JRM®
The Journal of Reproductive Medicine®

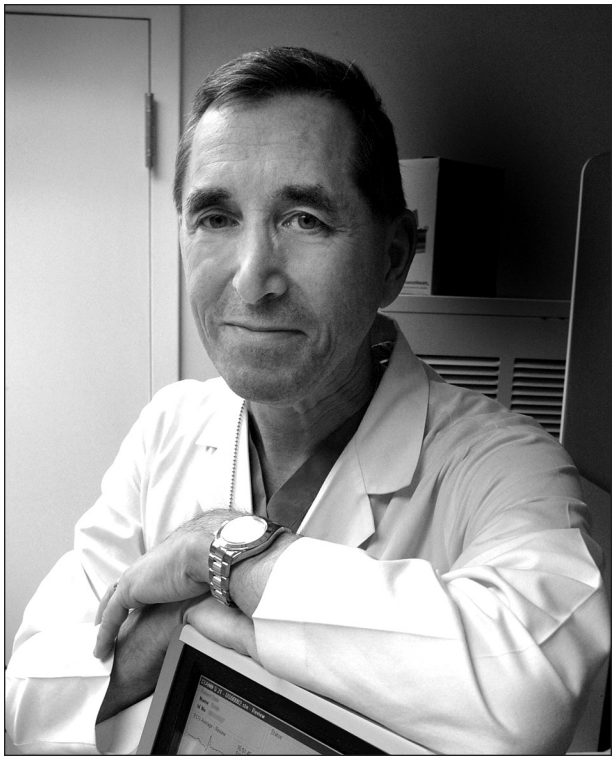
Volume 62, No. 9-10/September-October 2017

EDITORIAL

A Note from the Editor-in-Chief

Lawrence D. Devoe, M.D.

Welcome to the September-October 2017 Editor-in-Chief's page. This editorial column focuses on a report of implementing strategies to lower cesarean section (CS) rates.



Lawrence D. Devoe, M.D., Editor-in-Chief

In This Issue

- ***A Multi-Strategy Approach for Cesarean Section Reduction at an Urban Community Medical Center***
  I. A. Hoskins, T. Ellison, and R. Ruggiero

  The authors report on a proactive approach to lowering CS rates in their institution. After recognizing that their hospital had one of the highest CS rates in the state of New York, they reviewed prior interventions that had been published and had shown promising results. The group settled on 4 strategies that were then implemented in their hospital:
  - Requirement that every scheduled CS receive approval by one of 2 senior obstetricians within 72 hours of posting.
  - Requirement that all providers offer a vaginal birth after CS (VBAC) education class (or informational pamphlet) to all eligible patients.
  - Requirement that all intrapartum CSs receive a second approval by one of 2 attending physicians (Laborists) assigned to the Labor and Delivery (L&D) unit (emergency CS cases excluded).
  - The individual CS rates for every attending physician are posted on L&D.

  The postimplementation outcomes of interest were compared with those from a preceding 10-month period. A nearly 25% reduction (from

0024-7758/17/6209-10–0467/$18.00/0

39% to 29%) in post-strategy implementation CS rates was driven by a change in practice among service attending physicians. When compared with the control period, there were no significant differences in the maternal and perinatal outcomes of interest.

Editorial Comment

More than 2 years ago the American College of Obstetricians and Gynecologists (ACOG) published a consensus statement that contained a number of clinical recommendations on safe prevention of primary CSs (American College of Obstetricians and Gynecologists; Society for Maternal-Fetal Medicine: Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery. Obstet Gynecol 2014;123:693-711). While this publication created quite a stir in the obstetric community, it also helped to refocus our attention on a growing problem: the rising rate of CS in the United States without concomitantly better perinatal outcomes. A number of institutions around the U.S., like the one examined in this study, have initiated proactive programs to address their CS rates. While such programs may differ in their strategies, they all have one thing in common: to change the culture of L&D units.

Hoskins and co-authors are to be commended for taking a page from the past. When I began my training in obstetrics and gynecology, all primary non-emergent CSs required the concurrence of 2 board-certified obstetricians. At that time, my institution had a primary CS rate of 5% and an overall CS rate of 7% without offering VBAC. I am not certain when the practice of peer-review and approval of scheduled and/or intrapartum CS went away, but obstetric practice has changed considerably over the past 4 decades, and a relatively high CS rate is only one of the results of changing practice patterns. Altering the manner in which physicians practice can be a daunting task, particularly if compelling evidence to support this approach is scarce. While only 2 of the 18 clinical recommendations in the ACOG consensus statement are supported by strong evidence, 11 have moderate supporting evidence. It is unlikely that most recommendations will receive higher quality evidence since this would require randomized trials that are not likely to be performed. While obstetricians may not be able to dissuade patients who demand CS without medical or obstetric benefit or who decline VBAC when it is a reasonable option, as this study illustrates there are current approaches that can safely reduce CS rates provided there is institutional and provider buy-in. I hope that we as obstetricians have finally reached the tipping point in the cesarean epidemic and the trend of increasing CS rates can finally be halted and reversed.