

In The Literature

Commentary On:

Collard TD, Diallo H, Habinsky A, Hentschell C, Vezeau TM.
Elective cesarean section: What's driving this Trend?
Nursing Women's Health, 2008;12(6):480–488.

Putting Mothers and Babies at Risk: Promoting the Elusive “Cesarean Delivery on Maternal Request.”

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When the U.S. National Institutes of Health sponsored a State-of-the-Science Conference, Cesarean Delivery on Maternal Request (1), in March 2006 in the absence of scientific evidence to support its contention, it put women and their infants at serious health risk. By normalizing cesarean section without medical indication as a safe reproductive health choice to which United States women were entitled and were, in fact, already making, the medical professionals involved in organizing the conference were negligent in their duty to first do no harm.

Three years after this notorious event Collard and colleagues, in this article written for nursing maternity care professionals, are still debating “cesarean delivery on maternal request” as a reality and one that is possibly contributing to the record high national cesarean rate. They present this complex issue with some degree of confusion and lack of evidence-based information about what is and is not a medical indication for a cesarean section.

Maternal Choice or Physician Choice Cesareans?

The authors state, “elective cesarean sections must be examined so that all professional health care groups can agree on whether a woman’s request should be granted.” This suggestion implies that women are making informed choices, whereas, in fact, the physician may have subtly suggested that a cesarean section is the best option for a “big baby” and a woman, now frightened about possible complications, simply agrees to a scheduled cesarean without receiving full disclosure of the risks.

The authors also aim to “enable effective collaboration between patients and providers in making future health care decisions,” and “to provide interventions for nurses to use with patients requesting elective cesarean sections.”

The authors' discussion of this complex issue is at times confusing and lacks evidence-based information about what is and is not a medical indication for a cesarean section. Readers may also wonder why "all professional health care groups" **must agree** to grant or not to grant a woman's request for a non-medically indicated cesarean. Current authoritative patient education materials in the U.S. do not fully disclose the risks associated with cesarean surgery (2). However, if they did so, mothers would legally be entitled to their informed choice (3). The problem lies in the lack of transparency about the serious risks associated with cesareans. In their attempt to provide nurses with guidance on how to help women make an informed decision about choosing a medically unnecessary cesarean section, the authors also fall somewhat short in their knowledge of evidence-based care with respect to this surgical procedure.

The opening paragraph defines the term, "elective cesarean section" as "a mode of delivery requested by a woman when there's no medical indication." Although primary cesareans with no indicated risks have been growing rapidly in the U.S., no hospital inpatient data reflects the mother's intent to have chosen the surgery (4). In fact, based on current birth records or hospital discharge records, one can just as easily conclude that physicians recommended or convinced their healthy patients to undergo a cesarean section.

The authors cite the American College of Obstetricians and Gynecologists' (ACOG) *Surgery and Patient Choice* (5) and the *NIH State-of-the-Science Conference: Cesarean Delivery on Maternal Request* (1) proceedings as suggesting "that there's an increase in the number of maternal requests for cesarean section," which is contributing to the increase in the overall cesarean section rate. However, neither ACOG's Committee Opinion nor the NIH conference proceedings contains proof for these assumptions.

The authors then cite two other sources of "a low occurrence of maternal requests" for cesareans." The first source is the *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Experiences* (^), which provides the only accurate U.S. national data about the extent of women's intent to choose a non-medically indicated cesarean section. That rate is 0.4 percent, or 1 woman from the more than 1,500 who were surveyed.

The second source is a study that used National Hospital Discharge Survey data from 1991 to 2004 to identify maternal request cesareans (7). Again, there is no evidence of intent of the mothers for a non-medically indicated cesarean in those public records. Yet, the authors concluded from Gossman et al that from 1991 to 2004 an estimated 5.03 percent of women had a primary "maternal requested cesarean." The authors also include a note about an international estimate of the "elective cesarean section rate" as being between 4 and 18 percent... Here again, from the two studies cited it is not clear that it was the mother's intent to choose a non-medically indicated cesarean.

