

The WOMEN'S Health Activist®

A Voice for Women, A Network for Change

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Cesarean Section When It's Not Medically Necessary: Safe Practice or Risky Decision?

by Kathi Carlisle Fountain & Kristen Suthers, Ph.D.

Recently, you may have read news articles stating that cesarean sections pose no extra risk to women who are giving birth,¹ or that “it may be reasonable for many women to deliver by caesarean section even without a medical need.”^{2,3} The truth, however, is much more complicated than these misleading sound bites suggest.

In late March, the National Institutes of Health (NIH) convened a state-of-the-science conference entitled “Cesarean Delivery on Maternal Request” to explore the safety of elective cesarean section performed because the woman requested it rather than because it was medically necessary. (There are a range of situations in which U.S. providers typically judge vaginal birth's risks to be to be great enough to necessitate cesarean section — for example, when the baby is in distress or a breech position [feet first].) During the hearing's one and a half days, panelists reviewed the available scientific evidence and listened to comments and questions from advocates, scientists, and members of the health care community. It is clear, based on the evidence compiled by the panel, that very little research exists on the risks associated with cesarean sections that are chosen by the mother rather than being medically necessary.

On the conference's third day, the panel issued a report stating that there

was “insufficient evidence to evaluate fully the benefits and risks” of cesarean sections requested by women. Despite the lack of evidence on this subject, the NIH panel concluded that the risks of natural birthing and medically unnecessary cesarean sections were essentially equal. The National Women's Health Network disagrees — we believe that there is not enough scientific evidence to support the panel's statement on the comparable risks of medically unnecessary cesarean sections and vaginal births.

THE FREQUENCY OF “MATERNAL REQUESTS” HAS NOT BEEN ADEQUATELY MEASURED

The rise of elective cesarean sections was widely discussed at the NIH conference, including the fact that the number of cesarean sections is at an all-time high. In 2004, almost one-third (29%) of all U.S. births occurred as a cesarean section. Yet, it is virtually unknown how many of these cesareans

Features

2

Bio-Identical Hormones

4

Caregiving in the 21st Century

6

What Can the WHI Tell Us About How to Age Healthily? (Part II)

8

Young Feminists

11

Getting Burned: Radiation Exposure from CT Scans

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The National Women's Health Network improves the health of all women by developing and promoting a critical analysis of health issues to influence public policy and support consumer decision-making. The Network aspires to a health care system that is guided by social justice and reflects the needs of diverse women.

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are elective and requested by the mother. Some women choose to have a caesarean section that is not medically necessary because they fear complications associated with vaginal birth, worry that it will stretch the vaginal walls, or want to time delivery so that they will have help when they are back at home.

Hospital records and birth certificates do not clearly identify when a cesarean section is performed without medical reason at the mother's request. The only study to directly assess mothers' choices found that less than one percent of women chose to have a cesarean section that was not medically necessary. The incidence of medically unnecessary cesarean sections seems to be on the rise in the last five years, however, and recent media coverage of this issue has stimulated women's interest in whether this is a reasonable childbirth option.

THERE IS A LACK OF SCIENTIFIC EVIDENCE ON ELECTIVE CESAREAN SECTION VS. VAGINAL DELIVERY

Many women have heard negative stories about how vaginal birth can result in incontinence, sexual dysfunction, or pelvic organ prolapse. But, the NIH panel found only weak evidence connecting these problems to either vaginal or elective cesarean section birth. The best evidence on these birth consequences, labeled as "moderate" by the panel, indicates:

- Women's length of hospital stay is longer for those who have a cesarean section (whether elective or emergency), than for women who experience a vaginal delivery.
- Respiratory problems are much more common for babies delivered by cesarean section, especially those delivered before 39 weeks of gestation.
- Postpartum hemorrhage is more likely for women who attempt to deliver vaginally but have an emergency cesarean section.

CESAREAN SECTIONS CAN INCREASE RISKS FOR MOTHER AND CHILD

Despite the lack of evidence on vaginal vs. cesarean births, we do know that cesareans carry risk for both women and their babies. Cesarean sections require an incision to be made into the uterus; in a subsequent pregnancy, the resulting scar tissue can cause the placenta to attach too deeply (a condition called "placenta accreta") or too low (called "placenta previa") in the uterus. The more children a woman delivers by cesarean section, the higher her risk for placenta abnormalities. Unfortunately, many hospitals and insurance policies increase women's risks by restricting them from delivering vaginally if they have had a cesarean before. As a result, a woman's first cesarean section can limit her to future cesarean sections, and higher risk of placenta problems. Therefore, the NIH panel recommended that women who intend to have more than one child should not have their first child by elective cesarean section.

