (and reported liver rupture following induction at age 45 with pre-eclampsia), which she is bravely speaking out about.

COMMUNICATING LITIGATION COSTS – EST. £56.4 BILLION (42% OBSTETRICS)

17. With prophetic insight in 2008, Professor James Drife wrote: "*Obstetricians have acquiesced too readily at being excluded from so-called "low-risk" pregnancy, where most stillbirths occur. These attitudes have been described as "giving up on getting better". Sooner or later women will demand improvement, probably through the courts, but* ***surely we do not have to wait for litigation or a public enquiry before we take action***." (*Expert Rev. Obstet. Gynecol.*) Unfortunately, we did.

18. The Morecambe Bay Investigation and Montgomery v Lanarkshire Health Board Supreme Court judgment in 2015 may have finally triggered an overhaul of one of the most complacent* areas in healthcare. Dr. Bill Kirkup criticised "*fractured relationships between professional groups, and the unacceptable pursuit of normal childbirth – itself a worthwhile aim – but not when it occurs at any cost*", and Mrs. Montgomery was awarded £5.25m for her 1999 birth, when: "*If [she] had had an elective CS her son would have been born uninjured.*"

19. And what's even clearer than ever before from the NHS Litigation Authority (NHSLA)'s latest annual report is the staggering financial damage – as well as the physical and psychological damage for families – this acquiescence may have done. The overall long-term provision of financial position is now **£56.4bn** (up from £28.6bn last year, largely because of a HM Treasury change to the long term discount rate, which communicates estimated *future* costs, instead of the cost if paid out today). For the year 2015-16, obstetrics accounted for 10% of the year's 10,965 total claims, and 42% of the **£2.9bn** value of claims received.

20. "*All of which [the report says] present challenges in the context of long term financial sustainability.*" Absolutely, it does, and especially considering the laws on statute of limitations (especially for injured babies). Remember, the Montgomery case occurred *17 years ago*… The NHSLA says it's working with the DH and others on "***promoting safety***" and "*launching a consultation…to explore further options with our membership to incentivise the reduction of harm.*" (*2016*)

21. In 1989, the DH stepped in to reduce litigation pressure on maternity professionals via a '*NHS Indemnity*', and this shielded them in a way other countries didn't (e.g. USA). But given the NHSLA's new report, it may have been more in hope than expectation: "*The centralization of claims management under this system seems* ***likely to be financially neutral in its impact on the total of NHS expenditure****. There should be some gains from a build-up of claims management experience and, in the longer term, from* ***better risk management information****. Against this, the scheme managers will,* ***presumably, expect to turn a profit*** *for themselves and to build this into their pricing.*" (*Br. J. Anaesth 1994*)

PELVIC FLOOR

22. In 2012,[2] the NHSLA highlighted perineal trauma as one of the largest litigation areas for claims related to women, with allegations of negligence including failure to consider a CS. Four years ago, it reported 441 claims over 10 years, with an estimated total value of £31.2m, but given its new report, and a recent award of £1.6m for obstetric anal sphincter injury, it's very likely this figure is already much higher.

23. Sweden's 'no-fault' litigation system is frequently cited as a good alternative to these rising costs, but my organisation would want to hear the views of women impacted in this research first: "*obstetric anal sphincter rupture has increased markedly in Sweden, and significantly less frequently in Italy… 23 times higher risk*" (9.2% v. 0.4%).[3] Italy's CS rate is twice as high as Sweden's.

SOCIAL MEDIA

24. In 2016, women are communicating with each other about their births on an unprecedented scale, and with severe perineal trauma especially, one of the biggest sharing taboos is no longer silent. Every day, more and more women are bravely speaking out about living with nappies, incontinence pads, painful sex and multiple perineal surgeries. Secret and shameful is transforming into anger, demanding answers and taking legal action.

PROMOTING CHOICE OR RISKING LITIGATION?

