The Debate about Caesarean "On Demand"

Choice, Risk and the Politics of Birth

Conflict and Passion

"the most politically fraught of operations"
BMJ Editorial,1999

"Elective Primary CS - what's the big deal?"
ACOG Conference Report, 2002

"*performing CS for non-medical reasons is ethically not justified*" FIGO, 1999

"A blatant misuse of power"
Robert K. DeMott, Birth, 2000

“The assault on normal birth: The OB disinformation campaign”

Goer H. Midwifery Today,2002

“On the vaginal birth vs. CS debate, collaboration, respect and an open mind will help. Resolution between the two sides in the current climate is another matter.”

Young D. Birth, 2000

Confrontation in Kansas City: Elective CS and Maternal Choice

For a medical community and society that brings women to the point of preferring major surgery to childbirth, serious questions need to be asked – preferably before women start paying with their lives

Bastian, BMJ, 2002

Making substantial progress towards improving the quality of maternal health care is urgent: while we continue to discuss unnecessary surgical interventions, millions of women that require these procedures do not have access to them and risk their own and their children's lives

Langer and Villar, BMJ, 2002

ACOG

- *If the physician believes CS/vaginal birth promotes overall health and well being . . . ethically justified in performing or refusing CS. . . The burden of proof should fall on those who advocate for a chance in policy . . . Evidence to support the benefit . . . is incomplete.*

  ACOG Ethics Committee, Oct 2003

- **It is ethical for doctors to deliver a baby by CS even if the mother faces no known risks from conventional labour**

  Washington Post, Oct 2003

The Canadian debate

C-section: just for fun

Choosing Delivery by Cesarean:

Has Its Time Come?

Fisk, MIRU, 2002

The Canadian debate

Planned elective section: a reasonable choice for some women?

Mary Hannah, CMAJ

- **C section: soon you will get to choose**

  Toronto Star

- **C-sections to be available on demand, CMAJ says**

  Vancouver Sun

- **Canadian doctors agree to offer CS for women "to posh to push"**

  Ottawa Citizen
  March 2, 2004

SOGC response

- March 2 Media Advisory

  “still debating . . . Vaginal birth is the preferred option for most women . . . CS reserved for medical reasons . . . March 2, 2004 edition of the CMAJ led to confusion”

