Choosing caesarean section

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"With a scheduled caesarean section, you and your doctor have agreed to a time at which you will enter the hospital in a fairly calm and leisurely fashion, and he or she will extract your baby through a small slit at the top of your pubic hair. There are a lot of reasons to schedule a caesarean section—other women elect to have a caesarean because they want to maintain the vaginal tone of a teenager, and their doctors find a medical explanation that will suit the insurance company.”


This statement from a popular US paperback illustrates the degree to which society appears to condone women choosing caesarean section (CS) and doctors committing insurance fraud. Such a statement is reinforced when the incoming president of the American College of Obstetricians and Gynecologists calls this major abdominal procedure “life-enhancing”. CS has saved the lives of many women and babies around the world. So why not allow women the option to choose CS? Unfortunately, the option to choose (or demand) is not that simple. CS, even when elective, carries serious risks for mother and baby.

There seems to be a movement in medical circles to promote the right of women to choose CS. In 1997 an obstetric journal reported a survey of female obstetricians of whom 31% said that if they had an uncomplicated singleton pregnancy at term, they would choose CS. The BMJ and NEJ Med joined in. In 1999, in the BMJ, a feminist professor of English lamented “medical and social prejudices against women sidestepping their biblical sentence to painful childbirth are still with us” and a consumer advocate stated “I do not believe that anyone has the right to demand women give birth vaginally”.

There is an interesting relation between promoting women’s choice and the degree to which the procedure is doctor-friendly. A trial of vaginal birth after a previous CS (VBAC) is safer than a routine repeat CS but there are no articles in medical journals promoting the right of women to choose VBAC. CS is doctor-friendly; VBAC is not.

Risks

Basic to the attempts to justify women choosing CS is the statement: “caesarean section is safer than ever before”. There is a gradation of risk from obstetric emergencies through planned CS on maternal or fetal grounds to women’s choice elective CS with no medical indications. Most data on risks only separate “emergency” from “elective” CS but since many of the risks exist regardless of why the CS is done, women’s choice elective CS, as major abdominal surgery, still has proven higher risks.

The answer to the question “How safe is CS?” depends on who is answering. If a CS is done, the woman and her baby take the risks while if the CS is not done, the doctor takes the risk. This helps to explain why documented risks to the woman and her baby are not widely discussed and often not presented by doctors.

The most reliable maternal mortality data come from the UK Confidential Enquiries into Maternal Deaths. While it may have been obstructive politics which promoted the omission of the usual chapter on maternal mortality with CS from the latest report (1998) two scientists calculated the rate from data in the report. An elective CS with no emergency present had a 2.84 fold greater chance of the woman’s death than if she had a vaginal birth. Since a randomised controlled trial is not ethically possible, the UK data on 153 929 elective procedures give powerful enough evidence of the increased risk of maternal mortality with women’s choice elective CS.

Other risks include the morbidity associated with any major abdominal surgical procedure (anaesthesia accidents, damage to blood vessels, accidental extension of the uterine incision, damage to urinary bladder and other organs). 20% of women develop fever after CS, most due to iatrogenic infections. There are also risks due to scarring of the uterus, including decreased fertility, miscarriage, ectopic pregnancy, placenta abruptio, and placenta praevia. Widespread use of the unapproved drug misoprostol for labour induction has created a new risk. Women attempting VBAC who are given misoprostol have a rate of uterine rupture of 5-6% compared with a rupture rate of 0.2% of women attempting VBAC not given misoprostol. All of these risks affect subsequent pregnancies even if the original CS was not an emergency.

In an emergency CS where the baby has a problem during the labour, the risks to the baby of the CS will probably be outweighed by the risks of not doing it. Where the baby is not in trouble, the risks to the baby still exist, meaning that the woman who chooses CS puts her baby in unnecessary danger. That some women do choose CS strongly suggests that they are not told this.

The first danger to the baby is the 1-9% chance that the surgeon’s knife will accidentally lacerate the fetus (6% with non-vortex position). Obstetricians may be less aware of this risk—in one study only one of the 17 fetal lacerations was recorded by the obstetrician.