25. For decades, maternity care policy and practice has been largely protected from litigation by government indemnity, which is something international commentators often forget. Now RCOG recognises that Montgomery "*will have a significant influence on obstetrics and gynaecology practice in the UK, with potential impacts on doctor-patient communications, information sharing and informed consent. [It] began meeting with medico-legal experts last summer to gain a clearer understanding of the implications and requirements on the profession.*" (*RCOG press office, 2016*)
Yet still…
NICE CG190: "***Advise*** *low risk nulliparous women that planning to give birth in a midwifery led unit…is particularly suitable for them… and the outcome for the baby is no different compared with an obstetric unit.*" RCOG: "*One strategy for reducing the overall CS rate is the* ***promotion*** *of VBAC, where appropriate.*" (*NHS Trusts report, 2016*)

26. In 24% of uterine rupture claims there "*was an alleged failure to offer maternal counselling as to the mode of delivery.*" (*NHSLA, 2012*)
France example: "*The rate of litigations tripled in a decade… Uterine rupture was the most common cause of complaints.*" (*J Gynecol Obstet Biol Reprod, 2012*)
"*Claims for stillborn babies are also rising, with* ***experts warning of an "explosion" in payouts*** *as parents realise that their child's death should have been prevented.*" (*Times, 10/06/2015*)

27. Ironically, in a 2013 National Audit Office report, its vision to help the nation spend wisely was "*to encourage normality in births by reducing unnecessary interventions*", and the 2012 NHSLA report said, "*…we will work with the Care Quality Commission to 'ask the right questions' when reviewing maternity services…*". The CQC red flags hospital CS rates that are higher than the national average.

28. *Susan Bewley, chair of 2014 NICE CG190: "***Doing nothing in the face of normality does not have to be justified****... the onus of both ethical and clinical proof is on the interventionist side.*" (*The unethics of 'request' CS,* BJOG 2002)
Campaigner and obstetrician Wendy Savage: "*One of the problems… is that obstetricians don't find it easy to say no when a woman says she wants a CS… women and their families expect everything to be perfect, and if it is not they are upset, and doctors are influenced by that. I think* ***women and their families have to understand that life is uncertain***." (*Guardian 31/03/2016*)

CAESAREAN COMMUNICATION TO CCGS, HOSPITALS AND TRUSTS

29. In 2012, the RCOG, RCM and NCT set out a "*clear action plan*" to reduce CS rates to 20% and increase "*normal*" birth rates, which "*includes delivery by forceps and ventouse*" and delivery "*without epidurals*". It said midwifery-led birth units should be the "*default option*" for pregnant women and "*Every potential [CS] that is enabled to be a normal birth saves £1200 in tariff price alone. [This] saves the NHS money.*"[4]

30. It was vehemently opposed[5] by Advocacy for All (AFA), Csections.org, BTA, BTC, electivecesarean.com, Erb's Palsy Group, Perinatal Illness-UK and Pyramid Of Antenatal Change, as well as consultant anaesthetists, obstetricians and the BJOG editor-in-chief. But although the document was initially removed from RCOG's website, it was reinstated shortly afterwards.

31. The 2009 NHS Institute for Innovation and Improvement '*Toolkit for reducing [CS] rates*' claimed there was a "*general belief amongst clinicians that maternity units applying best practice… will achieve a [CS] rate consistently below 20% and will have* ***aspirations to reduce that rate to 15%***." The Toolkit contained behavior statements that the BTA highlighted as clinically negligent and those were subsequently withdrawn.

32. In 2008 and 2010, Royal Wolverhampton NHS Trust New Cross Hospital won the APPGM ***'The Normality of childbirth'*** Award (e.g. *'Model for high risk women in labour'*). In 2015, a CQC inspection criticised the hospital's CS rate, which had '*increased (worse) to 27%*' and praised its '*increased (better) 61%*' (and still rising), normal birth rate. But then in 2016: "*Warnings to Black Country hospital trusts over high stillbirth and newborn death rates*". (*8.17 per 1000; Express & Star 22/02/2016*)

33. Similarly: *NHS Ayrshire and Arran Midwifery award for promoting normal birth* (*RCM, 26/01/2012*), and
then: *NHS Ayrshire and Arran receive red flag warning over stillbirth baby rate* (*Daily Record, 19/02/2016*)

SCIENCE AND TECHNOLOGY NEEDS TO INFORM OBSTETRICS COMMUNICATION

PELVIC FLOOR SCIENCE

34. Technological advances in ultrasound and MRI imaging have given a research team at the University of Sydney a clearer understanding of the physical impact of birth. It reports: "*Over 30% of women who deliver vaginally suffer trauma that is associated with future morbidity such as female pelvic organ prolapse, sexual dysfunction and anal incontinence*". (*ANZOG literature review, 2014*)