SOGC response

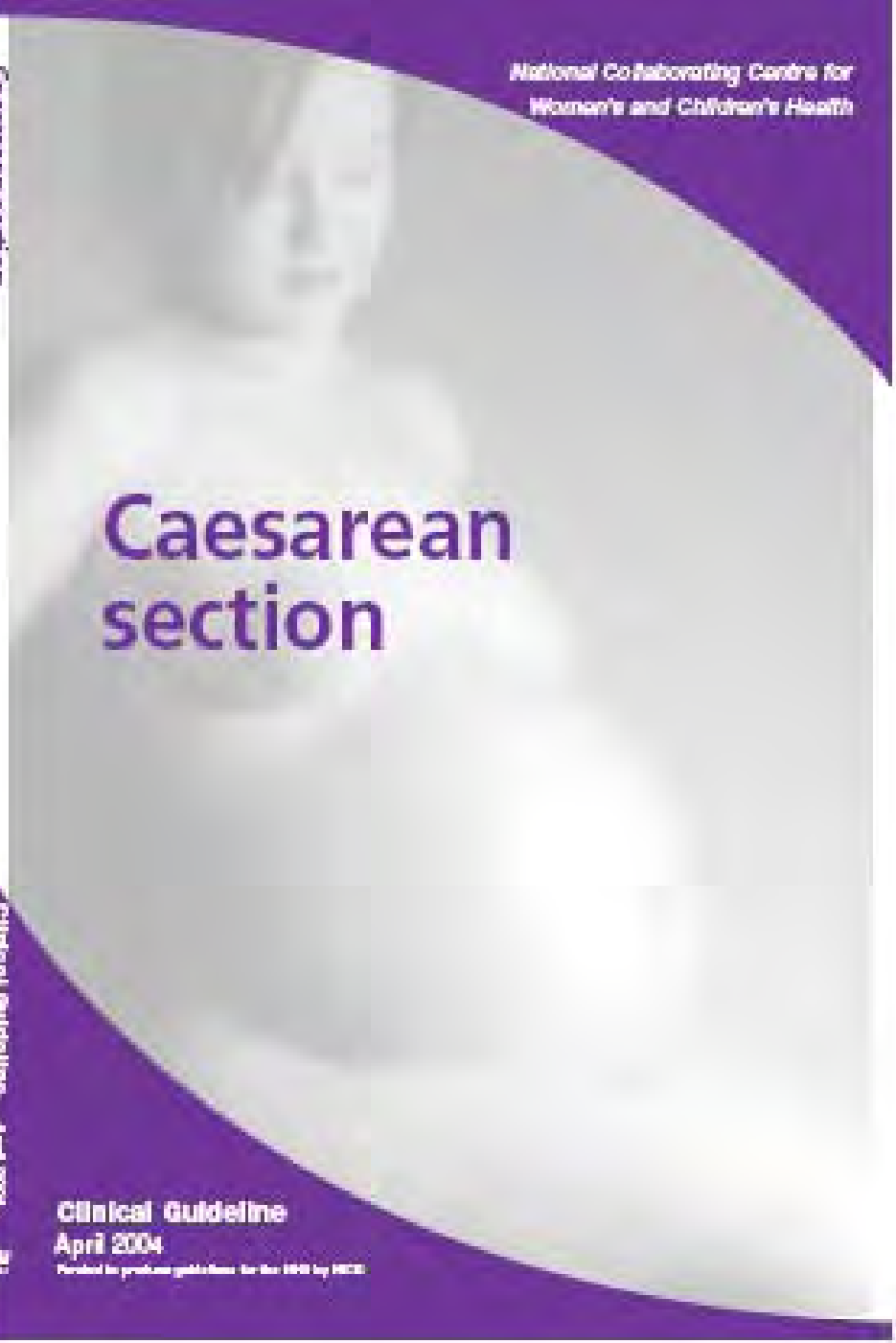
- March 10 SOGC Position

  “concerned that a natural process would be transformed into a surgical process . . . Limited resources . . . Continuous support in labour and delivery . . . Internationally . . . a tremendous disaster”

- SOGC Ethics committee statement still pending –the debate continues

National Collaborating Centre for
Women's and Children's Health

Caesarean section



Clinical Guideline April 2004

Caesarean section

Clinical Guideline
April 2004

NICE report

- National Collaborating Centre for Women's and Children's Health for the National Institute for Clinical Excellence and NHS
- Advocates on both sides have claimed support and offered critiques
- Request is on its own not an indication
- Safest birth for most women is vaginal birth
- Third party counseling when women request CS

NICE report

- Physicians have the right to refuse – recommends offering second opinion
- Support for one to one care
- Support for choice of VBAC
- Cost – savings of 10 million pounds per year if all requests without indication refused
- Women should be informed that planning a home birth reduces the risk of CS

NICE report

'After years of keeping us legs akimbo in the lithotomy position, our rulers now want us to jump down and push: Germaine Greer says it is too late to reverse the tide'

Germaine Greer, April 2004

The Guardian

Maternity Centre CS booklet

- What Every Pregnant Woman Needs to Know About Cesarean Section 2004

  be informed

  know your rights

  protect yourself

  protect your baby

www.maternitywise.org/cesareanbooklet/

Guardians of Normal Birth or Advocates for Choice?

Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life

Midwives encourage the woman to actively participate in her care throughout pregnancy, birth and the postpartum period and make choices about the manner in which her care is provided

Philosophy of Midwifery Care in Ontario,

College of Midwives of Ontario, 1994

Challenging Assumptions

- Choice
- Normal “natural” birth
- Risk

What is the social and political context of the experience, the science, and the popular culture of childbirth?

A Choice for **All** Women?

"not a choice if you are young, want to have more than one or maybe two children, or may live while pregnant in an area without ready access to a tertiary care centre"

Nicholas Fisk, MIRU conference, 2002

Using "Choice"

"It is time to reassess the practice of compulsory trial of labour in Canada, and ask whether our denial of patient choice in mode of delivery is justified"

Burnett, M. *Optional Caesarean: What Do Some Canadian Physicians Say?* JOGC, March 2002

The Politics of Choice

- In Canada, there is no law against abortion. . Its hard to argue when you think that a woman has the right to have her baby killed, why wouldn't she have the right to have an elective CS?"

  Margaret Sommerville, Chatelaine, April 2003

- "what's good for the goose is good for the gander"

