We discuss the contemporary practice of forceps delivery in Scotland, a country with affluent experience in operative vaginal birth. Globally, the popularity of forceps has significantly declined and undeniably it is considered by many a lost art. As a result, the volume and the complexity of the attempted forceps deliveries have lessened and more women undergo high-risk second-stage caesarean sections. Therefore, we have to draw our attention to realistic alternatives such as reinstating the skill of assisted delivery. Introducing these techniques in modern obstetrics can be a challenging task. The rates of forceps deliveries remain stable in Scotland, despite the opposite experience from most other countries. This paper is based on reviewing relevant guidelines and official national statistics. Forceps still have a place in modern obstetric practice in order to shorten labour when clinically indicated. Obstacles to forceps delivery are broadly due to the potential harm and the subsequent related medico-legal implications. Since the availability of specialists with substantial experience has been reduced, it sounds of paramount importance to conserve the learning of this valuable obstetric technique. Even more, initiatives that appoint future generations of obstetricians with expertise in performing forceps deliveries are an urgent educational priority. International recommendations and high-quality local workshops can facilitate this path.

Introduction

The toll of inflating caesarean section rates worldwide has alarmed governments and medical communities to express concerns and implement policies intending to alleviate the impact of this epidemic. When medically justified, caesareans can effectively prevent maternal and perinatal mortality and morbidity. However, there is limited evidence displaying any benefits of caesarean delivery for women who do not entitle to the procedure.1) Aiming to diminish preventable caesareans and the associated health consequences, executive summaries illustrate the importance of the operative vaginal delivery in tackling the caesarean sections in full dilatation, particularly in nulliparous women.2–4) Often, these propositions embrace almost exclusively ventouse devices. Although ventouse is a prudent and valuable way to preserve vaginal birth, it has its own drawbacks and limitations with a significant risk of failure compared to forceps. Hence, any intrapartum policy seems deficient without including the use of forceps as an option. The varied dexterity desired for forceps does have some distinct differences from vacuum extraction. Revisiting our guidelines dictate for applicable evidence-based recommendations for trainees wishing to master forceps delivery. These have to be exploited from the robust accumulated knowledge drawn from reliable resources. One of these can be the National Healthcare System (NHS) in the United Kingdom and more specifically the one in Scotland where allegedly being performed the most rotational forceps deliveries in the world.

Historical perspectives

The praise for the invention of the modern obstetric forceps is undoubtedly acclaimed by a family of French surgeons, the Chamberlens, who migrated to England in 1569. Until then, forceps were used as a destructive
Maternity statistics in Scotland

Forcesps delivery, conventionally, plays a vibrant role in Scottish healthcare. This remains unchanged in the last decades, regardless of the differing practice in other developed countries. For example, in the United States, the rate of forcesps has decreased sharply attributed to the preference for vacuum extraction or caesarean section when complex delivery is projected. In Scotland, access to obstetric care is free and is carried out the in the vast majority in public hospitals. All maternity units have senior professionals with the ability to conduct forcesps deliveries for both rotational and non-rotational purposes.

The obstetric epidemiology is closely monitored and the results are announced annually at the National Statistics publication for Scotland. Data obtained from the Scottish Morbidity Records submitted by each hospital to Information Services Division, who collects an extensive range of obstetric and neonatal demographics information since 1975. Even with no legal obligation, the registration submission compliance is extremely high and official figures meet the uppermost standards of trustworthiness and public value. These adhere to the Code of Practice for statistics and are awarded National Statistics status following assessment by the UK Statistics Authority’s regulatory arm. As a result, Scotland has some of the most reliable and accurate information on pregnancy and births available.

The most recent report highlights some vital points. In the financial year 2017, there were a total of 52,519 recorded live births in Scotland. The rate of elective caesarean sections was 13.9%. Caesarean sections in nulliparous were 30.8%, including both emergency and elective sections. The overall percentage of live singleton babies delivered by caesarean section was 32%, up from 25% in 2008.