35. Pelvic floor and anal sphincter trauma should be key performance indicators of maternity services. (*Dietz HP, Int Urogynecol J, 2015*)

36. RCOG: "*Approximately 90% of women tear to some extent during childbirth, however, in some women the tear may be more extensive. In England,* ***the rate of reported severe perineal tears has tripled from 1.8% to 5.9% between 2000 and 2012****.The overall incidence in the UK is 2.9% and 6.1% in first time mothers….*" (*2015*)
But note: RCOG's patient leaflet on severe tears focuses solely on diagnosis, management and treatment (not prevention) for first-time mothers.

37. Similarly, RCOG's 2015 patient leaflet, *Choosing to have a CS*, contains no information on pelvic floor risks, inaccurate statements on CG132, and advice that is at odds with NICE QS32. Inevitably, some doctors reportedly called it "*biased*" and "*very one-sided*" (*New Scientist, 2015*), and on July 19, I asked RCOG twelve specific queries and requested research citations for some of the leaflet's statements. On October 16, I received four brief answers, with no citations, but RCOG said: *"The leaflet is focussing on informing women*

of their choices…" Perhaps given that the DH and vast numbers of NHS hospitals don't even do this, it's a step in the right direction, but this is RCOG… and its communication here isn't good enough.

FETAL SCIENCE

38. Scientific advances in ultrasound could reduce the UK's rate of term stillbirth. RCOG says "*Ultrasound is a safe, diagnostic imaging tool*" (*17/10/2012*) but the NHS standard is one scan at 8-14 weeks and another at 18-21 weeks. After that, the NHS lets nature take its technology-free course – without communicating the benefits of a third trimester scan, or the increased risk of stillbirth after 37 weeks EGA.
Incredibly, **gestational age is not even cited as a risk for stillbirth**.

39. Scientific data informs women of their risk for breast cancer in each decade of their life (*e.g. 1 in 26 age 70, 1 in 227 age 30*), with breast screening and different prophylactic and treatment options optional; but the *information* on risk as age increases *is* communicated to the public. **So w*hy is it not the same for term babies in utero?*** The RCM unquestionably supports a woman's choice to abort her baby at this point (*Setting the record straight - The RCM and abortion, 16/05/2016; Abortion is part of our calling… Telegraph 20/05/2016*) but a '*low risk*' woman's choice to have a late term scan, or even a prophylactic CS, garners far less support: "*We are confident that when women are fully aware of the evidence they will not be asking for inappropriate caesarean sections.*" (*RCM quality & audit development advisor, 11/06/2013*)

40. Umbilical cord accidents (UCA) deserve the same attention as SIDS '*back to back*' advice. "*With an estimated 8,000 deaths per year in the United States from complications of UCA, an initial goal of 50% reduction of loss is possible. To achieve this goal requires the recognition by the obstetrical community of the issue.*" (*SILENT RISK - Issues about the Human Umbilical Cord. Jason H Collins MD MSCR, XLIBRIS, 2013*)

GESTATIONAL AGE MATTERS

41. "*The risk of stillbirth at term increases with gestational age from 2.1 per 10,000 ongoing pregnancies at 37 weeks of gestation up to 10.8 per 10,000 ongoing pregnancies at 42 weeks of gestation. At 38 weeks of gestation, the risk of expectant management carries a similar risk of death as delivery, **but at each later gestational age, the mortality risk of expectant management is higher than the risk of delivery (39 weeks of gestation: 12.9 compared with 8.8 per 10,000; 40 weeks of gestation: 14.9 compared with 9.5 per 10,000; 41 weeks of gestation: 17.6 compared with 10.8 per 10,000)***." (*nearly 4 million births; Obstet Gynecol. 2012*)
"*The risk of stillbirth increased continuously with gestational age in women with and without gestational diabetes, rising to its highest level at 42 weeks of gestation.*" (Am J Obstet Gynecol. 2012)

42. "*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 United States annually-**an impact that far exceeds any other strategy implemented for stillbirth reduction thus far**… 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.*" (*Semin Perinatol. 2006*)

43. "*Risk varies by maternal age, and delivery at 39 weeks minimizes fetal/infant mortality for both groups, although the magnitude of the risk reduction is greater in older women.*" (Am J Obstet Gynecol. 2013)