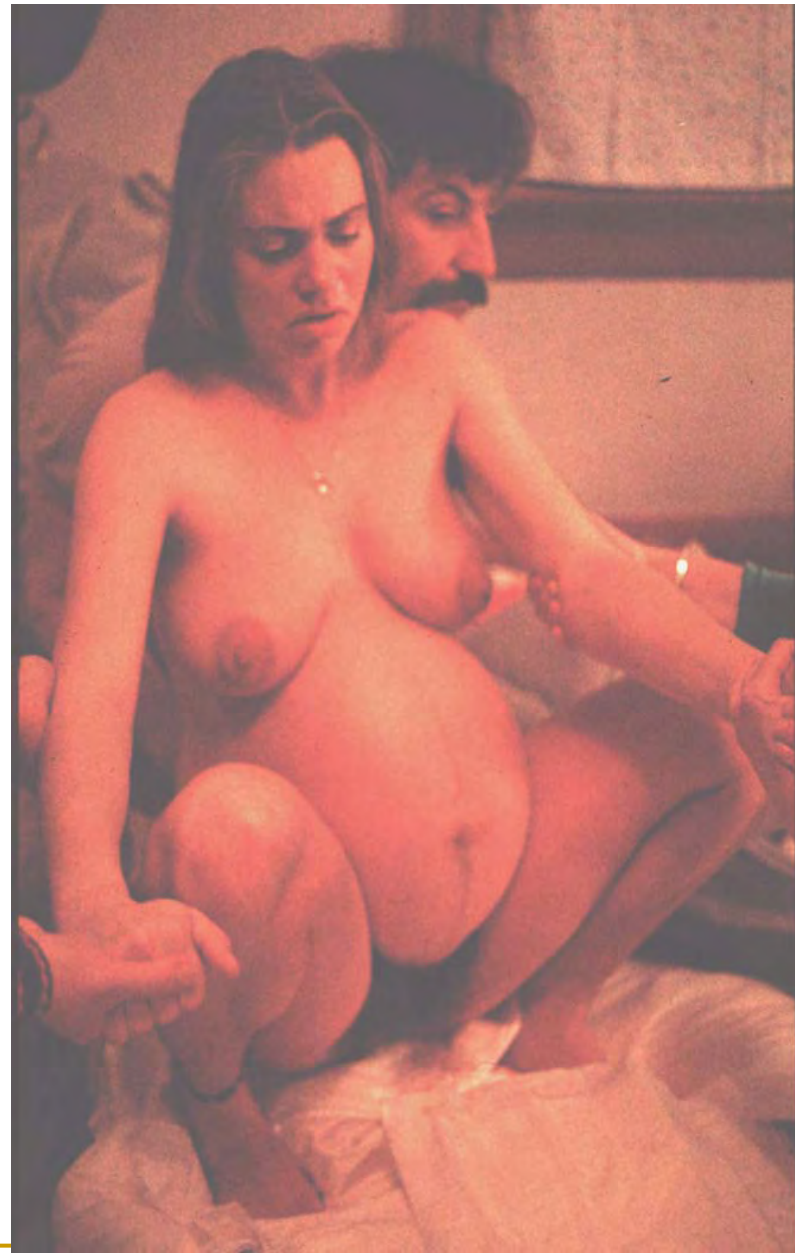
  Nicholas Fisk, Grand Rounds, SWCH, 2003

What's wrong with this picture?

- Choice of mode of delivery includes more than choice of CS
- Respect for women to make autonomous choices must apply to all modes of birth
- Discussion of risk must give a balanced view of risks of both technologic and low intervention approaches
- "choice" and "convenience" can cover for a preference for technologic approaches, fear
- Women's choices or physician's choices

Choice of mode of delivery

- Philosophy of birth as “normal”, physiological, social and cultural
- Supportive care in labour
- Intermittent auscultation
- Using upright postions in labour
- Eating and drinking in labour
- Choice of birth place -birth in local communities
- Known caregiver
- Choice of VBAC and ECV
- Support for unrestricted breastfeeding
- Community based care - midwifery and family practice
- Collaborative relationships between primary and secondary caregivers
- Care that respects women and provides non-judgmental choices



Women's choice?

- If the suggestion of CS by choice is about choice and autonomy rather than an "assault on normal birth" then those in favour should support a policy of offering all women a wide range of birth choices
- The conditions for this choice to be a choice would be the offer to all women of full choice of mode of delivery – and to have the range of choices supported by official bodies, by guidelines for practice and fully funded

Who would choose CS?

Caregiver's preferences

- London OBs - 17% (31% of women)
- UK midwives - 4%
- Irish OBs – 7%
- UK trainee OBs – 16% (men)/15% of women
- Dutch OBs – 1.4%
- Israeli OBs – 9%
- Australia/NZ OBs– 11%
- Danish OBs – 1%
- Canadian OBs – 30%

Caregiver's preferences

*Obstetricians themselves are probably the **most informed** of consumer groups*

Al- Mufti et al,
Eur J Obstet Gynaecol Reprod Biolol, 1997

Much more is made than is justified of the finding of a 17% choice of an ECS in an otherwise uncomplicated pregnancy by London obstetricians. . . A request for ECS for fear of the consequences of a vaginal delivery does not necessarily mean that the fear is rational. ***It is hard to put risks into proper epidemiological perspective when one's daily work relates to disease and damage to the reproductive and sexual organs***

Susan Bewley, Lancet, 1996

Caregiver's preferences

*. . . **midwives** are probably **in a superior position** when it comes to making an informed choice regarding mode of delivery; they overwhelmingly aim to have a vaginal delivery . . . The discretionary practice of . . .female obstetricians is not to be confused with whether women ought to request a CS . . .*

Dickson and Willett, BMJ, 1999

*Of course what is at stake here is not just what obstetricians might choose for themselves but whether their stated **preferences might colour** their willingness to agree to caesarean section in the absence of clinical indications*

