Authors' reply re: Assisted Vaginal Birth: Green-top Guideline No. 26. (Response to BJOG-20-0916)

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Dear Editor

Birth Trauma organisations advocate on behalf of women and babies who have experienced adverse outcomes and naturally they will take a risk-averse perspective on birth-related care. The latest version of the Assisted Vaginal Birth (AVB) RCOG Guideline (previously called Operative Vaginal Delivery) has focussed specifically on revisions designed to minimise the risk of traumatic injuries for the mother and baby.[1] The landmark Montgomery ruling that raised the bar on the standard required for informed consent has been embraced and endorsed within the guideline. [2] It is disappointing to read that Hull *et al* have concluded that "Montgomery is missing from RCOG's Assisted Vaginal Birth guideline".[3]

Hull *et al* have acknowledged the important counselling advice that has been recommended – antenatal discussion about AVB when planning birth in the third trimester (especially for first-time mothers), review of birth preferences when conducting routine labour ward rounds, and in depth counselling, where circumstances allow, if complications arise during the course of labour particularly during the second stage. However, the guideline apparently falls short of the Montgomery ruling in that we have not recommended "planned caesarean" as an option to prevent assisted vaginal birth.

The AVB guideline went through an extensive scoping process. The agreed scope was to address all key questions that arise in relation to labouring women who may require obstetric assistance in the second stage of labour - the assumption being that these women have the intention to labour and deliver vaginally. A guideline addressing maternal request "planned" caesarean section is an entirely different guideline. It is also incorrect to state that the RCOG have provided no direct guidance on this (see *Choosing to have a Caesarean section* , RCOG Patient Information (2015) based on NICE Clinical Guideline *Caesarean Section* (2011)).[4] The issue of pelvic floor morbidity was included in the literature search and has been discussed in detail.

The Montgomery ruling related to a woman with diabetes in pregnancy and a large for gestational age fetus who experienced shoulder dystocia resulting in her baby developing cerebral palsy. The importance of outlining, in advance, the birth options for this woman is clear, given the specific known risks associated with labour in her circumstances. Hull *et al* suggest on the same basis that all women should be advised that a planned caesarean section is an option to prevent assisted vaginal birth. If taken one step further the Montgomery ruling could be cited to support the argument that all women should be advised that the best way to avoid pregnancy-related complications is to avoid getting pregnant. Common sense would infer that this was not the intention of the Montgomery ruling.

Where this RCOG guideline is likely to be consistent with Birth Trauma organisations is in the recommendations on careful assessment, supervision and decision-making; clear communication and transparent consent procedures; and an overall approach that places safety as the first priority when deciding when and

when not to attempt a vacuum or forceps assisted delivery, and when to discontinue any such attempt. It is hoped that all relevant health professionals will review and implement the evidence-based, peer-reviewed recommendations within this guideline. They are designed to support women in achieving safe and joyful births, even when obstetric assistance is required.

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3. Hull P et al. Re: Assisted Vaginal Birth: Green-top Guideline No. 26. (First comment letter. Reference to be added).

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