The proportion of normal vaginal deliveries has fallen steadily from 76% in 1975 to 55% in 2017. The percentage of women who had an induction of labour was also increased to 33.1%. There is an expected pattern of increasing caesarean deliveries with advancing maternal age. Overall, the tendency towards women having their first baby at an advanced age continued, with 54% of maternities in mothers aged 30 years and over. More mothers are overweight or obese than are of a healthy weight (42%). 13% of singleton babies had a birthweight or 4,000 g or more, up from around 8% in the mid-1970s. Deprivation continues to influence health and 14% were smokers at the time of their antenatal booking appointment. The numbers of recorded stillbirth’s decreased by 4.7%. 6.6% of babies were born preterm compared to 6.1% in 2008. This rise is more pronounced for multiple births with 68% being born prematurely compared to 55% in 2008.

The prevalence of operative vaginal delivery in the United Kingdom is estimated to be 10–15%, yielding satisfactory outcomes for the majority of mothers and babies. Forcesps in Scotland were 9.2%, higher than those in England and Wales. Vacuum extraction was 2.9% and breech vaginal deliveries at 0.2%.3)

Current practice in Scotland

Indications

The recommended use of assisted delivery is evidently outlined at the national guideline from the Royal College of Obstetricians and Gynaecologists (RCOG).2) Forcesps aspire to abridge the second stage of labour by applying direct traction on the fetal skull. The three core indications are prolonged labour, suspected fetal compromise and maternal contraindications to expulsive efforts. A delayed second stage is defined as a lack of continuing progress for three hours with regional anaesthesia or two hours without regional anaesthesia in nulliparous women. In multiparous women, the times are lack of continuing progress for two hours with regional anaesthesia or one hour without regional anaesthesia. Maternal conditions that preclude prolonged maternal pushing include cardiac disease, hypertensive crisis, cerebrovascular disease or respiratory compromise. Most indications are relative, but the threshold to intervene is much lower in special circumstances such as sepsis, growth restriction, preterm labour, vaginal bleeding and previous caesarean section where the fetal reserves may be restricted and the fetal acid-base status can rapidly deteriorate. Other indications include the aftercoming head of a breech presentation and during the caesarean section.
Types and classification of forceps delivery
The RCOG has adapted criteria from the American College of Obstetricians and Gynecologists (ACOG) with standard international definitions taking into account the station and position of the fetal head in the pelvis. This is principally helpful in order to permit research and allow comparison between studies. The types of obstetric forceps used are mid-cavity (e.g., Simpson, Anderson, Haig-Ferguson, Neville-Barnes), low or outlet (Wrigley’s) and rotational forceps (Kielland’s). Mid-cavity forceps are taking place when the vertex is in a direct occipito-anterior position or in a slight rotation (less than 45 degrees). At outlet delivery, the baby’s head is at least +2 station. When the head is two-fifths (2/5) palpable abdominally and the presenting part above the ischial spines operative vaginal delivery is not practiced.

Prerequisites for operative vaginal delivery
Harmless forceps delivery necessitates a competent and skilful operator. Besides, it entails a thoughtful assessment of specific clinical situations, clear communication and expertise in the technical aspect. A deep understanding of the anatomy of the birth canal and the fetal head is essential, as the scope of any operative vaginal delivery is to mimic spontaneous birth, thereby expediting delivery with minimum trauma. If the fetal position is uncertain a bed-side sonographic visualisation of the fetal structures can easily clarify the findings.

Valid consent
Informed consent is obtained after offering a comprehensible explanation to the mother regarding the risks involved and alternatives. Verbal consent is sufficient for forceps in the delivery room, and the discussion is documented in the notes. When a trial of forceps is performed in theatre, signing a written consent is obligatory. In addition, information about operative delivery is a part of routine antenatal education. A printed birth-plan communicates maternal preferences or objections which are taken into account. Nonetheless, maternal understanding can sometimes be burdensome in emergency cases of fetal distress or maternal exhaustion. Hence, obstetricians are mindful to mention rare complications such as brachial plexus injury and shoulder dystocia when multiple risk factors exist.