Weaver, MIDIRS, 2001

Women's Preferences

Ireland 1.5%	Geary et al, J Perinatal Med, 1997
Australia 2%	Quninlivan, Aust NZ J Obst Gynaecol, 1999
Lit Review 1%	Gamble et al, Birth, 2000
Australia .3 - 6.5%	Gamble and Creedy, Birth, 2001
London, UK 7.6%	Eftekhar and Steer, BMJ, 2002
Sweden 8.5%	Hildingson, ICM, 2002
Norway 1.9%	Nyhus, ICM, 2002
UK 1-5%	National Audit, 2001
NICE 4-6%	NCCWCH 2004
Italy 4%	Italian law mandates choice of CS
Latin America 30 -75%	Brazil and Chile public and private

Women's Preferences/Reasons for CS

- Variation dependent on definition of medical indications – are breech, previous CS or difficult delivery as a medical indication
- Few women chose CS with no current or previous indication (1%)
- Strong association with previous negative birth experience e.g. emergency CS
- In nullips fear of birth (crowning) since childhood and hx of sexual abuse

Women's Reasons for Choosing CS: Fear and Anxiety

- Fear of being alone, helpless, in pain
- Fear for the baby
- Lack of information re risks
- Desire to avoid poor care and medical neglect
- Fear of health care workers
- Preference for "surgery from above" vs. "surgery from below" –choosing intervention to avoid intervention
- Fear of damage to pelvic floor – being cut or torn
- To access tubal ligation

Women's Reasons for Choosing CS: Convenience and Fashion

"Too posh to push"

- Ability to plan around work
- Desire for a known caregiver/support person
- Body image issues - to maintain sexual attractiveness
- Fashion trends set by the rich or famous

  Perfect Baby, Perfect Body, Perfect Doctor

  conflation of CS with cosmetic surgery

SEX & RELATIONSHIPS

Girls wanna be Posh

Valerie Gibson

Intimacies

Martha Stewart's conviction could not have come at a worse time. The domestic diva, one of the world's most recognized female business role models, was convicted just as International Women's Week began.

It was a blow for those women who held Stewart up as a shining example of focus and female achievement in the male-dominated world of big business.

But the celebration of International Women's Week still managed to highlight the far less controversial careers of plenty of other amazing women who have succeeded in the business and entrepreneurial world.

However, despite all the accolades for the numerous high-powered career women and the "look how far we've come" back-slapping of the designated week, do the

ably a rich sports star.

More than four in 10 of 25- to 34-year-olds said they would leave even a highly successful and powerful position to live a life of luxury with a guy who would pay all the bills. That figure rises even higher, to one in three, among the 18- to 24-year-olds.

Their most admired role models were Victoria Beckham, the Posh Spice wife of soccer superstar David Beckham, followed by actress/model Liz Hurley. The young women say they desire and envy their glamorous, jet-setting lives.

While such a response might not come as a complete surprise in our materialistic, celebrity-obsessed world, it will probably come as an offensive shock to many Canadian working women still trying to break through the proverbial glass ceiling to top jobs. Such women are

make successful headway in the workforce and in the executive boardrooms.

Women, after all, now represent 40% of the world's working population (1.1 billion of the world's 2.8 billion workers).

Yet a report by the International Labour Organization says that the rapid growth in the female work force has not been accompanied by real socio-economic empower-

"Unfortunately, many young women still believe in the myth of the 'knight in shining armour.'"

— Darla Campbell, Canadian Federation of Business and Professional Women's Clubs

ment. Nor has it led to equal pay for equal work.

Added to this disappointment is a growing disillusionment by many women about the intense focus and dedication needed to succeed which, when combined with daily home and family demands, leaves them exhausted and drained.

There's also the question of personal life. For example, many 30-plus women have discovered career success can often mean sacrificing not just their social life but the opportunity to find a lifetime partner or nurture a relationship.

More agonizing for many women at this biological clock-ticking stage of life is the often unavoidable decision to delay having a family because of the possible adverse effect on their career climb or the disruption to their own company's achievements.

It's a Catch-22 situation and, if the Bliss poll is an indication, it's

with feverish drive for success in the workplace? And is that fervour shared by their younger peers?

Not as much as might be believed, according to one poll recently conducted among young English working women.

Now, obviously there's a cultural difference between England and Canada and, despite similarities, many aspects of English daily life don't apply here. Still, the poll reveals a disturbing trend in some young women's attitudes that must, in part, be relevant in Canada.

Sponsored by the soft drink brand Bliss, the poll surveyed 1,000 women, aged 18 to 34, about their ambitions in the workplace. The results showed most of the women surveyed were not as ambitious about their careers as many might think — or want.

Apparently a high percentage said they would definitely swap their equality and their job any day for being kept by a man — prefer-

that it's essential for women to continue to

everything for a high-powered career is losing its allure for some young women.