A much more serious risk is respiratory distress. The CS procedure per se is a potent risk factor for respiratory distress syndrome (RDS) in preterm infants and for other forms of respiratory distress in mature infants. The risk of RDS is greatly reduced if the woman is allowed to go into labour before the CS. Another hazard is iatrogenic prematurity. Even with repeated ultrasound scans, there are errors in judging when to do an elective CS. Elective CS after spontaneous labour begins would reduce this risk. Both RDS and prematurity are major causes of neonatal morbidity and mortality.

Benefits

The benefits of CS do depend on the reason for doing it. When the CS is chosen by the woman, the lifesaving benefits from an emergency CS are not present.
Absence of pain, as a benefit to the woman, is a false promise. The ability to schedule a CS in advance does provide convenience to the woman and her family. The promise of maintaining “the vaginal tone of a teenager” (frequently promoted in popular books and by hospitals in Latin America) is real although more likely a benefit to the sexual partner than the woman herself. Less damage to the genitalia is claimed with CS but much of the damage in vaginal birth today is caused by hurrying an uncomplicated second stage, unnecessary use of forceps or vacuum extraction, and unnecessary episiotomy. In countries like Brazil, where full reproductive rights are not available for women, CS provides an opportunity for sterilisation without openly contravening the law.

For women’s choice CS there is no scientific evidence to suggest any benefits for the baby. Women who chose a “natural” or home birth have been criticised by doctors as selfish, as being concerned with their own needs rather than the safety of the baby, a criticism not based on evidence. Given the evidence on the risks to the baby and absence of benefits to the baby when women choose CS, the label “selfish” would better fit women choosing CS—were it not that to do so would be to blame the victims. Too often a woman’s basis for choosing CS is deep-seated fear and lack of confidence as a result of those doctors who themselves fear vaginal delivery and so fuel their patients’ anxieties.

In contrast, there are many benefits for the doctor. A common reason offered for high rates of CS is “defensive obstetrics”. In a recent survey 82% of physicians employed did this to avoid negligence claims. With a bad birth outcome doctors are sued and find themselves criticised for not performing interventions such as CS. Doctors are rarely criticised for unnecessary interventions. However, defensive obstetrics violates the fundamental principle of medical practice: that whatever a physician does must be first and foremost for the benefit of the patient. If a doctor does a CS because he or she is afraid of going to court or fears rising insurance costs, that doctor is not practising good medicine.

Obstetricians tend to blame women, lawyers, and the legal system for so much litigation, rather than looking at their own role. Ireland saw a 450% rise from 1990 to 1998 in medical negligence claims, with obstetrics and gynaecology accounting for nearly half of the payouts. The Medical Defence Union proposes a more accessible complaints procedure, a solution which may provide convenience to the woman and her family. The ability to schedule a CS in advance does provide an opportunity for sterilisation without openly contravening the law.
chat lines are full of misinformation on efficacy and risks with no control of validity.

Some believe clinicians’ ignorance to be a form of misconduct.18 Unless clinicians can provide correct information, women will not be able to make truly informed choices about their maternity care. A woman who chooses CS as a means of avoiding the “biblical sentence to a painful childbirth” is badly misinformed. By choosing a CS, she exchanges 12 hours of labour pain for severe postoperative pain and debility and a longer recovery period with weeks or even months of pain.

A liberated woman correctly strives not to be controlled by men but if she accepts the male dominated obstetric model, she gives up any chance to control her own body and make true choices. Volumes have been written about how liberating it is for a woman to give birth when she controls what happens. Women who demand choice but get only selected doctor-friendly information unwittingly buy into the medical position yet call it feminism.

Does a woman have an inalienable “right” to choose a CS? It has been clearly established in law that an individual has the right to refuse medical treatment but it does not follow that the converse is also true—that an individual has the right to demand treatment which is not medically indicated. If a woman asks for a CS but is refused because there are no medical indications, is it correct to say she will have a “forced” vaginal delivery? Pregnancy is not an illness. Most women need no medical or surgical treatment during pregnancy, delivery and the puerperium. Vaginal birth is the consequence of being pregnant, a state for which the woman and her sexual partner must take responsibility, not the medical profession.

If a particular procedure is against a clinician’s religious principles, he or she has the right to refuse to perform the procedure. Thus, a doctor cannot use the excuse that the woman chose a CS so “I am thereby obliged to perform it”. If a woman asks for a CS for which the doctor can find no medical indication and which, to the best of the doctor’s knowledge, carries risks for the woman and her baby which outweigh any possible benefit, the doctor has the right, perhaps even the duty, to refuse.