Analgesia requirements
Pudendal block and local infiltration with lidocaine at the maximum recommended dose of 3 mg/kg, usually suffice for low and mid-cavity forceps delivery in the room. Blocking the pudendal nerve reduces vaginal and perineal sensation sufficiently to allow low-cavity delivery, episiotomy and repair. Adjuvant analgesia with use of Entonox is available. Regional anaesthesia is more appropriate for trials, therefore spinal or epidural top-up is offered, especially since there is a chance of caesarean section. Aortocaval compression is avoided by left-lateral tilt and intravenous fluids reduce the risk of a sudden drop in blood pressure, with effect to uteroplacental perfusion. Combined spinal-epidural techniques and general anaesthesia are less common. In all cases, the multidisciplinary team is aware that the mother’s health is of utmost importance and anaesthetic procedures are not without risks.
**Venue**

The forceps are frequently embarked in the delivery bed. Trials are conducted in theatre, with facilities to immediately proceed to emergency caesarean section. High body mass index, fetal macrosomia, sparse expulsive efforts and occipito-posterior position are indicating a more difficult birth. With experience comes the accurate prediction which attempts undertaken will be successful. Prioritisation of the workload is crucial as any invariable delay can have a negative impact on the outcome in cases of anticipated fetal hypoxia. Personnel trained in neonatal resuscitation are involved early when indicated.

**Procedure technique**

Forceps delivery requires a systematic approach that satisfies unequivocal criteria. The mother is supported in a modified lithotomy position, with buttocks at the edge of the bed without excessive hip abduction. The level of the bed should suit ergonomics, allowing good balance for the operator and appropriate pulling predominantly from arms, providing the temptation to employ force from upper bodyweight. Aseptic technique is maintained throughout the procedure. The doctor is scrubbed up before cleansing and draping the woman. The bladder is emptied and a thorough examination is performed. The cervix must be fully dilated and no evidence of cephalo-pelvic disproportion present. The lubricated matching pair of blades is inserted atraumatically in between uterine contractions. Using anatomical landmarks, correct application is secured when sagittal suture runs in the midline and not more than a tip of a finger fits in each fenestration between the blade’s heel and the fetal head. The posterior fontanelle should be one finger’s breadth above the shanks of the forceps. Calm and controlled traction is employed in conjunction with uterine contractions and maternal pulsing. Patois’ manoeuvre is achieved with maintaining horizontal traction with the right hand and vertical pressure with the left hand. Retaining a flexed head allows the pelvic axis to accommodate the smallest head diameter and distend gradually the soft perineal tissue. When traction is not exerted, the blades are relaxed to reduce cranial compression. Identifying ongoing descent is mandatory to the process continuation. The handles are elevated in a “J”-shaped movement once the occiput is below the symphysis pubis. This resembles the natural birth achieving physiological head extension. Once the head is delivered, the blades are disarticulated, the head restitutes, and delivery of the shoulders and the rest of the body follows. Sequential use of instruments is discouraged, though if delivery deems imminent forceps can be favoured in avoiding a presumed problematic caesarean section. Rocking movements and fundal pressure (Kristeller manoeuvre) are prohibited. Routine administration of antibiotics is not a common practice.

**Use of episiotomy**

Despite some conflicting evidence, the consensus in forceps is that once the head is crowning and perineum is thinning, it is critical for the accoucheur to routinely perform a mediolateral episiotomy to help to negotiate the resistance of the perineal muscles. The episiotomy is achieved away from the midline, with a larger cutting angle as when the perineum distends the midline might be deceivably closer than it appears. Support of the perineum is suggested and it is included at the proposed OASI care bundle of reducing perineal trauma. The author has described a novel forceps technique which accredits the operator to evaluate a more restrictive use of episiotomy, provided compliance with the Anterior Non-Episiotomy Forceps Delivery (ANEF) approach. The refined ANEF technique demonstrates promising results in reducing the incidence of significant perineal trauma and tocophobia.