44. "*A policy limiting elective delivery before 39 weeks of gestation was followed by changes in the timing of term deliveries. This was associated with a small reduction in NICU admissions; however, macrosomia and stillbirth increased.*" (*Obstet Gynecol, 2011*)

45. "*Between 2007 and 2013 in the United States, the adoption of the 39-week rule caused a progressive reduction in the proportion of term births occurring before the 39th week of gestation. During the same*

interval the United States experienced a significant increase in its rate of term stillbirth. This study raises the possibility that the 39-week rule may be causing unintended harm." (*Am J Obstet Gynecol 2016*)
Note: NHS maternity care tends to work towards a 40-week rule…

46. "*…the push to strictly enforce the 39-week rule should be reconsidered and guidelines concerning the use and timing of early-term labor induction should once again allow for both provider-level clinical judgment and individual patient input.* ***Given the literal "life and death" importance of this issue****, and given the need to fairly balance the ethical principles of Beneficence and Autonomy,39 there is reason to consider a moratorium on the enforcement of the 39-week rule until further research, including adequately powered randomized clinical trials, can better measure its benefits and risks.*" (AJOG 2016)

47. "*With a 4% increase in rate of CS at our institution, a significant decrease in the occurrence of major birth trauma was observed.*" (*J Perinatol 1998*)

RESEARCH COMMUNICATION
48. Even Sands, the largest stillbirth charity in the UK, appears to be reluctant to communicate the prophylactic benefits of a timely CS. Its 2012 report *Preventing Babies' Deaths – what needs to be done*, makes some excellent points (e.g.) "*Routine antenatal care with its focus on low intervention has few tools for assessing fetal wellbeing in the third trimester and babies continue to slip through the net and die.*" But there is not a single mention of planned CS, and a quick search for 'caesarean' on its website returns just two references on induction research, both of which contain '*avoiding CS*' as a positive outcome. Also, the word CS does not appear in "*Sands' vision, purpose and priorities 2014-2017*".

49. Ironically, RCOG's President said of Sands' 2012 report, "*We would therefore* ***encourage scientific funding agencies to support more research in this neglected area*** *which could further our understanding and reduce the number of cases.*" (*18/01/2012*); only to publish a "*clear action plan*" just months later (#29 above) to reduce CS rates to 20% and increase normal birth rates.
Note: Stillbirth is normal.

50. Another charity, the *Pyramid of Antenatal Change*, was founded in Scotland by parents Robert Devine and Barbara Mane after their baby Amalia was born silent on October 21st 2007. The charity corresponded in writing with both the RCOG and RCM leaders, culminating in a meeting and presentation to the RCOG president in London on September 15th 2010. Nevertheless, it says real progress is not happening and too many babies are still dying.

CHALLENGES OF REPORTING SCIENCE TO THE GENERAL PUBLIC

51. Giving evidence, David Shukman, made a very good point about audience clarity, fear, lack of comprehension and the need to be very careful about choice of language. This is especially true of health stories like CS where one week it is positive news and the next it is negative.

52. Shockingly, when NICE CG132 on CS was published in 2011, recommending CDMR support, NICE's own newsroom published an interview with the guideline chair, using this language:
"*because* ***they have misunderstood****,* ***they have been misinformed****, for cultural reasons why they have latched onto vaginal birth being a bad thing… There are other women who have perhaps* ***misconceived*** *some of the risks… where* ***we are able to debunk myths*** *then that may be where* ***we can turn things around*** *and allow women to make* ***an informed choice to have a vaginal delivery****… [Women are] now going to be* ***empowered to choose a vaginal birth*** *over a repeat caesarean section.*"

53. David Shukman also talked about how the BBC assesses the quality of scientific research ("*Is this a 10-year study involving 10,000 people, done by very reputable organisations, who then submitted their work to*

peer review and had it published?").
On this point, I'd like to provide one example where even this is not 100% reliable. In 2010, The Lancet published a WHO study that concluded, "*To improve maternal and perinatal outcomes, CS should be done only when there is a medical indication.*" Nigel Hawkes, then director of Straight Statistics wrote: "Funny Figures from WHO" and "A Bad Case of Bias against Caesareans"; he asked, "*Did none of the 23 think this an odd conclusion to have reached? Did no one check the arithmetic in the tables, which are full of errors? The Lancet is a distinguished journal—**were its referees asleep**?*"
My official complaint to The Lancet's ombudsman was upheld in September 2010, and the Lancet was asked to: "*Review their process of peer review, Consider whether all reasonable (ie not libellous etc) comments on an article could be put up on their website and linked to the article in question, and Have another statistician look at this particular paper and proceed accordingly.*"