"Unfortunately, many young women still believe in the myth of the 'knight in shining armour' coming along to rescue them," says Darla Campbell, vice-president of The Canadian Federation of Business and Professional Women's Clubs, who finds the poll results "shocking. What we need is less fantasy thinking, more positive role models and more good news stories about women's achievements to inspire them."

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A high percentage (of young women) said they would ... swap their equality and their job any day for being kept by a man — preferably a rich sports star.

VICTORIA BECKHAM AND INSET, LIZ HURLEY

— AP file photos

Got a question ab
Contact Val at The Sur

THE GLOBE AND MAIL
SATURDAY, MARCH 13, 2004

Refused to have C-section, woman faces murder charge

Case refuels U.S. debate over competing rights of pregnant women and fetuses

BY SUZANNE GOLDENBERG
WASHINGTON

A woman in Utah is facing a murder charge after refusing to undergo a cesarean-section delivery in a case that has reignited the U.S. debate on the competing rights of fetuses and pregnant women.

In what many see as a test of new state and federal legislation expanding the domain of human life, 28-year-old Melissa Rowland is accused of exhibiting "depraved indifference to human life" for disregarding doctors' advice to give birth to her twins by cesarean section.

The Salt Lake City resident was warned numerous times between Christmas and Jan. 9 that her unborn twins were likely to die if she did not get immediate medical treatment, court documents allege. When she delivered them on Jan. 13, a baby girl survived but her twin brother was stillborn.

If Ms. Rowland is convicted of criminal homicide in causing her unborn son's death, she could face life in prison.

"This is an individual who knew very well that if she did not get treatment, and did not get a specific treatment at that time, that her child may very likely die," assistant prosecutor Kent Morgan said.

It was not clear why Ms. Rowland ignored repeated medical advice that her twins were in danger, but her lawyer said she has a long history of mental illness.

The prosecution alleges that it was a case of vanity — that she did not want to carry a scar from the surgery — but Ms. Rowland rejected that allegation.

"It was all medical concern. None of it was vanity," she told The Associated Press yesterday during an interview in jail.

She has been in custody since mid-January on a child-endangerment charge involving the surviving twin, who has been adopted by a family Ms. Rowland knows.

In an interview with a radio station, she said she had no objections to the surgery, and that in fact the twins had been delivered by cesarean section.

"I've never refused a C-section," she said. "I've already had two prior C-sections."

Ms. Rowland said she has two children who live with their grandparents in Virginia.

Her lawyer, Michael Sikora, said she moved to Salt Lake City with a boyfriend, and is either divorced or estranged from her husband.

The case has become yet another symbol of America's culture wars, a struggle encapsulated by last month's passage in Congress of the unborn-victims-of-violence bill.

The bill, which would make the murder of a pregnant woman a double homicide, is the latest victory for an anti-abortion movement emboldened by the presence in the White House of an ideological ally.

Women's groups say George W. Bush's presidency has given new impetus to anti-abortion activists, who have tried to chisel away at women's rights through bills such as this one and other legislation banning late-term abortion.

The legislation on fetal violence has yet to clear the Senate. But the Utah episode, state and federal legislative projects, and a presidential election in November during which Mr. Bush will try to shore up his right-wing base have caused trepidation among women's organizations.

"Unquestionably, they are relying on the argument that the fetus is a person from the moment of conception," said Lynn Paltrow of National Advocates for Pregnant Women.

But she argued: "This leads not to the protection of fetuses, but to the arrest of pregnant women.

"In the United States, citizens — including pregnant women — have the right to refuse unwanted medical treatment, and apparently Utah prosecutors don't believe that applies to pregnant women," Ms. Paltrow said.

According to court documents, Ms. Rowland visited several Salt Lake City hospitals in the weeks before she gave birth because she could no longer feel the fetuses move. She was advised to go to one of two hospitals for immediate care, but nurse Regina Davis is quoted in the documents as saying that Ms. Rowland told her she would rather both babies die than go to either hospital.

HANDOUT/REUTERS

Melissa Rowland, 28, has been charged with murder after allegedly ignoring medical advice to have a cesarean section.

On Jan. 2, Ms. Rowland visited a doctor and was told she should undergo immediate surgery. But she left after signing a document that said she understood the risks to the fetuses.

At another hospital later that day she was alleged to have told a nurse that the doctor had wanted to cu her "from breastbone to pubic bone."

Guardian News Services

Fear and anxiety about birth

- We need to examine our systems of care, especially in regard to difficult labours -is the request for ECS symptomatic of failing to provide quality, compassionate care for vaginal birth?

