Cesarean Section on Demand

Is It Ethical?

Michael C. Klein, MD, CCFP, FCFP, FAAP (neonatal-perinatal)

As presented at the University of Toronto's Family Medicine Forum (November 2004)

The ethical issues

While some American professional organizations may sanction pre-emptive Cesarean section (CS), the Society of Obstetricians and Gynaecologists of Canada (SOGC) states that vaginal birth is preferred, as it is the safest option for most women. The SOGC also states that vaginal birth carries with it less risk of complications in current and subsequent pregnancies than CS.

While patient choice and autonomy are important, so is a truly informed choice. And to reach an informed choice, time is required. Decision-making is often a dynamic process that requires more than one physician visit and likely well more than an hour of discussion.

Pelvic floor fears

It is true that women are concerned about bowel, bladder and sexual functioning and they are being bombarded with information on these elements—as are we professionals. But to reduce childbirth to plumbing is unfair and many of the studies are flawed due to their short duration.

Urinary incontinence (UI) is easy to measure, but the positive aspects of childbirth are not and are easily ignored in favour of the new "science." Vaginal childbirth can be growth-promoting, joyous, maturational and a powerful shared, but admittedly difficult and occasionally traumatizing, experience.

So, how should we weigh the vastly different experiences of having a child vaginally versus by CS? The answer—we get through CS and do a good job of supporting the family, but it is usually not the celebration that vaginal childbirth can be.

The research shows that at one year post-partum, women are marginally better off after CS in terms of UI. However, the baseline level

Gail's case

- Gail, a 37-year-old nulliparous woman presents with a request for a pre-emptive Cesarean section (CS).
- She says she has been following the recent press and that well-known celebrities have decided not to have a vaginal birth and been able to easily find a doctor to honour their request.
- Further, she tells you urinary incontinence and trouble with her sex life is not worth the joys of natural childbirth.
- While such requests used to be unusual, they no longer are; 1% to 3% of pregnant women request CS.

Dr. Klein's point of view

A society focused on convenience, short-term gratification and some very real job and family issues make the process of informed consent a challenge.

In the end, the professional must cover the full scope of issues and do it well. Failing this, informed consent is not possible and professional ethical obligations will not have been met.

of UI is about 10% in a nulliparous population and the difference in vaginal versus CS may be in the order of 16% for women who have had only CSs and 21% for those having only vaginal births. And for moderate or severe UI, the corresponding differences are 4%, 6% and 9% in nulliparous CS and vaginal births, respectively.

1% to 3% of pregnant women request CS.

Most flatal/fecal incontinence is related to forceps. And almost all sexual issues seen early postpartum are gone by six months, except again for those related to difficult forceps.

But difficult forceps and their pelvic floor consequences can be avoided by opting for CS during labour. Therefore, it is not necessary to make a pre-emptive CS decision in advance in order to avoid forceps. It is only necessary for the woman and her doctor to understand each other.

Maternal morbidity

Overall maternal health and health in the present pregnancy and future pregnancies is clearly better in vaginal birth. In the present climate of restricting vaginal birth after CS, one CS is committing women to subsequent CSs, with increase in associated problems in placentation (previa, accrete, percreta, abruptions) and infertility, ectopics, stillbirth and bowel obstruction due to adhesions. And the CS excess surgical morbidity due to infection, surgical mishap, bleeding and excess rehospitalization makes vaginal birth the safest option.

Newborn morbidity

The rare benefits of CS are offset by excess respiratory distress, persistent pulmonary circulation, special care baby unit admissions, future asthma and excess feeding problems.

Fear of childbirth

This is the big one. It is based on genuine fear, often based on misinformation and separation from family and supports. And it can be obviated by discussion, learning the basis of the fear, real and imagined.

Pain management planning can be very helpful. And for some women, such as those with a history of sexual abuse, CS may be the best option. Dx

Dr. Klein is an Emeritus Professor of Family Practice and Pediatrics, University of British Columbia, and an Honorary Staff Member, Children's and Women's Health Centre of British Columbia, Vancouver, British Columbia. For more information on this article, Dr. Klein can be reached via e-mail at *mklein@interchange.ubc.ca*.