

## Elective abdominal delivery — should mothers have the right to choose?

Elsewhere in this edition (p. 257), we publish an incisive commentary by Alan Rothberg on caesarean section rates in South Africa. Caesarean section, technically a fairly simple and straightforward surgical procedure, has a long history of generating debate. A current argument is between the conventional position that caesarean section should only be performed for medical indications, and the opposing view that, all things being equal, a pregnant woman ought to be able to choose to deliver abdominally purely for reasons of convenience. The latter view derives largely from the growing evidence in the literature that elective caesarean section (ECS) in experienced hands and in the absence of contraindications can be almost as safe for mother and child as a vaginal delivery.

Maternal mortality from ECS has become an extreme rarity, and is no longer sustainable as an argument against the ECS option. In the April 2003 edition of the *Journal Article Summary Service*, editor and publisher Athol Kent ([atholkent@mweb.co.za](mailto:atholkent@mweb.co.za)) observes: 'With the incidence of 1 death in 78 000 women as quoted in recent British figures, plus data from Israel reporting ECS being safer than a vaginal delivery ... morbidity has replaced mortality on the negative side of the argument.' Kent goes on to note that 'those arguing in favour of ECS make the point that a woman's decision to labour may end in an emergency CS with its attendant risks, whereas an ECS removes such risk. Where CS rates are already high because of low tolerances for intrapartum variables, it may be statistically advantageous for a woman to opt for an ECS.'

Granted. But women may have their own reasons for choosing ECS, based on the prevailing local cultural norms and beliefs. Brazil, with a caesarean section rate approaching 90% in the private sector, is a case in point, albeit an extreme example. One Brazilian obstetrician writes: 'I have been put under pressure to perform caesarean section many times, from patients, husbands, and relatives. Some unjustified fears cause this situation, including the fear of fetal distress during labour, the fear that a vaginal delivery will ruin the woman's sex life, and the idea that a caesarean section is better since it is the preferred form of delivery for rich women in our country.'<sup>1</sup> Nuttall agrees, pointing out that in Brazil 'women's bodies are perceived as sexual rather than maternal and the genitals as being for sexual intercourse rather than for childbearing'.<sup>2</sup>

In Western societies, Kent believes ECS is promoted in part by 'women's expectations of having fewer children at a later age, plus greater longevity, [which] have raised quality-of-life issues that are different to those of a generation ago, [coupled with] a major change in the attitude of the profession towards maternal autonomy ... and cooperative and informed decision making'. Increasingly, doctors all over the world are complying with women's requests for ECS. An audit at one hospital in a wealthy suburb in the UK showed that 14% of caesarean sections were performed solely on maternal request. The proportion of mother-initiated surgical intervention ballooned to 72% when patients with a previous caeser who declined a trial of labour were added to the total.<sup>3</sup>

In the real world, far more obstetricians face malpractice litigation for failing to do a caeser than for doing one. A doctor who declines a request for ECS and is not in a position

subsequently to justify that decision faces considerable difficulty should something untoward happen during labour. Evidently, the community sees the caesarean operation as offering greater security for a good outcome than vaginal birth. Unhappily, some doctors will apparently also counsel women to accept ECS solely for their own convenience or benefit.

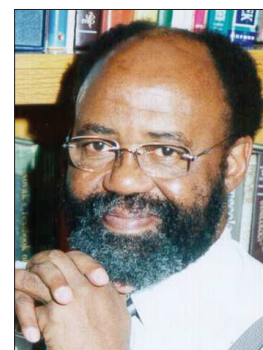
ECS is closely linked to socioeconomic conditions. It is more prevalent in wealthier countries, communities and suburbs, which also happen to have the lowest perinatal, infant and maternal mortality rates.<sup>4</sup> Accordingly, in South Africa ECS is prevalent in the more affluent private sector. The converse is true in the largely under-resourced and overcrowded public sector. Here, lack of operator experience and/or appropriate facilities for intra- and postoperative care often means that even emergency caesarean operations cannot be performed, something that has been identified as a significant contributor to the country's unacceptably high levels of maternal and perinatal loss.

ECS contributes to increased caesarean section rates, but debates about caeser rates are probably as false as they are fruitless. There is no such thing as an evidence-based caesarean section rate. Since the first-ever caesarean operation, caeser rates have risen steadily with the evolution of new knowledge, new indications, and new perspectives along with the increased safety of operative intervention. 'The rate of caesarean sections is not the issue,' according to Groom and Brown. '[Caeser rates] differ hugely between and within countries and reflect numerous variables. What matters most is that those women who need a caesarean section get one under optimum conditions and that those who do not need a section get appropriate care and support through labour.'<sup>4</sup>

That said, it is important to acknowledge that ECS is not entirely risk-free. Febrile morbidity and sepsis, wound infection, blood loss, operative injury, predisposition to placenta praevia and uterine rupture, and anaesthesia-related complications may be uncommon, but always remain a potential threat for mother and baby. The likelihood is that most women will always prefer to have their babies naturally, everything else being equal. It is unethical for a doctor to recommend operative delivery under false pretences, without a genuine medical or obstetric indication. But where a woman has been appropriately counselled as to the risks and the alternatives, and provided there are no contraindications to the operation, she should probably have her wish if she insists on an elective caesarean delivery.

**Daniel J Ncayiyana**

*Editor*



All of the following references were accessed on the eBMJ on 17 March 2005 at <http://bmj.bmjournals.com/cgi/content/full/320/7241/1072/a>

1. Quadros LGA. Brazilian obstetricians are pressured to perform caesarean sections. *BMJ* 2000; 320: 1072
2. Nuttall C. The caesarean culture of Brazil. *BMJ* 2000; 320: 1072
3. Eftekhari K. Women choose caesarean section. *BMJ* 2000; 320: 1072
4. Groom K, Brown SP. The rate of caesarean sections is not the issue. *BMJ* 2000; 320: 1072.