**Management of occipito-posterior position**

Delivery as face-to-pubes is firmly discouraged due to high failure rate and predispose for serious perineal trauma. In selected emergency cases, forceps can be used for delivery with extreme care for maintaining head flexion and generous episiotomy. Instead, rotation to direct occipito-anterior position is commonly offered. Manual rotation, digital rotation, rotational vacuum extraction and rotational forceps techniques can be endorsed where malposition encounters. The same principles apply to the transverse position.

**Kielland’s forceps**

Largely, rotational forceps are out of fashion with progressively fewer numbers of both operators and educators. Despite the medico-legal concerns, Scotland is one of a few areas where the art of mid-cavity rotational delivery is still taught by experienced practitioners. Familiarity with Kielland’s is encouraged for all trainees, notably for those embarking on the labour ward. Advanced Training Skills Module (ATSM), where they are trained as vigilant operators able to select the best-suited instrument to the individual circumstances with anticipation of arising complications. Kielland’s require tactile sensory feedback with regard to tissue resistance, and force is avoided at all costs. Any level of asynclitism is corrected by the unique sliding lock. In view of the lack of pelvic curve, the traction is applied more acutely downwards. Kielland’s represent a sustainable alternative with a plethora of studies suggesting where the expertise exists, the efficacy is high and adverse outcomes relatively low.
Abandoning the forceps delivery

Forceps delivery is stopped where there is no descent with moderate traction during contractions or where delivery is not looming after three sufficient pulls. The bulk of malpractice complaints are related to failure to pause the procedure promptly, eschewing repeated efforts in the presence of inadequate progress. Maintaining a ‘willingness to abandon’ the pulls is a vital protective mechanism against a fixed operator on intrinsic vaginal birth. Use of sequential instruments, increased traction force or excessive pulls is all evidence of suboptimal care and associated with increased neonatal trauma.

Repair of injuries

Once the delivery is completed, maternal tissues are methodically evaluated. In an ordered manner, the cervix, the vagina and the perineum are examined to exclude any trauma. The accurate repair of anal sphincter injuries can prevent most of the long-term consequences of faecal incontinence or urgency. Physiotherapy is arranged for all women with anal sphincter injuries. Previous anorectal trauma does not preclude future vaginal delivery, provided women are asymptomatic and understand the risk of recurrence. Women with faecal incontinence are offered elective caesarean delivery.

Aftercare following operative vaginal delivery

Paired cord blood samples are processed and recorded following any operative delivery. In absence of allergies and contraindications, diclofenac 100 mg per-rectum is given and regular oral pain-relief prescribed. Bladder care is based on monitoring the timing and volume of the first void. A post-void residual is measured to ensure retention does not go unrecognised. Forceps can be linked with fear of childbirth and rarely may manifest as a post-traumatic stress-type syndrome. Psychological morbidity can be controlled with debriefing prior to discharge and a few months postnatally should be needed. Opportunities are given to discuss the indications for operative delivery, management of any complications and future prognosis. Best practice is the woman to be reviewed by the obstetrician who conducted the delivery.2)

Risk management in forceps delivery

Medico-legal claims in obstetrics amount to the majority of litigations in the UK. Clinical Negligence Scheme for Trusts (CNST) emphasises the importance of concise and meticulous documentation. Litigation is often multifactorial though inferior technique, suboptimal communication and inappropriate management of impending complications increase claims. Any deviation from usual practice frequently is referred to as substandard care. Untoward clinical events, including unsuccessful forceps, OASI, major post-partum haemorrhage, unexpected admission to the neonatal unit, low Apgar scores and cord arterial pH under 7.1, trigger an incident report as part of effective risk management process. Root cause analysis intends to reflect on these, modify preventable risk factors and prevent such adversities. Regular risk management reviews aim to detect certain contributory factors and formal reports indicating recommendations are issued.12) In addition, a positive culture of praising excellent care is cultivated. This can invariably improve the standards of healthcare provided and reduce the financial burden of litigation.