54. The Lancet's manifesto promises "*only the best research papers, based on their quality of work and the progression they bring: **the best science** for better lives.*" Notably, The Lancet published the WHO's infamous 15% threshold for CS rates, though did not report news on the WHO's 2009 clarification that it had "*no empirical evidence*" for its 1985 recommendation.

55. Victoria Borwick MP made an important observation (in Q.128), and while it's not a criticism of the SMC, in the context of birth science, a search on its website generated just 11 CS experts/stories over 13 years, 14 for maternity, 0 for pelvic floor and prolapse, 2 for incontinence and numerous for birth. Also, the SMC's expert for The Lancet's *Ending Preventable Stillbirth Series* (*18/01/2016*) was RCOG; an organisation that supports 'promoting normality' (stillbirth is normal) and reducing CS rates to 20%.

GOOD PRACTICE
56. The BMJ and BJOG have an excellent system of reader engagement. Users can submit letters of response to a publication, allowing public debate with cited references. In 2013 for example, I was able to challenge[6] the assertion by midwifery lecturers and professors that "*NICE says caesarean section is not available on demand unless clinically indicated.*"

COMMUNICATING CONTEXT BEYOND THE IMMEDIATE "STORY"

57. In April 2016, the death of baby Kristian Jaworski received considerable national media coverage. The mother's CS request was denied, with repeated instrumental delivery attempts before eventual emergency CS. What the majority of the public didn't learn was the hospital's history.

58. Maria Panteli successfully settles claim into the avoidable death of baby at North Middlesex Hospital (*LeighDay 03/10/2011*)
Baby died of fractured skull after Caesarean section delayed (*Telegraph 19/11/2009*)
"***We also hope that these events will prevent it from happening to anybody else***."
Hospital apologises for baby's death (*LeighDay 02/11/2004*)
"*Even once they realised the baby was breech, they allowed the labour to continue, rather than considering a caesarean section… The Trust also agreed…**to prevent a similar incident happening again***."

59. The hospital's website is littered with phrases including, "*Promoting normality*", "*Philosophy - We believe that pregnancy and childbirth is a normal physiological process.*" It boasts of a CS rate "*relatively low compared to other London maternity units"* and a higher normal birth rate (65%) than England's average 60.7% (emergency CS was higher too, 17%). And it said, *"**This was positive given the high-risk population.***" "*The labour ward managed capacity by delaying elective caesareans or induction.*"

EXAMPLES OF NEGATIVE CDMR COMMUNICATION

60. Negative reporting can sometimes happen when journalists and presenters react to an idea, rather than the latest scientific evidence, and naturally, draw on their own personal experience too. Fortunately, the examples below are tempered by positive examples too (e.g. BBC News' willingness to change a sentence online when contacted and *The One Show* editor revisiting the CDMR issue following my correspondence).

61. BBC News: *Caesarean births:* ***Fad or folly?*** (*Talking Point 29/05/2001*)
"*Ninety per cent of women risk complications with Caesareans.*"
Scientifically, 100% of women risk complications with any birth.

62. BBC The One Show (*22/08/2011*)
Dr. Sarah Jarvis: "*Now, to put it into perspective, the WHO says 'no way should more than 15% of women in a country be having cesareans. In our country, it's 25%, so they can't all need them.* ***There has to be a yummy-mummy, a too-posh-to-push effect out there****. I have to say.*"

63. BBC London's Vanessa Phelps: ***Folly*** *of caesarean births for everyone*. (*Express 01/11/2011*)
"*Remember when 'too posh to push' was a criticism? We must hope NICE sees sense before natural labour becomes so unpopular that those women who refrain from a c-section are seen as abnormal.*"

