CfM Position on the Issue of “Maternal Request” Cesarean Sections: Ill-Advised for Healthy Normal Mothers and Babies

Adopted by the Board of Directors of Citizens for Midwifery, 6 June 2006

Citizens for Midwifery supports the rights of women to autonomy and bodily integrity regarding maternity care and birthing choices. Such choices should be made in the context of full disclosure and honest, unbiased and complete informed consent processes, which are rarely provided for cesarean sections. Cesarean sections for no medical indication, by “maternal request” or not, add serious risks, unnecessarily use scarce and costly healthcare resources, and entail extra costs born by the public. Citizens for Midwifery supports maternity care that nurtures and enables normal birth with minimal interventions. For healthy mothers and babies, replacing normal healthy birth with major abdominal surgery almost certainly would have enormous unintended and harmful consequences, and therefore is ill-advised.

Rationale and Supporting Information

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Summary

The issue of “maternal request” cesarean sections, also referred to as “elective” or “patient choice” cesareans, has become a topic of increasing public and medical debate.\textsuperscript{1-5} Contrary to popular media
coverage, a new survey shows that extremely few women actually request cesarean sections, and increasing evidence shows that cesarean sections are not “as safe as” vaginal birth for normal deliveries. However, obstetricians are performing cesarean sections for no medical reason at a small but increasing rate, even though most of the women believe there is a medical reason. Cesarean sections for no medical reason are costly, deceptive and harmful to mothers while benefiting hospitals and obstetricians, and reflect a lack of informed consent.

**Misuse of data and terminology**

Various terms that are not equivalent have been used interchangeably, adding to misunderstanding. In medical terms, an “elective” cesarean section is any performed that is not an emergency procedure; this includes cesareans performed on recommendation by the doctor for a variety of risk factors and situations such as “failure to progress,” along with the very few performed at the request of the mother. Elective cesareans include those performed for “no medical reason” or “no indicated risk.” However, the term elective has also been used, erroneously, to mean “maternal request” cesarean. Technically, “patient choice” and “maternal request” cesareans are subsets of “elective” cesarean sections. Because our references use these terms inconsistently, they are noted with quotation marks in this document. The term maternal request cesarean suggests that without consideration of any possible risk factors or other information from the doctor, the mother independently requested a cesarean section, especially starting early in the pregnancy. This term, “maternal request” most accurately denotes what the issue is really about.

While medical records can only provide information on which cesareans were performed for “no medical reason,” whether any cesarean was by “patient choice” or by “maternal request” can only be determined by asking the mother. In March 2006 Childbirth Connection released results of a new survey of mothers that included questions about cesarean sections – the first direct research on this issue in the U.S. The survey results showed that out of 1315 women surveyed nationally who could have chosen a primary cesarean only one (.08%) did so. Of the 252 mothers surveyed who actually had primary cesarean sections, this same woman was the only one (0.4%) who reported that she actually requested her cesarean. As stated by Childbirth Connection: “These first national results from women themselves clarify that demand from mothers for planned primary cesareans with no medical reason is virtually non-existent. Maternal request for such cesareans is not a factor in escalating cesarean rates.”

In addition, available data illustrates that the popularized phenomenon of women increasingly seeking “maternal request” or “patient choice” cesarean sections are essentially a figment of our cultural imagina-
Headlines such as “‘Patient Choice’ C-section Rate Rises by 36%”\(^8\) demonstrate a serious misrepresentation of the data provided. The headline was based on information from hospital discharge data which shows only that there has been an increase in no indicated risk cesarean sections, that is, cesarean sections performed prior to labor for no recorded medical reason. The data does not include any information about women’s choices and does not mean that all these women requested cesarean sections as some have asserted.\(^8\)

These increased rates of no indicated risk cesareans likely do reflect the following: women who believe they are following medical advice even in the absence of a medical indication or other risk factor; a very small number of women who choose an elective cesarean, many of whom likely lacked complete information; women who suffer from tokophobia, a psychiatric disorder of unrelenting fear of childbirth (for which there is treatment that does not always involve cesarean section); and underreporting of obstetric factors and interventions (a known problem with birth certificate and hospital discharge data).\(^9\)-\(^13\)