Prevention strategies

Any operative intervention should be clearly indicated. As operative vaginal delivery is associated with maternal and neonatal morbidity, prevention strategies that reduce the necessity for forceps are implemented. First of all, women are offered one to one care and continuous support for the duration of active labour. Presence of birthing partners is encouraged as this improves spontaneous delivery rates. Furthermore, women are motivated to be mobile and avoid prolonged supine position. Instead, upright or lateral positions are preferred in the second stage of labour and this results in a reduction in the number of assisted deliveries. Epidural analgesia is always accessible, though women are informed that increases the chances for forceps delivery. Another recommendation for reducing the need for rotational and mid-cavity deliveries is the delayed pushing in primiparous women with an epidural for one to two hours or until they have a strong urge to push. Use of oxytocin at the second stage of labour is used when indicated and always with extreme caution in multiparous women, as ceased uterine activity at these cases might indicate obstructed labour.2)

Training curriculum

Conducting secure forceps is an integral part of training in Scotland, based on merits from different teaching methods, which in return transpire into uneventful assisted deliveries. Forceps obligate competence and confidence, both of which are mastered by practice. This is not easy to achieve with reduced training time, based on European Working Time Directive regulations. Therefore, based on best practice, junior doctors are not allowed to attempt perceived risky procedures unsupervised. As a result, forceps deliveries are performed by a doctor who has appropriate experience or by trainees under adequate direct supervision to succeed the delivery and manage complications that may arise. It is unwise if due to risk factors complicated delivery was anticipated and senior input was not requested in advance, as that can sometimes be proved detrimental to the mother or the baby. Obstetricians are guided to achieve experience in spontaneous vaginal delivery prior to commencing
training in operative delivery. The RCOG facilitates supervision by recommending dedicated consultant sessions on labour ward. Transferring expertise helps juniors to recognise their own limitations and timely ask for help when there is doubt on any aspect of the delivery. For a trial of instrumental in theatre, the consultant usually attends or is immediately available should require. That has been associated with improved obstetric outcomes and better decision making. This is also an invaluable training opportunity where trainees can receive immediate individualised feedback. Assessment of the core clinical skills is submitted at the relevant Objective Structured Assessment of Technical Skills (OSATS) form. Once competency is achieved, doctors can conduct unsupervised deliveries. Thereafter, trained practitioners audit their performance and monitor their independent practice regularly.\textsuperscript{23} Frequent labour ward skills and drills boost multidisciplinary approach in safely expediting deliveries.

Simulation is another important element of the training in a more protected environment and there is overwhelming evidence that improves the performance of individuals and obstetric teams. Simple mannequins help the trainee to develop a smooth approach to forceps application and proper traction. Courses offered to all trainees include the Basic Surgical Skill, the Practical Obstetric Multi-Professional Training (PROMPT) and the Operative Birth Simulation Training (ROBuST) course in order to safeguard provision of highest quality of care. These include short lectures, practical demonstrations and hands-on practice. Aside, they cover important generic topics including teamwork, communication and documentation.

Attentiveness in educational objectives is given to ensure that future specialists acquire essential skills to correctly manage women within well-functioning teams. As forceps delivery demand high-level clinical skills, hospitals usually have a nominated trainer responsible for coordinating training, setting up local and specialist courses and maintaining vigilance in intrapartum care and labour ward management.\textsuperscript{33}

**Nontechnical skills**

Besides the theoretical knowledge and practical ability, nontechnical skills play a pivotal role in enhancing women’s wellbeing. These components are perplexing and go far beyond the manual dexterity. They encompass a range of cognitive and social skills that promote respect for women’s and their partners’ dignity and augment an environment in which women feel secure, acknowledging the right of the privileged mother-centred care. Elements of these extend but not limited to situational awareness, decision making, teamwork, non-verbal communication and professional behaviour. The accomplished accoucheur must be able to demonstrate sound professional judgement, usually within limited time and in an emotional and vulnerable environment. Serene behaviour and endorsing confidence in the caregivers can reinforce the positive outcome of the procedure. Attention to detail involves formulating clear goals and sharing plans of action with other members of the team such as midwives, healthcare assistants, neonatologists, anaesthetists and senior obstetric staff. High nontechnical skills are considered among the highest attributes of clinicians and those more likely to be recollected.\textsuperscript{14}

