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ABSTRACT

Elective Cesarean Section: How Informed is Informed?

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The national c-section rate has sky rocketed to nearly 25 percent of all births, although its widespread use has not improved birth outcomes. Elective Cesarean surgery for non-medical reasons is now available to women. The ethical dilemmas of elective Cesarean are perceived as involving confusion about what constitutes informed consent and exposure of women to unnecessary surgical risk. The midwifery model is presented as an alternative method for birthing considerations. This model emphasizes health promotion, risk reduction and active family participation in prenatal care decision making.

Key Words: Elective Cesarean Section, Ethics of c-section, Informed Consent, Childbirth

Elective Cesarean section: How Informed is Informed? - Zeidenstein

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Introduction

It is proposed that elective Cesarean surgery does not constitute a judicious use of technology or health care dollars. The widespread use of Cesarean surgery in the United States has not improved birth outcomes (Raymond, 1993). In fact, in a large retrospective study, relative to babies born by spontaneous vaginal birth, those born by either planned or unplanned cesarean section, had a four-fold risk of death before hospital discharge. (Towner & Castro, 1999).

Pregnancy and birth are normal physiologic events. Eighty percent of pregnancies are considered normal and uncomplicated. Based on this evidence, the World Health Organization (WHO) and the International Federation of Gynecologists and Obstetricians (FIGO) have set 10-15% as the standard cesarean rate. However, the national c-section rate has sky rocketed to nearly 25% of all births (FIGO Committee report, 1999). The excessive number of Cesareans in the United States misappropriates limited health care funding; both in training too many obstetric surgeons (obstetricians) and too few vaginal birth specialists (nurse midwives). The health care cost savings by bringing U.S. Cesarean section rate into compliance with WHO recommendation would be \$1.5 billion/year. The health care cost savings if midwifery care were utilized for the 75% of U.S. births would be \$8.5 billion/year (American College of Obstetricians and Gynecologists, 2000). In light of these facts, can nurse midwives ethically support offering elective Cesarean sections to healthy women?

Background

The growing normalization of caregivers' recommendations and women's requests for Cesarean birth outside of clear, compelling and well-supported medical indications constitutes a profound cultural shift. It involves both a loosening of criteria for various medical indications and consideration of surgical birth without any medical indications at all.

In the spring of 2004, The Maternity Center Association (MCA) developed and published the consumer booklet, "What every pregnant women needs to know about Cesarean section." The Maternity Center Association is the oldest national U.S. organization advocating on behalf of mothers and babies. It was established in 1918 as a national voluntary health agency to improve the maternity care system. The MCA invited many national nonprofit organizations to join in developing the brochure and more that 30 of these groups participated. The systematic review was directed by Carol Sakala, PhD., MPH, director of programs at the Maternity Center Association; hundreds of articles were reviewed and relevant outcomes were assessed to provide the background research for the development of the consumer booklet (Maternity Center Association, 2004).

The American College of Obstetrics and Gynecology (ACOG) Committee Opinion 289, now introduced as an ethics opinion entitled, "Surgery and Patient Choice," suggests that a physician and his/her patient have an obligation to weigh the benefits and risks of cesarean surgery (ACOG Committee Opinion #289, 2003-2004). Opinion 289 states that after a risk/benefit discussion the physician can be confident that informed consent has been provided, and thus may support the patient's choice of an elective Cesarean surgery as the mode of birth for a healthy pregnancy, (Minkoff & Chervenak,

2003). Lack of evidence that compares the benefits and burdens of elective c-sections versus vaginal births is the stated basis for their conclusion. As a result of this ACOG opinion, elective Cesareans are now a legitimate topic for discussion between an obstetrician and a pregnant woman in the United States.

ACOG Opinion 289 states that if the physician believes that performing a Cesarean delivery “promotes the overall welfare of the woman and her fetus more than vaginal birth, he or she is ethically justified in performing a Cesarean delivery.”

ACOG defends their opinion in a letter to the editor in the *Washington Post* on February 14, 2004 (Zinberg, 2004). The author states that “...In the absence of data on the long-term risks and benefits..., no single, correct response exists for a physician confronting such a patient request”. It is further stated that “The jury is still out on whether elective cesarean will become a standard of [care] or commonplace within the delivery room.”