If a patient presents with viral influenza and demands antibiotics, the clinician has the right to refuse on the grounds that antibiotics will not help and because the overuse of antibiotics will lead to antibiotic resistance that could threaten the wider community. The overuse of elective CS also threatens the larger community. Not even the richest countries can do it all. Choices must be made about which medical and surgical treatments to fund. A CS which is done because a woman chooses it requires a surgeon, possibly a second doctor to assist, an anaesthetist, nurses, equipment, an operating-theatre, blood ready for transfusion and a longer postoperative hospital stay. If a woman receives an elective CS simply because she prefers it, there will be less resources for the rest of health care. In Brazil there are hospitals with 100% CS rates, health districts with 85% CS rates, and an entire state with a CS rate of 47.7%.17 This is a huge drain on the limited resources of that country. Worse, maternal mortality rates have risen in those areas of Brazil with these high CS rates.18 CS on demand is an expensive and dangerous luxury.

Another ethical issue is the right to equal access in health care. In many countries there is not equal access of women to basic, essential maternity care such as emergency CS. But it is a very different ethical issue to ask: if wealthy women can choose CS, should all women have this right? Discussions of equal access need to start with the question: access to what? Should we insist that since wealthy women can buy surgical augmentation when they feel their breasts are too small, we should use public funds for health care, even though limited in every country, to allow all women surgical breast augmentation?

In the light of these ethical issues, the Committee for the Ethical Aspects of Human Reproduction and Women’s Health of FIGO (the international umbrella organisation of national obstetric organisations) states in a 1999 report: “Performing cesarean section for non-medical reasons is ethically not justified.”19

**Why is there promotion of women choosing CS?**

After a two-decade rise in CS rates in many countries, efforts to bring this rate back down have finally begun to take effect. The US goal of reducing the rate from 25% to 15% by this year was not quite met. However, some are fighting against this effort to lower rates by questioning the recommended optimal CS rates;20 by suggesting that lowering the rate may be dangerous;3 or by pleading that CS is what women want.1–5

There is no evidence that a rate of CS over 7% saves lives.7 The most quoted optimal rate is WHO’s 10–15%.20

This at variance with a WHO consensus conference attended by 62 participants from over 20 countries. Following a thorough review of published work participants were aware of all the risks of CS. They then studied variations in CS rates and found several countries with very low maternal and perinatal mortality rates had CS rates close to 10%. There was no evidence that CS rates above this level lowered mortality rates. The final consensus recommendation was modified to 10–15% (10% for general populations, 15% for high-risk populations). This recommendation was anything but arbitrary.

Some believe that babies are getting bigger while women’s pelvic outlets are not. I find no proof that babies are getting bigger. Furthermore, in Sweden, Denmark, and the Netherlands the CS rate is close to 10% with some of the world’s lowest maternal and perinatal morality rates—and there is no evidence that those women’s babies are smaller or their women’s hips bigger than they are in the USA, Canada, or Brazil.

Another claim is that technological advances explain why “Childbirth has become very safe.” However, there is no proof of a causal relation between outcome and use of technology or increasing CS. There has been no significant improvement in industrialised countries in the past 20 years in rates of cerebral palsy, low birthweight, maternal mortality, or the fetal component of perinatal mortality. A US National Center for Health Statistics study comments: “The comparisons of perinatal mortality ratios with cesarean section and with operative vaginal rates finds no consistent correlations across countries,”4 a verdict echoed by the Oxford National Perinatal Epidemiology Unit, UK.5

One reason for the promotion of high CS rates is rarely discussed. When maternity care is characterised by medical hegemony and midwives are marginalised CS rates are higher—eg, in North America and urban Brazil. Having a highly trained obstetric surgeon attend a normal birth is analogous to having a paediatric surgeon babysit a healthy 2-year-old. Midwifery uses a different model, she gives up any chance to control her own body and make true choices. Volumes have been written about how liberating it is for a woman to give birth when she controls what happens. Women who demand choice but get only selected doctor-friendly information unwittingly buy into the medical position yet call it feminism.
Doctors tend to prefer technology; as a leading obstetrician in Canada said: “Nature is a bad obstetrician”.

References
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