**Discussion**

Our mindset has evolved since 1985 when the World Health Organisation (WHO) published the Statement on Caesarean Section Rates proposing an ideal range to be between 10% and 15%. Nowadays, prominence is given on offering caesareans to women in need, rather than aiming to reach an explicit target.\textsuperscript{35} High caesarean section rates show no sign of fading.\textsuperscript{15} This tendency may have a long-term impact on the overall rate of vaginal births, despite the efforts of improving uptake of vaginal births after caesarean sections (VBAC).

Women are more likely to achieve vaginal delivery in the following pregnancy after forceps than after a caesarean. The simultaneous increase in the use of a vacuum leads to more failed instrumentals, which is counterproductive in tackling second-stage caesareans. Likewise, a caesarean section can be a dangerous procedure, especially in resource-poor countries.

Controversies on safety, lack of operators, change in women’s attitudes and fear of litigation in an unfortunate outcome have greatly reduced the appeal of forceps. Undoubtedly, forceps have the peril of causing serious harm, but the same relates to any other instrument in inexperienced hands. Unbiased research on the topic has established the overall adverse maternal and fetal risk as low.

Majority of the women still opt for a more satisfying spontaneous vaginal delivery, regardless of a growing minority of caesareans on maternal request. Obstetricians should endeavour to enhance women’s wishes and improve the birth experience. Maintaining forceps into clinical practice might constitute the indispensable resort in assisting childbirth. In many cases, solely use of ventouse is either not adequate, or not indicated with restrictive guidelines on the number of permitted pulls.

In Scotland, in order to meet women’s expectations, forceps is a substantial alternative in the armour of the adept obstetrician. Moreover, robust hands-on teaching, aid trainees to achieve competency in the use of rotational and non-rotational techniques, with Kielland’s been in use widely. The clinical outcomes are assessed regularly.
Experiences from a healthcare system with one of the highest rates of forceps deliveries in the world

in a transparent way and instructions are implemented accordingly in order to optimise effectiveness. State-of-the-art workshops might be a major educational tool to encourage others to reincorporate forceps into practice and expand precipitously decreasing experienced providers, authorising further on the job training. This will uphold the proportion of technically advanced forceps deliveries which can still be less invasive intervention than an emergency caesarean. Clinicians should remain realistic about the value of forceps and strive to refine the technique and minimise complications.

Conclusions

Forceps have a long history and worth a place as an essential component in contemporary intrapartum management. With competent operators and strict adherence to comprehensive guidelines, the outcomes can be excellent. There is great gain by keeping this fundamental art alive. With widespread promoted enhanced recovery pathways, women deserve uncomplicated instrumental vaginal deliveries which typically have a shorter hospital stay, fewer readmissions and, after all, reduced cost of care, even when this is counteracted by possible pelvic floor morbidity.

Forceps can form the amble intervention in demand and Scotland has an imperative tradition in the field. Advocating forceps with a high safety profile is mostly related to an experienced operator for accurate assessment of each clinical scenario which directly determines the successful outcome. The knowledge can be preserved by vigorous exposure as a part of the core training curriculum. Undoubtedly, skilful obstetricians in forceps deliveries and supply of appropriate equipment are likely to positively empower labouring women and contribute significantly in achieving improved obstetric standards.

Ethics approval

Not required.

Acknowledgements

The author would like to greatly acknowledge Professor Satoru Takeda at the Center for Disease Control and Prevention for his unassuming assistance.

Disclosure of conflicts of interests

None declared by the author.

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