

1 **Letter to the Editor:**

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3 **Title Page**

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5 **RE: Using Robson's Ten-Group Classification System for comparing caesarean section rates in**
6 **Europe: an analysis of routine data from the Euro-Peristat study**

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34 **RE: Using Robson's Ten-Group Classification System for comparing caesarean section rates in**
35 **Europe: an analysis of routine data from the Euro-Peristat study**

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37 Dear Editor,

38 We found this an interesting study and appreciate the value of comparisons across the European
39 continent. We did, however, notice that although a description of caesarean rates between the
40 countries and Robson's Ten-Group Classification System groups was provided¹, interpretation of the
41 underlying reasons for these differences could not be made. Recording data such as this without
42 analysis of the clinical context and patient population does not allow for holistic patient care.

43 There is an increasing awareness of the benefits of a personalised approach to medicine. A
44 comparison of such data in isolation belies this and may lead to the chasing of target caesarean
45 section rates to the detriment of maternal and fetal outcomes.

46 A major limitation of the study was not providing context to clinical data. An example can be seen in
47 the analysis of preterm caesarean section rates where conclusions on differences are drawn without
48 inclusion of the overall rate of preterm births and therefore the proportion of these cases delivered
49 by caesarean is not reported. Equally, low socio-economic status as well as immigrant populations
50 are widely accepted to suffer from poor maternal and fetal outcomes². With stark socio-economic
51 differences across the nations described, a holistic individualised approach accounting for patients'
52 characteristics to provide optimum care is imperative, rather than risking falling victim to an
53 accounting exercise. Aiming for a target caesarean section rate through comparison with
54 neighbouring countries is harmful as populations and their clinical needs differ remarkably. As an
55 example, previous studies have shown significant differences in pre-eclampsia across different
56 nations³.

57 We are concerned that viewed in isolation this form of data may lead to ‘caesarean section league
58 tables’ resulting in incumbent pressure to target a given rate. The detriments of such an approach
59 can be seen in the recent Ockenden report⁴, published in 2020. The report describes a culture of
60 maintaining low caesarean section rates within one UK NHS trust, whose caesarean section rates
61 from 2006 to 2018 were consistently around 10% below average. This report details several
62 individual cases whereby earlier recourse to caesarean section would have avoided fetal death or
63 injury. Although it cannot be concluded that all the poor outcomes reviewed in this report are a
64 result of this culture, it is certainly pause for thought.

65 Whilst datasets such as that presented hold important roles for the future it is imperative that their
66 analysis is driven by an understanding of the need to personalise the data to prevent erroneous
67 conclusions being drawn. Perhaps a modified caesarean classification driven by this personalised
68 approach is required to better understand inequality driven differences.

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70 **Contribution to Authorship:**

71 All authors have contributed equally to the concept and writing of this letter.

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73 **Disclosure of Interests:**

74 There are no conflicts to declare.

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