Beware selection bias

As experienced front-line obstetricians with leadership responsibilities, we have concerns with the conclusions and implications of the article by Muraca and colleagues on operative delivery in the second stage of labour.[1]

Although an important strength is the size of this population-based study, its retrospective nature likely introduced selection bias, because attempted vaginal delivery would almost certainly have occurred at lower stations in the pelvis than in women directly delivered by cesarian section.

Clearly, we endorse the decision to perform a cesarian section at higher stations, irrespective of fetal head position, as long as the second stage of labour was optimally managed, including appropriate augmentation with oxytocin. An unknown in this study is the crucial role of malposition because, in this scenario, the skill of the delivering physician is crucial in making a judgement on the appropriate use of a Kiwi vacuum or Kielland forceps to achieve safe delivery in an optimized fetal head position.

We cannot reliably impart these essential skills in five-year resident training with reduced work hours, but we can grow these skills in larger volume units with continued mentorship of junior faculty. Other countries have effectively addressed this need via specialized training courses that Canada urgently needs to emulate.[2] Failing to lead in this manner likely will further increase the rate of cesarian section in the second stage of labour, when with appropriate training, safe midpelvic deliveries can continue to be performed.[3,4]

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