

A similar case can be made for increasingly aggressive vaginal birth after cesareans and prolonging the first and second stages of labor, not due to a lack of training, but because studies have shown that these procedures are inherently more dangerous than CD.⁵ Besides the medical-legal problems that the obstetrician is almost surely to face when complications arise, there is the psychological toll that follows from being involved in a case that resulted in a patient's injury whether or not there was any negligence on the obstetrician's part. And therein lies the rub. The eternal conflict exists between the people sitting behind desks, dictating what practicing physicians should do without regard to the effect it will have on their patients, their practices, their lives, and their livelihoods, and the obstetrician who is responsible for the well being of two patients in every clinical encounter. Obstetricians must resist the pressure to depart from accepted safe procedures for the minefield of unproven practices, at the behest of administrators who have no evidence of their safety, for their patients' sake as well as their own. ■

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REFERENCES

1. Dietz HP, Campbell S. Toward normal birth—but at what cost? *Am J Obstet Gynecol* 2016;215:439-44.
2. Cohen WR, Friedman EA. Perils of the new labor management guidelines. *Am J Obstet Gynecol* 2015;212:420-7.
3. Cohen WR, Friedman EA. Misguided guidelines for managing labor. *Am J Obstet Gynecol* 2015;212:753.e1-3.
4. Leveno KJ, Nelson DB, McIntire DD. Second-stage labor: how long is too long? *Am J Obstet Gynecol* 2016;214:484-9.
5. Grantz KL, Gonzalez-Quintero V, Troendle J, et al. Labor patterns in women attempting vaginal birth after cesarean with normal neonatal outcomes. *Am J Obstet Gynecol* 2015;213:226.e1-6.

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REPLY



Many thanks for your comments. We agree with every word. Let us dare to go a step further.

We are beholden to societal trends that affect our entire culture. The distortions we see in obstetrics and gynecology, this turning away from rational thought toward ideology, is universal. You refer to “people sitting behind desks”—well, the people causing such distortions are everywhere. They are in our midst because some of us have bought into this ideology and in fact have built a career on it. This is deplorable. We should never forget that we are working for the well-being of our patients, not to serve political correctness or statistical “norms.”

One would assume that the litigious environment in the United States would act to protect practitioners there from the most extreme consequences of this trend and to a degree this is the case. We are encouraged that after previous iterations were rejected, this article was published in the *American Journal of Obstetrics and Gynecology*.¹ It is a positive sign that the editorship of this journal is opening up our subject to scrutiny and debate. This gives us hope for the future of obstetrics and gynecology. ■

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REFERENCE

1. Dietz HP, Campbell S. Toward normal birth—but at what cost? *Am J Obstet Gynecol* 2016;215:439-44.

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Current base deficit is not a relevant marker of neonatal metabolic acidosis



TO THE EDITORS: The article by Clark et al¹ is a relevant attempt to assess the limits of electronic fetal heart rate monitoring to prevent neonatal metabolic acidosis (NMA), which is an intermediate biological marker of asphyxia and risk of neonatal encephalopathy. The challenge is to identify clinical information, biomarkers, and electrophysiological indicators that would best support clinical

decision and better identify newborns who will benefit from therapeutic hypothermia to prevent postasphyxia cerebral damage. Although results from animal studies were promising, clinical research is still inconclusive when identifying biomarkers of asphyxia in human newborns,² most probably due to the lack of specificity of these biomarkers. At the present time a reliable biological marker