What Is the Real Question?

Once the assumption is made that mothers are “choosing” cesareans, it is necessary to understand what women’s motivations are, and consequently, whether or not a health practitioner is justified in honoring their request. Becoming embroiled in this discussion detracts from the real question that should be asked: When U.S. physicians, supporting staff, and hospital administrators increasingly advocate for women’s right to choose cesareans for non-medical reasons but deny women the right to labor for a vaginal birth after cesarean (VBAC), are they providing optimal care for mothers and infants? And are they really promoting informed choice?

Hundreds of maternity care units across the United States currently offer no other choice for women with a previous cesarean than to undergo a repeat operation (8). More than 90 percent of U.S. women today have a repeat cesarean section. Thus, continuing to discuss the elusive rates of cesareans “on maternal request” is a diversion from the real problem. The U.S. maternity care system is intentionally or unintentionally harming childbearing women and their infants by sustaining a record high cesarean delivery rate. Moreover, it is also violating women’s right to have a safe access to vaginal birth after a previous cesarean.

Collard *et al* correctly argue that cesareans are not without serious health risks and that perinatal nurses should “support a lengthy discussion between the provider and the woman to include a complete description of the advantages, disadvantages, misperceptions and complications or their delivery options.” They encourage nurses to advocate for their patients as well as determine “whether fully informed consent has been obtained, including the knowledge of long-term consequences.” Unfortunately, if nurses were to use solely the information included in this article as a basis to assist childbearing women in making fully informed decisions, they would be providing their patients with outdated and biased information.

The authors list “Medical Indications for Cesarean Section” and cite ACOG’s 2005 patient education pamphlet, *Cesarean Birth*, as the source (9). Included in this list are “previous cesarean birth” and “multiple gestation pregnancy.” The belief that cesarean section is the only safe option for women with a prior cesarean or those with a twin pregnancy reflects outdated concepts that research has long since disproved. Also included in this list is “macrosomia.” Evidence shows that screening for macrosomia during pregnancy and scheduling a cesarean to “prevent” complications neither produces accurate results nor improves outcomes. However, quoting ACOG sources to support cesarean section for these reasons reflects an unquestioned trust in the quality of maternity care policies issued by the organization.

What Is the Quality of the Evidence Behind Current Official Maternity Care Policies?

It should be noted that less than one quarter of all obstetric practice recommendations issued by the organization and current in 2006 were categorized as Level A. This category is based on good and consistent scientific evidence, according to criteria established by the U.S. Preventive Health Services Task Force. (Task Force criteria ranged from Level A to Level E.) One third of all ACOG recommendations at the time included no Level A sources at all (10).

Whereas national maternity care policies in countries like Great Britain are evidence-based, and drafted and approved with the input of dozens of stakeholders (multidisciplinary professional associations, consumer advocacy groups, hospitals, and others), overall fewer than two physicians were involved in the drafting of each of the 55 obstetrics and gynecology practice bulletins current in 2006. Around the world, those who craft health policies and practice guidelines look to the Cochrane Database of Systematic Reviews, considered the “gold standard” for scientific evidence on health care issues. Nevertheless, only 1 percent of the 3,953 references listed in all of ACOG’s practice bulletins were citations from the Cochrane Database. Unfortunately, Collard et al have based some of their arguments on official maternity care policies without further examination of their merits.

Recently, the Miami Herald reported that 7 of 10 babies were born by cesarean section in one medical center. One University of Florida professor of obstetrics and gynecology is quoted as saying, “Cesareans have become so safe and relatively easy for women... no rushing around, the baby doesn’t have to come out right away... They’re happy and pain-free and walking around the first day” (11). Are mothers responsible for all these cesareans? Women whose physicians recommend a cesarean section and women who are thinking of about a nonmedically indicated cesarean should have access to full disclosure about the risks of the operation. Only then can any statement be made to support elective cesarean section on maternal request.

The suggested Patient Information Form below provides a document that, if signed by a childbearing woman would accurately demonstrate that she is choosing a cesarean section that is based on informed consent.

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