We also know that pre-term cesarean delivery (e.g. delivery before 39 weeks of gestation) can inhibit the fetus' ability to transition to breathing air, which increases the risk that a newborn will spend time in the neonatal intensive care unit. For this reason, the NIH panel recommended that obs document lung maturity and gestational age before proceeding with an elective cesarean before 39 weeks.

NIH PANEL FAILS TO SET PUBLIC HEALTH GOALS

The NIH panel explicitly rejected establishing optimal numeric goals for the prevalence of cesarean sections such as those set by other public health entities. (The World Health Organization and the U.S. government's "Healthy People 2010" standards both have a goal that no more than 15 percent of all first deliveries should occur by cesarean section.) Instead, the panel concluded that decisions on delivery modes should be

individualized, and the conference statement asserts that: "optimal cesarean delivery rates will vary over time and across different populations according to individual and societal circumstances."

This stance might have far-reaching consequences for researchers who are attempting to track the prevalence, and analyze the safety, of different modes of delivery, as the elimination of numeric goals could reduce the likelihood that these data will be collected and made available. It may also make it harder for individual women who want to use such data to compare providers' track records so that they can select one who is more likely to support their decision to plan for a particular mode of delivery.

CONCLUSION

The NIH panel noted that most of the literature evaluating the risks of cesarean sections fails to distinguish between planned and emergency procedures, making it very difficult to state definitively the risks associated with elective cesareans. The panel concluded that more research is needed to determine the true risks and benefits of elective cesarean sections, and suggested exploring the feasibility of randomized trials.

The NWHN questions the practicality of such a randomized trial of birthing methods; a woman's preference for the type of delivery she wants is extremely likely to affect her birthing experience, and random assignment may skew the results because of participants' dissatisfaction with their assignment. Further, if the trial was restricted to women who have no preference between cesarean section or vaginal birth, it would bias the data, as women participating in such a study are likely to be atypical.

In theory, with good informed consent, elective surgery isn't unethical. But the trend toward elective c section reveals problems with how we deal with childbirth and parenting in the U.S. Women have valid reasons for being concerned about vaginal birth, but the NWHN believes we should address those concerns through research and training to improve women's birthing experiences, instead of turning to abdominal surgery as the solution. For the full report, see <http://consensus.nih.gov/2006/2006CesareanSOS027html.htm>. For NWHN's Fact Sheet, see website: http://www.nwhn.org/publications/fact_details.php?fid=27. -

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Maternity Center Association Update

After nearly 90 years of advocacy, the Maternity Center Association is operating under a new name: Childbirth Connections. The organization recently announced its plans to implement a new name, logo, and website to reflect its contemporary focus of promoting safe, effective and satisfying evidence-based maternity care.

A friend and ally of the Network, Childbirth Connection is a national non-profit organization that's advocated on behalf of pregnant women, mothers and their infants since 1918. Childbirth Connections' mission is to make the childbirth experience as safe and satisfying as possible; to this end, it provides invaluable research and education to American families across the nation. Its ultimate goal is to improve the quality of maternity care available to all U.S. women.

Using a woman- and family-centered approach to the pregnancy and childbirth experience, Childbirth Connection offers a unique perspective and important force to counterbalance changes taking place in the increasingly profit-driven U.S. health care system. Carol Sakala, Childbirth Connection's Director of Programs, identifies this need as the driving force behind the organizational changes. She says, "Child-bearing women and their families are experiencing increasingly harsh and inappropriate care, and our work is needed now more than ever. Our new name and public face position us to continue our long tradition of maternity care quality improvement in the 21st century."

In addition to policy and advocacy leadership, Childbirth Connection also provides education and outreach based on the best available research on subjects ranging from planning pregnancy to choosing caregivers and birth places.

Visit Childbirth Connection's new website at: <http://www.childbirthconnection.org/home.html>. For information on c section, see the resources page at: <http://www.childbirthconnection.org/article.asp?ck=10169&ClickedLink=547&area=27>