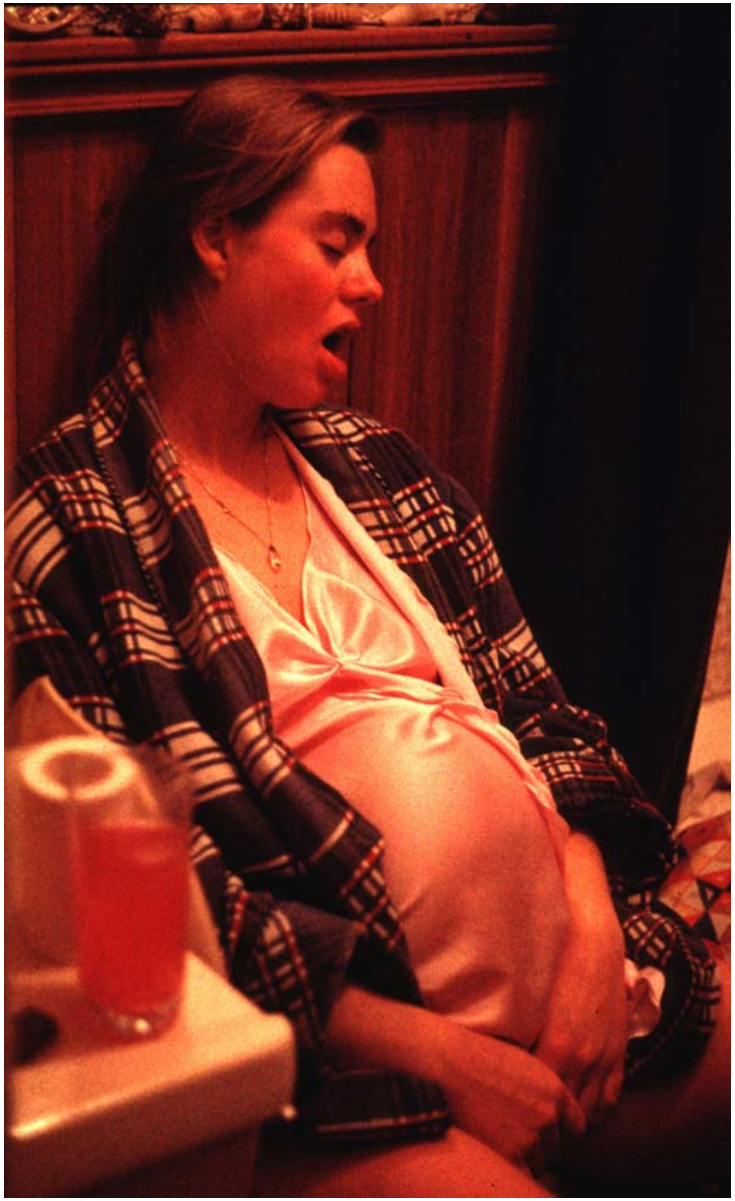
- CS should not be offered as a substitute for reassurance, accurate information, counseling, supportive care in labour and/or pain relief

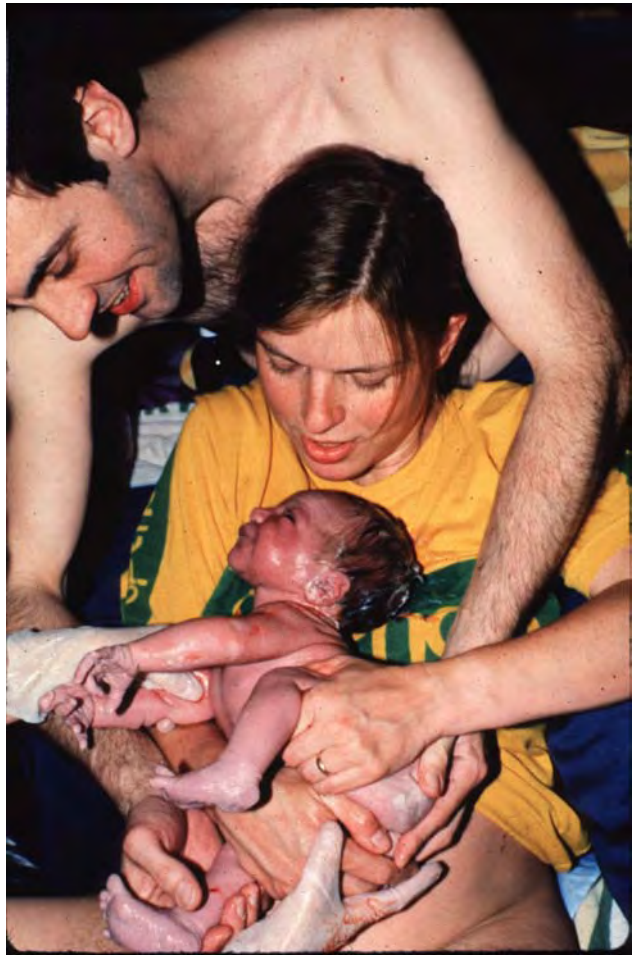
When a pregnant women asks for an obstetrically unmotivated CS, counselling is necessary. . . Women who need and accept short term psychotherapy with an obstetrically well-informed therapist stand a good chance of an uncomplicated vaginal delivery

