

Letters

The authors reply regarding transparency, balance and perspective on intervention at full dilation

We are pleased Walker and colleagues¹ echo our sentiment² regarding the need for a balanced perspective on delivery options. We welcome the opportunity to clarify our methods, to reiterate that our conclusions do not suggest that any mode of delivery is superior to another and to underscore that dismissing the high rates of injuries associated with operative vaginal delivery (OVD) is inconsistent with a balanced perspective and signals a disregard for pregnant peoples' autonomy in making evidence-informed decisions regarding childbirth.

Walker and colleagues have questioned the quality of our data owing to "small-scale, noncontemporaneous, province-specific" validation studies. However, we cited a 2016 national reabstraction study that evaluated the accuracy of maternal trauma and found 97% agreement (95% confidence interval [CI] 95%–99%) with medical charts in hospitals across Canada.³ Further, the aggregation of third- and fourth-degree perineal tears is the established definition of obstetric anal sphincter injury (OASI).⁴ No evidence has suggested that 3A versus 3C and fourth-degree tears predict qualitatively different long-term outcomes. Although the article cited by Walker and colleagues provides no insight into long-term outcomes, the National Institute of Child Health and Human Development's Pelvic Floor Disorders Network showed that anal incontinence rates at 24 weeks postpartum after 3A and fourth-degree tears were 25% (95% CI 16%–36%) and 35% (95% CI 16%–57%), respectively.⁵

Their insistence that outcomes such as postpartum hemorrhage should have been included to capture "true maternal morbidity" concerns us. The implication

that one's continence, pelvic and sexual health are not true measures of morbidity is a legacy of the paternalistic paradigm that considers obstetric trauma to be an acceptable outcome of childbirth. Evidence from Canadian hospitals suggests that consent practices for OVD reflect these assumptions.^{6,7} One study found a fourfold lower rate of satisfaction with the consent procedure among those who had OVDs compared with those who had cesarean deliveries in labour;⁶ another study found 68%–92% of charts at Mt. Sinai and St. Michael's Hospitals lacked documentation regarding neonatal or maternal risks in the consent discussion for OVD in 2019.⁷ Informed consent must be prioritized to ensure pregnant people can weigh the risks and benefits based on their personal values and priorities.

Lastly, our findings show that the average obstetrician in Canada who attends 200–250 deliveries per year would see 4–5 cases of maternal trauma with OVD annually. Understandably, 5 cases per year per obstetrician may not appear to pose a public health concern. Only after seeing the accumulation of these cases at a population level can one appreciate the magnitude of harm, the importance of clear and informed consent, and the need for widespread quality improvement. Although our clinical colleagues guide our work on OVD, our research uses an interdisciplinary, collaborative approach that integrates clinical and epidemiologic insight to further our collective goal of improved maternity care.

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