In response to ACOG Opinion 289, a coalition of national groups issued a joint press release in November 2003, “Elective Cesareans Place Mothers and Babies at Risk” (American College of Nurse-Midwives Press Release, 2003). The organizations were: American College of Nurse-Midwives (ACNM), Lamaze International, Doulas of North America (DONA), the Coalition for Improving Maternity Services (CIMS), and the Association of Nurse Advocates for Childbirth Solutions (ANACS). Mary Ann Shah, immediate past President of ACNM and Deanne Williams, Executive Director of ACNM, contributed an article to the May/June, 2003 issue of *Journal of Obstetric, Gynecologic, and Neonatal Nursing* entitled, “Soaring Cesarean section rates: a cause for alarm” which called on all health care professions to “proceed with caution” (Williams & Shah, 2003).

In an invited commentary to the *Journal of Midwifery and Women’s Health (JMWH)*, 49:2, entitled, “Cesarean Section on Demand: Round One”, Shah and Williams, promote informed decision making to avoid the mistakes of the past ‘when practice by convenience, without evidence to support the claimed benefits, has been found to put the lives of women and babies at risk...’ (Shah & Williams, 2004). The International Cesarean Awareness Network, Inc. (ICAN) declared April 2004 as Cesarean Awareness Month and adopted a burgundy ribbon as the symbol of Cesarean awareness to be worn upside down to symbolize the state of distress at the number of preventable and unnecessary Cesareans (Summers, 2004). *JMWH*, 49:2, takes an assertive stand in educating both providers and consumers about cesareans with two articles: one, “Counseling Women about Elective Cesarean Section”, and the other consumer-oriented piece, “Should I have a C-Section?” (Leslie, 2004; Share with women, 2004).

While ACOG suggests that an elective Cesarean is plausible because there is an “absence of significant data on the risks and benefits of Cesarean delivery,” there is, however, evidence about the risks of separate components of cesarean surgery vs. vaginal birth. The Maternity Center Association, in collaboration with a group of leading national maternal child health organizations, sorted through available research to help pregnant women make sense of the conflicting messages about the benefits and burdens of Cesarean surgery. (Maternity Center Association, 2004).

One difficulty in the research has been that individual studies comparing different ways of giving birth tend to focus on a small number of possible effects. The MCA project reviewed hundreds of relevant and better quality studies to help women

understand the full range of concerns that are at stake with decisions about how to give birth. There are 33 areas where Cesarean section was found to involve more risk than vaginal birth. These areas are further broken down into level of risk ranging from very high to very low. Areas considered being of moderate to very high risk for the mother include: hemorrhage, pain, infection, placental implantation problems in future pregnancies. Concerns about effects of Cesareans on babies include moderate to high risk for: respiratory problems, accidental surgical cuts, not breastfeeding and asthma (Maternity Center Association, 2004). Mental distress is examined in several studies which found that women with spontaneous vaginal births scored better on mental health scales for anxiety, depression, and somatization. The vaginal birth mothers experienced an increase in self-esteem (Fisher & Astbury, 1997). There is no difference in any of the psychological measures between planned and unplanned cesarean groups studied.

The Dilemma of Autonomy in Informed Consent

Traditionally, four general moral principles are applied to particular ethical problems: autonomy, beneficence, nonmaleficence and justice. These principles are grounded in Kantian deontology, Mill's utilitarianism ((Mappes & Degrazia, 2001), Judeo-Christian morality and the Hippocratic Oath. Autonomy is, basically, the capacity to make and act on one's own decision. However, the conception of autonomy that has emerged in bioethics, especially in the matter of informed consent, seems much narrower.

The ethical dilemma of elective Cesarean involves confusion about what constitutes informed consent (Mappes & Degrazia, 2001). The informed consent process can be analyzed as containing three elements: information, comprehension, and voluntariness. Of course, the motives for obstetricians are not to do harm to either mother or fetus when they decide that an elective Cesarean is an ethical choice. But in a typically paternalist physician-patient relationship, the physician might present only information on risks and benefits of a procedure that he or she thinks will lead the patient to making the 'right' (i.e., the physician-supported) decision regarding care. How well can we expect the surgically trained obstetrician to present the risks and benefits of natural childbirth? It is rare that medical residents or nursing students participate in a socially supported family birth even once in their training. Female medical residents often choose elective Cesareans for themselves (Al-Mufti, McCarthy & Fisk, 1996).