In March 2006, the National Institutes of Health held a State-of-the-Science conference on “Cesarean Section by Maternal Request” even though they had no actual data regarding mothers requesting cesarean sections. Evidence from birth certificates does indicate that as of 2001 obstetricians were performing a small but increasing percentage of primary cesarean sections for no medical reason, comprising about 2% of all births,\(^14\) and these have been claimed as “maternal request” cesareans. Obstetricians are trusted experts, and women assume that they “need” the procedure when an obstetrician offers a cesarean section; by acquiescing they believe they are following medical advice even if there is no actual medical reason for a cesarean section. While this might be considered a “patient choice” or even a “maternal request” cesarean, from the mother’s point of view it was not necessarily at her request or even by her choice. In fact, Childbirth Connection found that nearly 10% of women felt pressured by their physicians to have cesareans.\(^6\) The NIH used our tax dollars for a conference to address an almost non-existent trend, while failing to address the rapidly rising rates of cesarean section and other costly and often unnecessary interventions.

Headlines and government agencies should be asking why obstetricians are performing unnecessary surgery on healthy pregnant women for no medical reason, not furthering the fiction of increasing rates of “maternal request” cesareans.

What about informed consent?

Maternity care providers are legally obligated to obtain “informed consent” from the woman before performing a cesarean section or any other medical intervention (unless in a life-threatening emergency).
Citizens for Midwifery is aware that meaningful “informed consent” is largely missing from maternity care in general, and believes that women are not being given adequate and unbiased information about the risks and benefits of cesarean sections. Data from Childbirth Connection confirms this assertion.

In the case of “elective” cesarean sections, only the mothers themselves can tell us what kind of “informed consent” process was provided to them, if any. The Listening to Mothers II Survey conducted by Childbirth Connection (2006) makes it clear that women want to be fully informed, but that they are not receiving complete and accurate informed consent before cesarean sections are performed. Childbirth Connection found that “81% of mothers stated that before consenting to a cesarean section, it is necessary to know every possible complication, and 17% felt it necessary to know most complications.” However, close to half of mothers surveyed who had cesareans were poorly informed about specific complications of cesarean section and could not answer correctly questions regarding the risks and benefits of cesareans.[6]

For women to be adequately informed, they should be provided with information that is complete, accurate and unbiased, based on research evidence, and covers the known and potential risks and benefits of the procedure and of alternatives, including doing nothing. In addition, women should be informed of any potential conflicts of interest for the hospital, care-provider, or person providing the information. They should have adequate time to read, understand and discuss the information before giving or refusing consent, and informed refusal should be accepted respectfully. Furthermore, women desiring a cesarean section due to fear of childbirth (tokophobia) should be offered information, therapy and support before any decision about a cesarean section is made.

**Economic and legal issues are promoting more cesarean sections**

Although most obstetricians sincerely care about their patients and do their best to provide what they believe is the best care, non-medical pressures may influence physicians to perform more unnecessary cesarean sections. Economic and legal factors, including liability insurance coverage, liability fears, hospital economic management, efficiency and convenience, and insurance reimbursement rates are influential factors. Promoting “patient choice” cesarean sections is a convenient way to increase the number of scheduled cesarean sections, the most cost-efficient of all for hospitals and obstetricians.[15] Citizens for Midwifery believes that legal and economic concerns should never justify performing unnecessary, costly and risky major abdominal surgery on healthy women.
Physician beliefs influence patient decisions

The beliefs, opinions and attitudes of the medical staff toward cesarean sections almost certainly play an important role in women’s decision-making processes, although research on this topic is not yet available. As trusted experts physicians play key roles in convincing women that a cesarean section is medically necessary, or that a cesarean section is desirable or even preferable to vaginal birth, despite substantial evidence that all cesareans increase harmful risks for mothers and babies. Following are examples of beliefs and opinions touted as “fact” but not supported by the best evidence available, beliefs and opinions which physicians and their organizations have used to try to convince women that “patient choice” cesarean sections are a good idea:

- Obstetricians make false assertions about safety

  Representatives of the American College of Obstetricians and Gynecologists (ACOG) have publicly claimed that cesarean sections are just as safe as vaginal births, and therefore women should be given a choice.[11] However, the majority of the research clearly debunks this assertion.[16-19] This research shows that, when compared to hospital-managed vaginal births, cesarean sections are associated with higher rates of maternal death, infection, hemorrhage, organ injury, anesthesia complications, re-hospitalization; slower recovery and poorer health; increased rates of secondary infertility; increased risk in future pregnancies of still births, scar ruptures, and life threatening placenta problems; risks to future general health associated with scar tissue; increased risks to the infant of respiratory problems, and persistent pulmonary hypertension leading to increased NICU admittance. Some weak research suggests that women having planned, pre-labor cesarean sections may be at slightly lower risk for some of these adverse outcomes. However, almost all of these potential adverse outcomes are unique to cesarean sections. Cesarean sections also decrease the rate of breast-feeding initiation and long term breast feeding success.