64. BBC Radio 4 Woman's Hour Jenni Murray: **The madness** of Caesareans on demand (*Daily Mail 01/11/11*)
"*…it seems the 'too posh to push' brigade has won itself something of a triumph… This will deliver a potentially terminal blow to* ***those of us who have campaigned for years*** *for women to be given the proper support to give birth to our children* ***as nature intended****.*"
Note: BBC Feedback (*04/2014*) *"…BBC programmes are supposed to be impartial but I'm not sure if that can be said of Woman's Hour, at least when it comes to feminism… Woman's Hour is in fact a powerful advocate for women's empowerment...*"

PROFESSIONAL FEAR OF COMMUNICATING

65. The Committee discussed young scientists' careers, the pressure to publish and the perception of communication engagement versus lobbying. For medical professionals working in obstetrics and gynaecology, there can also be a pressure 'not to rock the boat', especially when working in hospitals with CS rate and 'normal birth' targets. When I first began interviewing obstetricians, even a more established doctor told me they supported CDMR but 'I'm not going to stick my head above the parapet in the media'; another said they had enough experience and standing in their hospital to make their own decision but were aware that others might not feel so confident.

FEAR OF RESEARCHING AND COMMUNICATING CAESAREAN SCIENCE

66. "*What a disaster it would be if it was found elective caesarean was safer than vaginal birth. We're on dangerous ground here. Everyone practises defensively now. People are so nervous they would abandon vaginal delivery with any excuse."* (*Dr. Robson, SMH, 16/10/2003*)

67. Dr. McLellan: "*if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a CS, and it's not in the maternal interests for women to have CS*". (*Montgomery case, 2015*)

68. There are evidently fears among medical professionals of what might happen if all the risks of a VD are communicated to women, but Lady Hale made it very clear in her Supreme Court judgment that women

should still not be deprived of risk information: "*Whatever Dr McLellan may have had in mind, this **does not look like a purely medical judgment**. It looks like a judgment that VD is in some way morally preferable to a CS: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter.*" (*Montgomery case, 2015*)

69. "*The researchers comment that if such a trial showed that CS is as safe as normal birth, the resource implications would be enormous and the NHS would have to consider whether it would be willing to offer such a choice.*" (*Br Med J, 2005*)

70. Canada's SOGC: "*The society is concerned that a natural process would be transformed into a surgical process... The SOGC will continue to promote natural childbirth…*" (*Birth, Klein 2004*)

71. "*The most common primary indication for elective Caesarean section was maternal choice…*" (*Aust NZ J Obstet Gynaecol, 1999*)

73. "*Undoubtedly, nowadays we are more aware of pelvic floor problems but are not yet doing enough to prevent and obviate them. Despite randomised trial evidence of antenatal perineal massage preventing trauma, few units practise this routinely. If concerns about childbirth damage are overplayed, anxiety in both obstetricians and women will be increased... If obstetricians consider labour destructive and dangerous, they will not be able to pass on any confidence in women to labour.*" (*BJOG 2002*)

74. "*Is it scaremongering to tell prospective parents of the risks, however relatively small, of their baby dying before or soon after birth… or is it giving them the power to make truly informed choices about their own health and pregnancy care?*" (*Sands, 2012*)

Conclusion

75. "The realities of science are not producing a shiny research paper, with absolutely no uncertainties in it. It is a messy, human subject…" (Imran Khan) It's a challenge to "*work out which scientific experts are credible and which evidence base is credible. That is absolutely critical.*" (Fiona Fox) The importance of "*talking to patients and finding out what they want from a research project*" is also critical. (Dr Webster)

Thank you to the Committee for accepting my submission to its inquiry on Science communication.

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FURTHER INFORMATION

Stop glossing over the risks of natural birth to cut caesareans (*New Scientist, 21/07/2015*)
Doctors should warn women about the real risks of childbirth (*New Scientist, 16/07/2016*)
UK doctors may officially warn women of vaginal birth risks (*New Scientist, 16/07/2016*)

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"*reasons are usually considered, and motivated by a genuine desire to avoid the potential problems of vaginal birth.*"

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"*We encourage "family planning" and prepregnancy counselling, we routinely perform antenatal screening, and we offer prenatal diagnosis—all of which are "unnatural" and promote a concept of the "designer baby." Can we do all this and then refuse a woman a safe mode of delivery (caesarean section) that removes the gambles associated with labour and which she personally finds unacceptable?*"

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