Commentary The unwelcome consequences of Guideline authorship

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Conflicts of interest: The author provides expert opinion for medico-legal cases involving cerebral palsy and perinatal death.

Clinical practice guidelines are designed to promote good practice, increase patient safety, and reduce unwarranted variation in care. The Royal College of Obstetricians and Gynaecologists (RCOG) produce evidence-based guidelines on common and important aspects of patient care. The guidelines are commissioned from specialists in their fields. An extensive peer-review process takes place, followed by public consultation, after which the final version is approved and published. Additional information is provided in a more accessible format for service users. I have contributed to this work over the past two decades as a guideline author, committee member and chair.

Guideline revision

The fourth edition of the Assisted Vaginal Birth (AVB) guideline was published in 2020.[1] There were three authors, two UK based and one in Ireland, all of whom had co-authored previous editions of the guideline. The revision process was informed by new evidence, correspondence from a coroner, and changes in the law (including the Montgomery ruling on informed consent). Dissemination of the fourth edition reflected a change in policy with publication in the British Journal of Obstetrics and Gynaecology (BJOG). This approach increases international reach, provides greater recognition of the work of authors (although authorship is "on behalf of the RCOG"), and facilitates debate through the correspondence pages of the journal.

Alternative perspectives

Vacuum and forceps assisted births account for 10-15% of all births in England and a small number of cases are complicated by significant morbidity and mortality. For most women and babies, it is a balance between the risks and benefits of not intervening, of using an instrument, or performing a second stage caesarean section. There are short- and long-term potential complications and implications for future births. Not surprisingly there are individuals who hold strong views about AVB, and some believe that forceps should be abolished entirely. This was reflected in one submission during the consultation phase from a patient

advocacy organisation who suggested that planned caesarean section should be recommended to women as a means of avoiding AVB. The co-author group together with the Guidelines committee, felt that the point they were making was about avoiding labour, rather than avoiding AVB, and was better addressed by the RCOG guidance "*Choosing to have a Caesarean section* ". We did, however, make specific recommendations on the importance of antenatal education, intrapartum counselling, shared decision-making, informed consent, and postnatal review. There was an entire section on the importance of the Montgomery ruling.

Post-publication correspondence

Following publication of the guideline, we received a request from BJOG to respond to a letter they planned to publish. The letter was from Birth Trauma association members and repeated the same point about planned caesarean section they had made during the consultation process.[2] The letter had the heading "*Montgomery is missing from RCOG's AVB guideline* " and they asserted that the omission of planned caesarean birth from the guideline "*could have serious legal consequences"* . We responded in keeping with our previous response.[3] We received a request to respond to a second letter from an Australian gynaecologist (affiliated with a Birth Trauma association) who stated that the guideline "*conveys a pro-forceps bias that does little to help clinicians make informed choices* " and "*is potentially exposing the RCOG to substantial medicolegal liability* ".[4]Following our response to this letter we received a third letter from a Dutch and Australian gynaecologist, again accusing the guideline of failing to meet the expectations of the Montgomery ruling and supporting practices that "*unnecessarily place women at risk of pelvic floor trauma* ".[5] We brought this body of correspondence to the attention of the RCOG executive as we had concerns that there was an agenda to influence the guideline in a particular direction.

Formal complaint

A month later, I received notification from the Irish Medical Council (IMC) that I was being investigated in relation to a complaint about my authorship of the RCOG AVB guideline. The complaint was personal in nature and questioned my fitness to practice. I was accused of "*mysognistic attitudes towards patients (sic)* ", and of showing "*extreme disrespect, contempt and paternalism towards patients"* . This complainant had never been under my care, had never met me in person, and appeared to reside outside Ireland. I contacted the RCOG and my co-authors in the UK. The RCOG recognised the wider implications of guideline authorship being challenged in this way and engaged directly with the GMC who agreed to put in place measures to protect its members. The RCOG attempted to engage with the IMC on my behalf but to no avail. In contrast to my UK colleagues, I had to participate in a process lasting eight months before I was finally informed by the council that they had "*formed the opinion that there was not sufficient cause to warrant further action being taken in relation to the complaint* ". This protracted process was time-consuming and disturbing. I have no doubt that it was designed to intimidate me and ultimately to deter me from participating in future guideline development. The IMC have since implemented changes to their procedures with the CEO and an "authorised officer" now screening complaints rather than direct referral to the preliminary proceedings committee as occurred in my case. This may limit future complaints of this type receiving undue attention.

Way forward

Evidence-based guidelines are a powerful resource for driving best practice and equitable healthcare. They are not perfect, reflecting limitations in the evidence on which they are based, and the challenge of reconciling polarised views at the peer review and stakeholder consultation stages. Timely revisions ensure that they improve as knowledge advances. Dissemination and visibility is enhanced by publishing them in journals. Guideline authors are not remunerated and participate for the benefit of patients and health professionals. I am proud to have worked with the RCOG on guideline development, and it would take more than a few hostile letters or a vexatious complaint to deter me. However, there are many who would be deterred, and we need to ensure that this valuable role is safe guarded from external influences that attempt to undermine authors when pursuing a particular agenda. It is particularly disappointing when health professionals, who should know better, participate in these behaviours.

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