AIMS For a better birth...

Ideological birth wars: The academic debate goes on, but where does this leave us?

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A recent article published in the British Medical Journal[1] provoked quite some controversy in maternity circles, and the ensuing debate[2] highlighted a continued and unsettled controversy about "where women should give birth." Here, AIMS Volunteer Jo Dagustun seeks to unpick the arguments and explore what this all means for the maternity services and their users. In summary, Jo suggests that this latest debate demonstrates that maternity service transformation into a service that BOTH supports women well via the provision of high-quality information AND improves maternity care for all is still some way off. Nothing new there then…



Jo Dagustun

The original BMJ article – via some seemingly straightforward analysis of existing maternity statistics – wades into the vexed issue of "risk stratification." On the basis of their data work, the authors suggest some major changes to the way in which maternity services declare who is "low risk" and who is "high risk." (Yes, we know: this sort of label can be deeply unproductive. But let's go with it for a bit, on the basis that such labels might at least be helpful for service organisation…)

These changes – if adopted as the authors envisage – would potentially raise barriers, and certainly "raise eyebrows," if, for example, a first-time mother wanted support to birth at home or at a birth centre not co-located with obstetric services. This is because from the authors' perspective, all first-time mothers who are not already in line for a planned caesarean would now be classed as "high risk'." They reason this because the figures show that nearly half of these women will end up with a "complicated birth."

The definition of complicated birth used by the authors is in itself quite controversial, mainly because it

includes both medical interventions and health outcomes (apples and pears, you could say). It also excludes a consideration of long-term mental health outcomes; this is surely quite an omission. We are clearly still awaiting the day when all players in the healthcare system truly support an understanding of health as including both physical and mental health, and also one in which the longer-term effects of birth are properly taken into account.

The key, and strikingly familiar, point of contention is between different understandings of the nature of the risks of childbirth. For sure, the risks are various and highly personal to each individual. But is the key reason that problems arise because women are fundamentally flawed, that our bodies are flawed, that the physiological process of birth cannot be trusted and should be put "on trial," under close supervision and in a place where medics are close to hand, especially for first-time mums? Or are many of the problems related to the fact that our maternity services just aren't adequately focussed on understanding and supporting both the needs of the individual service user and the physiological process of birth?

In general, most people would agree that "more information is good," but this is true only if the information is accurate and its biases are clearly identified. Although the article purports to offer more information – to aid women's decision-making – we would ask readers to take care. The detail is important and not all information is as politically neutral as it seems. AIMS is passionately keen to ensure that women are not misled about the birth-related risks they are likely to face when they make decisions about their maternity care. As such, we would hope to see more methodological sophistication when reports on such data are published.

I wrote a response to the article. Whilst it wasn't selected for publication by the BMJ, AIMS colleagues thought that readers might be interested to see it, so it is reproduced in full below.

An open letter to the Editor of the BMJ on behalf of AIMS, 6 October 2020

Risk of complicated birth at term in nulliparous and multiparous women using routinely collected maternity data in England: cohort study

I am grateful to the authors for their careful work in bringing this quantitative analysis to publication. They present here thought-provoking statistics indeed.

Just why is it, for example, that nearly half of all women traditionally categorised as 'low risk' (excluding those undergoing a planned caesarean), and giving birth for the first time at term, experience such high levels of the interventions and poor outcomes selected by this team?

I fear, however, that this paper provides a stunning example of authors offering implications and conclusions that barely relate either to the preceding results and analysis or to the current policy context. Before jumping to policy recommendations based on the notion that certain levels of birth outcomes, within certain populations, are inevitable, and that first-time mums ought to be advised to

birth 'in a setting that enables rapid access to care by an obstetric or neonatal team, including midwife led units', I'd strongly advise the authors – and readers - to pause for thought.

This is because this line of argument curiously and unacceptably ignores the broader ecology of birth. We surely cannot simply assume that the physiological process of birth inevitably fails so frequently, absent a close examination of the context in which such complications occur?

I would suggest that a more productive line of enquiry – and basis for policy recommendations in this area, which the authors seem curiously keen to make – might have been to contemplate*what it is about the way in which our maternity services provide support to maternity service users that leads to such outcomes?*

So, what are the issues related to the delivery of maternity services that urgently need to be addressed, to support better outcomes? Here, I'd recommend a close examination of the Better Births (2016) report, alongside the related and ongoing Maternity Transformation Programme. There is an existing rich seam of policy work underpinning this Programme, and it is disappointing that this is not reflected here. Indeed whilst an intellectual enquiry into risk stratification for operational purposes may serve some purpose, this goal seems fairly obscure given the nationally agreed policy shift towards (a) a stronger focus on a woman's right to make decisions about her care (on the basis of balanced, evidence-based information to support her in making an informed decision), (b) service provision which is increasingly able to support personalised care (shifting away from the conveyor belt approach to 'care' which is sadly all too common still), and (c) a new transformational model of relationship-based care that is firmly rooted in an evidence-base of improved outcomes (continuity of carer).

I appreciate that it might be difficult for some hard-working and well-intentioned healthcare professionals to even contemplate the line of enquiry I suggest here. But it is equally difficult for me to accept that the authoritative platform of the BMJ is being used to platform such ill-informed, misleading and potentially dangerous policy recommendations as are presented in this paper. Reviewing the open access peer review papers associated with this article, I would also suggest that the BMJ looks urgently at the diversity (especially methodological) of those involved in that process.

For future reference, I'd also strongly recommend that the term 'women with a singleton birth at term after a trial of labour' is not accepted for use in the BMJ. It is not the physiological process of labour that is, or should be, on trial in this situation, and I cannot think of any other physiological process that would be conceptualised in this way. This terminology is inappropriate in this context, and – in this case – worryingly suggests an underlying but undiscussed set of beliefs on the part of the author team, the non-disclosure of which does not sit well with the scientific rigour that your readers have come to expect. Nor, I suggest, is it suitable to refer to women as 'candidates' for a certain type of birth setting.

Yours

Jo Dagustun

Volunteer, AIMS

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1 *Jardine, J, Blotkamp, A, Gurol-Urganci, I, Knight, H, Harris, T, Hawdon, J, van der Meulen, J, Walker, K & Pasupathy, D (2020) "Risk of complicated birth at term in nulliparous and multiparous women using routinely collected maternity data in England: Cohort study." British Medical Journal 371: m3377.* - www.bmj.com/content/371/bmj.m3377

2 Demonstrated by the rapid responses to the article and by the discussion on social media - www.bmj.com/rapid-responses