- Cesarean sections do NOT protect against pelvic floor problems

  Representatives of the American College of Obstetricians and Gynecologists (ACOG) also have used the public media to promote “patient choice” cesarean sections for the purpose of preventing or avoiding incontinence problems later in life.[1,3] Their statements have misrepresented the medical research on incontinence and have deemphasized long term effects and rates of incontinence occurring in all women including those who have never been pregnant. Furthermore, their statements have failed to account for the effects of unnecessary but widely used medical practices and
interventions during labor and delivery, such as forced pushing on command, episiotomy, lithotomy position, and assisted delivery (forceps and vacuum extraction) that can contribute to pelvic floor problems after vaginal birth.\[^{20,21}\] ACOG subsequently used what they claimed was the “demand” for cesareans to avoid incontinence problems to justify an ACOG Ethics Committee Statement that it is ethical for obstetricians to perform cesarean sections for no medical reason.\[^{22}\]

- **Medical management of vaginal birth causes problems**

  Cesarean section outcomes typically are compared to hospital-managed vaginal birth outcomes. Women attempting to give birth vaginally in the hospital are subject to a broad spectrum of practices and interventions\[^{9}\], most of which have never been shown to be either safe or effective or have been shown to be harmful or ineffective, and all of which can and often do interfere with the progress of labor, leading to avoidable complications and cesarean sections.\[^{21}\] Complications in these vaginal births, including pelvic floor dysfunction and incontinence as well as cesarean sections, are then blamed on “vaginal birth” instead of on hospital management practices and interventions. Researchers should be comparing no medical indication cesarean section outcomes with outcomes of healthy, normal, undisturbed vaginal births attended by midwives in out-of-hospital birth settings. These births occur with the least possible amount of interference and intervention.\[^{23}\] providing data on vaginal birth itself rather than vaginal birth disturbed by interventions and management protocols.

**Physician bias**

A review of the current medical literature on obstetricians’ attitudes toward elective cesareans found that up to 84.5% perform or are willing to perform “patient choice” (maternal request) cesarean sections for no medical reason.\[^{4,24-29}\] In fact, between 21.1% and 31% of obstetricians would choose a cesarean section in place of an anticipated uncomplicated vaginal birth for themselves or their partner.\[^{4,26}\] Women, on the other hand request cesarean sections at the significantly lower rate of .08%.\[^{6}\] Given the misinformation, misrepresentation and misinterpretation of research promoted by the American College of Obstetricians and Gynecologists and many obstetricians, these findings are not surprising. However, obstetricians’ preference for cesarean sections is likely to lend serious bias to the information they present to their patients. As one doctor stated, “it may be difficult sometimes to separate patient choice cesarean delivery from doctor’s choice cesarean delivery.”\[^{27,30}\]
The Myth of Choice

Pro-elective cesarean articles have touted “patient choice” (maternal request) cesarean section as a women’s rights issue.[1,31] However, the medical profession has worked to obstruct women’s rights when it comes to issues such as access to home birth, vaginal birth after cesarean section (VBAC), and midwives[30, 32, 33] that are all strongly supported by research evidence as safe, low-cost and effective options for most healthy low-risk women. In contrast, physician-promoted “elective” cesarean sections cause harm and are very expensive. It is hypocritical to argue “patient choice” and autonomy so selectively.

National Institutes of Health on “Cesarean Section by Maternal Request”

The National Institutes of Health (NIH) convened a panel for a State-of-the-Science conference in March 2006 on “Cesarean Delivery on Maternal Request” (CDMR). According to the draft report (posted March 29, 2006), the panel’s overall conclusions are: “The available evidence and data comparing risks and benefits of [planned vaginal delivery] PVD and CDMR are sparse and provide few clear conclusions.” And: “There is insufficient evidence to evaluate fully the benefits and risks of CDMR as compared to PVD, and more research is needed.”[34] On this basis, the report recommends that if the mother initiates the topic, the doctor should engage in individualized discussion with her, which can lead to a decision that the cesarean is the best choice for her. In other words, the very physician who stands to benefit from a decision to perform a planned cesarean on maternal request section is responsible for counseling the woman. The ethical issues of legal and economic influences and biases were barely mentioned, and no provision was included for how a woman might determine if her physician was giving her complete and accurate information.

