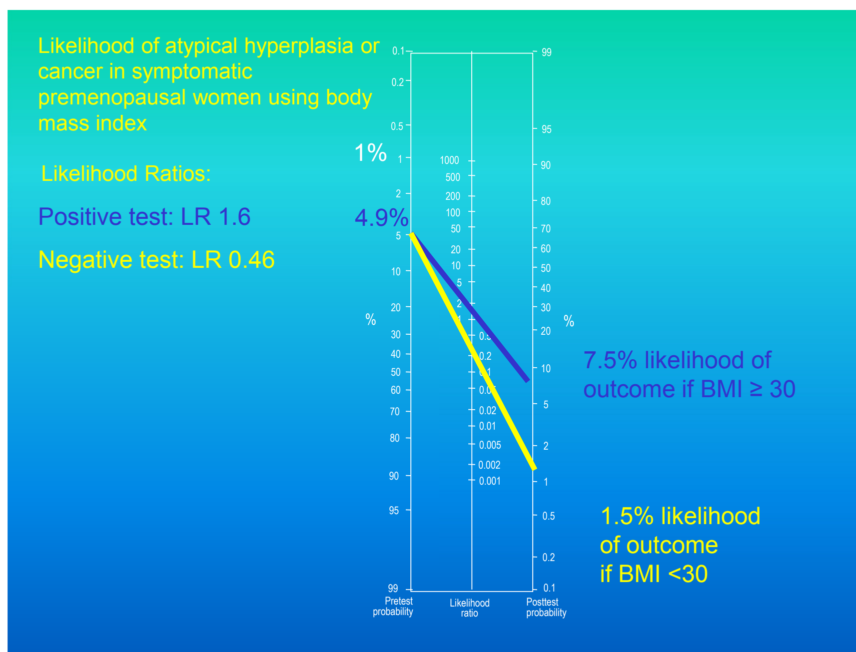
**FIGURE**
**Using likelihood ratios to modulate risk of disease**




*Wise and Farquhar. Limits to likelihood ratios. Am J Obstet Gynecol 2017.*

secondary care, 36% were already taking hormonal medical therapy; the prevalence of disease was 4.9%, and these women at higher risk warrant invasive testing. ■

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The authors report no conflict of interest.

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# Regarding “Toward normal birth—but at what cost?”

**TO THE EDITORS:** Thank you for your article, “Toward normal birth—but at what cost?”[1] I have always looked forward to reading the *American Journal of Obstetrics and Gynecology*, especially over the past 1-2 years because the Journal seems to be one of the only authoritative sources willing to question the wisdom and safety of decreasing the cesarean delivery (CD) rate and other practices recently recommended.[2-4]

I have been practicing obstetrics and gynecology for 35 years. The delivery of safe and effective care to our patients is one of the most important goals of our discipline. However, despite this, certain medical and governmental institutions want to reduce the CD rate without any studies demonstrating the safety of new CD guidelines, and even in the face of past and current studies that have shown their increased dangers. The move to revive the use of procedures such as instrumental vaginal deliveries and vaginal breech deliveries, which have generally been abandoned, and rightly so, expose the front-line obstetrician as well as mother and baby to increased risks due to lack of training in these areas.

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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The author reports no conflict of interest.

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

**TO THE EDITORS:** The article by Clark et al[1] 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