Is the obstetrician likely to anticipate and respond in an informed way to several nonmedical situations that may influence a woman's consideration of an elective Cesarean? They are concerns about pelvic floor disorders, profound fear of childbirth, and convenience. The fact is that research does not support the claim that a Cesarean birth prevents pelvic floor disorders such as incontinence. Incontinence in later life seems to be related to other health factors, such as excess weight and smoking rather than mode of birth (Burgio & Zyczynski, 2003). A large study of nulliparous nuns found no significant pelvic floor compromise between the nuns and women who have given birth vaginally (Buchsbaum, Chinn, Glantz, & Cuzick, 2002).

Extreme fear of childbirth that is not addressed by the physician may lead women to choose a cesarean. A small proportion of women, both first-time and experienced mothers, have an extreme fear of childbirth (Maternity Center Association, 2004). It is normal for an expectant mother to experience some degree of fear and anxiety, but what

about a woman who has deep fears of vaginal birth? The practice of identifying factors that would make a woman feel safe during labor and vaginal birth and then ensuring their provision may remove initial fears of loss of control. Psycho-therapy sessions can help many women to explore and overcome their fears. Participation at a vaginal birth which provides continuous support throughout labor may alleviate fears of powerlessness and isolation (Hodnett & Gates, 2004).

Autonomy Analyzed in Gender Studies Ethics

Gender studies contributions to bioethics examine an awareness of the effects of race, class, gender, ability and sexual orientation in the distribution of power in a context of medical care, rather than a narrowly construed understanding of autonomous choice. Feminist writings on reproductive technology highlight the ways in which limited knowledge and power differences between the 'experts' and women influence autonomous decision making (Mackenzie & Stoljar, 2000). The low social status given to activities such as labor and birth alter the ethical landscape of health care practices. The lack of autonomy for women and their families in decision-making that surrounds birth are reflected in the structure of hospitals that remove babies from mothers at birth and place medical routines above human connections between mother, baby and new families.

The work of Carol Gilligan in the field of cultural feminism suggests that women communicate differently than men. In her research she finds that women include a variety of broad social influences as a basis for their decision making (Gilligan, 1982). Women take into account emotional connections between people. Such differences highlight the disadvantage women experience in the linear and logical world of obstetric decision making that affect birth, babies and thus future generations. Although there are many female obstetricians in the United States, they are socialized within the obstetric medical milieu which fosters linear decision-making (Wagner, 1994).

Autonomy focuses on the individual and free will. Institutional and provider culture and beliefs about the best way to give birth have influence on the difference in numbers between vaginal births and Cesareans. Obstetricians are trained to be surgical experts. In a large study of 171,000 births in New Jersey, obstetricians (OBs) were divided into groups according to whether the OB had a low, medium, or high c-section rate. The low rate OBs were more likely to attend women who were <20 years old, black, had Medicaid, smoked and drank alcohol. Medium and high-c/section rate OBs performed markedly more c/sections in every category (Li & Rhodes, 2003). The MCA report states "... an individual woman could reduce her risk [of Cesarean] by selecting a caregiver and birth setting with a cautious practice style..." Should practice style be part of an elective cesarean interpretive discussion between a woman and her obstetrician? Is this a valid component of informed consent?

There is apparently no thought given to the positive effects of labor on mother and baby; the increase in a woman's self-esteem from having a socially supported birth experience; the potential for effective bonding and breastfeeding; the health of the newborn; and the baby's human touch connection to the world.

Conclusion

A broad, humanistic approach to bioethical principles will need to enter the debate. The nurse midwifery model of care should be utilized to foster health promotion and active participation in prenatal care decision making. Issues related to autonomy and informed consent require examination within the context of women's actual health care experiences. Table 1. includes considerations to make an informed decision:

Table 1: Considerations to Make an Informed Decision:

Your legal right to make informed decisions
The risk and benefits of surgical delivery compared with vaginal birth
Your personal values and preferences on these matters
The options available to you through your insurance and in your community

(Adapted from MCA, April 2004)

The over use of surgical technology has not improved health care anymore than constant email, cell phone contact, and PowerPoint have improved the quality of communication. ACOG's conclusion that elective Cesarean is an ethical choice is simplistic. Midwives will have to step into the current debate and take a stance that addresses the complexity of women's autonomy and informed consent within the patriarchal hierarchy of reproductive health.

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