Ryding, Acta Obstet Gynecol Scand,1993

RCT on treating anxiety about birth showed 62% of those requesting CS chose vaginal birth after counselling. Lower birth concerns, anxiety levels and shorter labours (6.8 vs 8.5 hours)

Saisto et al, Obstetric Gynecol, 2001





Changing Attitudes to Technology

"I'd rather be a cyborg
than a goddess"

Donna Haraway,
Manifesto for Cyborgs

CS and Home Birth

- Both may be strategies for seeking control
- Both chosen by a minority of women (Canada)
- Both choices may be seen as balancing risks to gain benefits – re safety, esp morbidity and “experience”
- Both may relate to concerns re quality of care, seeking known caregivers
- Opposite focus for fears and feelings of safety – ”natural” body experience vs. institutionalized medical care
- Women seeking home birth may prefer ECS to routine hospital care Anderson, MIDRS, 2001

Benefits and Risks to Fetus

- CS at 37-38 weeks to prevent IUD and birth asphxia
- With 100% rate of CS there would be a small but significant reduction in PMR
- 260,000 CS could save 200 babies per year
- 1309 CS to save one baby

Dunn, MIRU,2002

Benefits and Risks to Fetus

- Risks: TTN, RDS and PPHN, NICU Admissions
- Consequences of CS for early contact
- Long term: asthma, breastfeeding, parenting
- Risks in subsequent pregnancies increased
- rates of stillbirth higher after previous CS

Smith, Pell and Dobbie, Lancet, 2003

ECS and Maternal Mortality

- The risk of maternal death is **increased 2-4x** with ECS vs vaginal birth ECPC, UK National Audit
- For the minority of women who avoid an emergency procedure ECS may be 2-3x safer
- For the majority of women who would have normal births ECS is less safe

Risk in Future Pregnancies

- The risk for women and babies increases in subsequent pregnancies
- MM of ERCS 17.9 compared to NSVD 4.9 per 100,000
- MM rates as high as 1 to 2 % have been reported in some Brazilian private clinics

Maternal Morbidity with CS

- Operative and post operative complications
- Postpartum recovery
- Ectopic pregnancy
- Placental abruption
- Placenta accreta and percreta
- Infertility
- Uterine rupture
- Hysterectomy
- Risks increase with parity

The Pelvic Floor Debate

"functioning sphincters are the basis of civilization"

Murphy M. *Choosing Cesarean Birth: An Alternative to Today's Crisis in Natural Birth* OBGYN NET 2003

"we should leave vaginal birth to the animals"

Fisk, N. MIRU conference Nov 2002

"we believe it is imperative to reevaluate modern obstetric practices both for the patient's benefit and for our medicolegal protection"

O'Boyle AL, Davis GD, Calhoun BC. *Informed consent and birth : protecting the pelvic floor and protecting ourselves* Am J Obstet Gynecol 2002

Protecting Women's Pelvic Floor

- growing evidence that forceps, long second stages, episiotomy, epidural, 3rd degree tears, large babies contribute to pelvic floor trauma
- evidence that vaginal birth may not be the long term determining factor - pregnancy, lifestyle, age, fitness, body size and genetics
- best approaches to prevention and treatment are not clear –long term data needed