Additionally the report omitted important research and confounding factors of CDMR risk factors, while criticizing existing research for failing to account for confounding factors. For their report, the panel declined to include mention of research or clinical findings that did not meet their rigid and narrow criteria for inclusion in the systematic review, even though published research outside their narrow focus would have clarified several key questions. Conference participants, however, did raise many concerns based on a variety of published research and clinical experience that suggested areas where additional research clearly is needed. Unfortunately, participant contributions are only marginally apparent in the posted report. For example, early in the report the panel states: “A number of potential outcomes were not assessed due to a lack of data availability or clarity. Among these were hospital readmissions, adhesions [caused by the cesarean scar], and chronic abdominal and pelvic pain syndrome;”[34] in fact these were some of the concerns brought up by conference participants. Inexplicably, the panel failed to include these unknown outcomes as...
potential adverse outcomes for CDMR in their list of recommendations for future research, or as considerations for decision-making.

In the research the panel did include, the confounding effects of common interventions for planned vaginal birth were essentially ignored. While “planned vaginal births” included all unplanned cesareans, the panel failed to fully acknowledge the confounding effects of typical labor and birth management practices in causing complications, leading to higher rates and risk factors for cesarean sections for planned vaginal births.

The panel also omitted any mention of the new Listening to Mothers II survey data,[6] the only hard data now available regarding the prevalence (actually lack of prevalence) of “maternal request” cesarean sections in the US, even though that data was provided to all of the panel members and the authors were conference participants. Instead the panel relied on birth certificate and hospital discharge data, which, as pointed out above, does not contain any information regarding maternal intentions or requests. The result: the NIH report includes data that is inaccurate and provides an artificially inflated incidence of CDMR.

Finally, the report includes almost no hard numbers regarding risks and benefits. Even if risks of one outcome or another might be slightly more or less for planned vaginal vs. planned cesarean, without knowing the actual magnitude of the risks to start with, or the magnitude of the differences, the report is essentially useless for evaluating what the findings might mean for an individual woman seeking information on which to make a decision.

“Cesarean Section on Maternal Request” is a diversion from the real issues

The current focus on the fictitious trend of “patient choice” cesarean sections diverts attention from the very real and serious fact that the U.S. has the highest rates of cesarean section ever, at 29.1% of births in 2004 and increasing.[35] The U.S. rate is nearly twice the 15% rate for cesarean section recognized as reasonable by the World Health Organization.[36] In contrast, low-risk women attended by midwives in homes and birth centers end up with cesarean sections only 3-6% of the time, while low risk women in hospitals have cesareans around 20% of the time, with no differences in infant mortality outcomes.[37, 38] Cesarean sections are associated with significant risks of immediate and long term harm to mothers and babies and cost much more than vaginal births — an economic burden on government, businesses and families.
“Cesarean Section on Maternal Request” is one more harmful obstetric fad

So-called “patient choice” or “maternal request” cesarean section, as it is being promoted, is just one more of many ill-conceived maternity care “Fads and Fashions.” Chloroform, “twilight sleep,” episiotomies, separating mothers and babies at birth, and replacing breastfeeding with artificial baby milk, among other practices, were all enthusiastically adopted as standard practice for normal healthy mothers and babies without good supporting evidence and without considering unintended consequences. History shows that, once embraced by physicians, the practices became policy and almost impossible for childbearing women to avoid. Only after decades of suffering by women and babies were efforts initiated to move away from these discredited practices. The evidence is clear that cesarean section for no medical reason includes harm and risks greater than vaginal birth with proven appropriate care. Citizens for Midwifery believes that the idea of cesarean section on maternal request, should it be accepted as “the thing to do,” would be just one more fad that, after becoming the “norm” and injuring untold mothers and babies, will years later be discredited as dangerous. The normal physiological process of birth is very complex yet successful. The evidence shows that normal healthy women give birth safely and successfully to healthy babies when they have woman-centered midwifery care.[23,39-41] For healthy mothers and babies, replacing normal healthy birth with major abdominal surgery almost certainly will have enormous unintended and harmful consequences and therefore is ill-advised.

5. American College of Nurse-Midwives. The REDUCE Campaign: Research and Education to Decrease Unnecessary Cesarean Sections. 2006 [cited March 21, 2006].