Protecting Women's Pelvic Floor

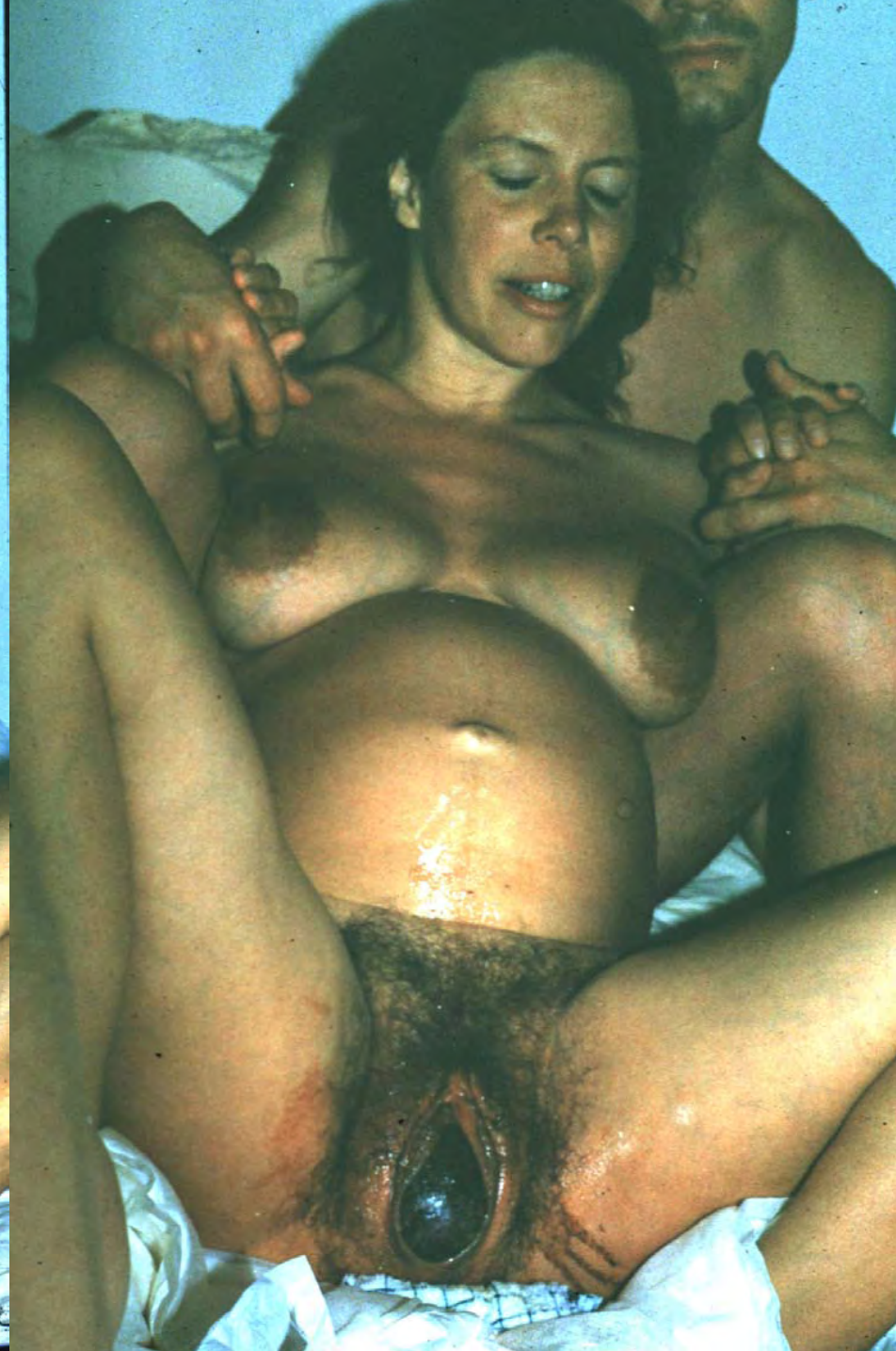
There is no doubt that both morbidity and mortality are higher following a caesarean section and therefore ***extreme caution*** *needs to be exercised when consenting to caesarean section. . . It is a matter of concern that 35% of primigravid women sustain occult anal sphincter damage during vaginal delivery and that less than 20% of doctors feel adequately trained to recognize and repair perineal trauma.* ***However the solution lies not in by passing natural childbirth but aiming to make vaginal delivery safe.***

Sultan, BMJ, 2002

Protecting Women's Pelvic Floor

It is true that the pelvic floor may be damaged during vaginal delivery. ***Rather than*** *stimulate ever more ready recourse to* ***Caesarean section****, however,* ***our first concern should surely be to review aspects of the modern management of labour that may contribute to it*** *– for example, maternal posture and mobility, the use of epidural anaesthesia, the length of the second stage of labour and the liberal use of episiotomy.*

Stirrat and Dunn, BMJ, 1999

Surgical fix for non-surgical problems

- Issues underlying request for CS need to be addressed –fear, control, body image
- Offering surgery should not be the first recourse
- Seek new solutions to the litigation crisis
- Risks of ever increasing rates of CS include loss of skills re vaginal birth

Discussing CS on Demand

- Explore the woman's concerns –are there other ways to meet her needs?
- Evidence supports offering third party counselling
- Acknowledge the debate, the uncertainties and the risks
- Current practice is to discuss when woman requests ACOG, SOGC, Best Research and Practice

Participating in the Debate

- Advocating for physiologic birth as the safest approach for most women
- Advocating support for full range of birth choices
- Improving care for low intervention vaginal birth
- What cultural support do women need to make giving birth “with their bodies” a viable and rewarding choice? How do we increase confidence and self esteem rather than fear?

Conclusions

- Respect for women to weigh and balance risks and benefits of many kinds of birth choices should be reflected across all maternity care not limited to choice of CS
- Support of CS by choice without support for other birth choices supports medicalization of birth and undermines choice and safety

Conclusions

- CS debate has sparked some important work re the value of vaginal birth
- Potential for distraction of attention and resources from other important issues
- Continued work to most accurately assess those at risk who need birth interventions
- Cultivate a system that
  - respects and supports normal birth
  - uses technology and resources appropriately
  - nurtures confidence and respects choice