

## THINKING THROUGH THE DEBATE ABOUT CAESAREAN SECTION "ON DEMAND"

### PART I: THINKING ABOUT CHOICE

### PART II: THINKING ABOUT RISK

## CONSIDÉRER DANS TOUS SES DÉTAILS LE DÉBAT SUR LES CÉSARIENNES DE CONVENANCE

### PARTIE I : CONSIDÉRATIONS SUR LE CHOIX

### PARTIE II : CONSIDÉRATIONS SUR LE RISQUE

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#### **ABSTRACT**

The debate about choosing Caesarean section when there is no medical indication raises many questions for midwives and other maternity care providers about choice, risk, normal birth and our role in a society where attitudes towards technology are changing. Both the popular and professional literature about this debate and the claims of benefit to fetus and mother need to be examined in a social and political context. Midwives have an important role to play in emphasizing that the safest system of care would support low intervention approaches to vaginal birth for the majority of women. The overwhelming reason women choose Caesarean section is fear and anxiety about birth. The request for Caesarean surgery "on demand" can be seen, in part, as a call to improve care for pregnant women and vaginal birth.

#### **KEYWORDS**

maternal request, Caesarean section, elective, vaginal delivery

THIS ARTICLE HAS BEEN PEER-REVIEWED

#### **RÉSUMÉ**

Le débat sur le choix d'une césarienne lorsqu'il n'y a aucune indication médicale soulève de nombreuses questions pour les sages-femmes et les autres prestataires de soins obstétriques, sur le choix, le risque, l'accouchement normal ainsi que sur notre rôle au sein d'une société dont les attitudes envers la technologie changent. Nous devons évaluer dans un contexte socio-politique autant la documentation populaire que professionnelle sur ce débat ainsi que les prétentions que la césarienne soit dans l'intérêt de la mère et du fœtus. Les sages-femmes ont un rôle important à jouer en faisant valoir un système de soins qui, pour être le plus sécuritaire pour la naissance par voie vaginale favoriserait une approche à faible intervention pour la majorité des femmes. Pour les femmes qui choisissent une césarienne, le facteur décisionnel dominant est la peur et l'anxiété liées à l'accouchement. La demande pour cette chirurgie de convenance pourrait être perçue en partie, comme un appel pour l'amélioration des soins pour les femmes enceintes ainsi que pour l'accouchement par voie vaginale.

#### **MOTS CLÉS**

demande maternel, césarienne, élective, accouchement par voie vaginale

CET ARTICLE FUT RÉVISÉ PAR SES PAIRS

## PART I: THINKING ABOUT CHOICE

### INTRODUCTION

The question of whether Caesarean section (CS) should be available as a “choice” when there is no medical indication for the surgical procedure has aroused a heated international debate, not only in the medical and midwifery literature but also in the popular press.<sup>1</sup> Over the past decade the debate has gone through several rounds, with a great deal of media coverage, particularly in Britain and in the United States. The debate has emerged more recently here in Canada. In recent months the controversy again hit front pages across the country and led to an interesting interaction between the medical press and the media.

In the *Ottawa Citizen* headlines read: “Canadian doctors agree to offer caesarean sections for women ‘too posh to push’”.<sup>1</sup> In the *Vancouver Sun* we had: “C-sections to be available on demand CMA says”.<sup>2</sup> The *Toronto Star* claimed: “C-section? You’ll soon get to choose”.<sup>3</sup> These articles were then followed by a flurry of radio and television coverage, by editorials and letters to the editor.

All of this was stirred up by what appeared to be a misunderstanding of an opinion piece written by Mary Hannah in the March 2, 2004 edition of the *Canadian Medical Association Journal (CMAJ)*.<sup>4</sup> In her article “Planned elective cesarean section: a reasonable choice for some women?” Hannah referred to upcoming guidelines to be released by the Society of Obstetricians and Gynaecologists of Canada (SOGC). By the next day, print, television and radio coverage referred to “new guidelines” as if they had been established by the Canadian Medical Association (CMA). By the end of the day the SOGC had responded by issuing a Media Advisory stating that the CMAJ article had led to confusion. They clarified that no guidelines had been released and that the ethics committee deliberating on the topic was still working.<sup>5</sup> The advisory also clarified that to date “no decision has been made to support elective C-sections” and that vaginal birth is considered the safest option for most women. By the next week, the SOGC had released a strong statement endorsing vaginal birth as the standard of care and linking the debate about Caesarean section on demand to the need for one to

one care of women in labour, strained health care resources and to international health issues.<sup>6</sup> Interestingly there was no media coverage of the release of this statement. Supporting vaginal birth apparently is not news.

This phenomenon of media over-interpretation had already happened in the United States when a position statement by the American College of Obstetricians and Gynecologists (ACOG) that seemed to be characterized by not taking a position drew strong criticism from both sides of the debate.<sup>7</sup> Yet it was reported in the *Washington Post* with the headline “It is ethical for doctors to deliver a baby by CS: even if the mother faces no known risks from conventional labor”.<sup>8</sup>

The inclination of the media to sensationalize the issue of choosing CS, to focus on fashion and convenience as the motivators, and to seek and perhaps create a conflict between medicine and the proponents of “natural birth” needs to be taken into account when dealing with this issue. The potential for misinformation is sobering.

I first became involved in thinking through CS “on demand” when invited by the University of Toronto Maternal and Infant Health Research Unit (MIRU) to debate Nicholas Fisk. Fisk, an obstetrician from London, England, has been one of the foremost advocates of the choice of CS without indication or, as he titled his presentation: “CS just for fun”.<sup>9</sup> I was asked to take the “No” side on the question of whether all women should be offered the choice of CS.

My involvement in the MIRU conference “Choosing delivery by Caesarean: has its time come?” proved to be only the beginning of an ongoing engagement with this subject. The popularity of the topic in both professional and popular circles is an issue worthy of analysis; the debate both reflects and constructs ways that we think about women and birth, about bodies and nature, about the role of science and technology in our lives.

In this article, I will discuss some of the theoretical concerns that frame the question of how midwives might think through the debate and the social context

for the question of CS by choice. This question has highlighted for me how important it is for midwives and all maternity care providers to examine the politics that can influence how we understand evidence, think about choice and risk, and make clinical decisions. I hope to touch on some of the themes and questions that will come up for midwives as they talk with colleagues, the media and clients about CS “on demand”.

## CONFLICT AND PASSION

*“the most politically fraught of operations”*<sup>10</sup>

BMJ Editorial, 1999

*“performing CS for non-medical reasons is ethically not justified”*<sup>11</sup>

FIGO, 1999

*“Elective Primary CS - what's the big deal?”*<sup>12</sup>

ACOG Conference Report, 2002

*“A blatant misuse of power”*<sup>13</sup>

DeMott RK, *Birth*, 2000

*In Canada, there is no law against abortion. It's hard to argue when you think that a woman has the right to have her baby killed, why wouldn't she have the right to have an elective CS?”*<sup>14</sup>

Sommerville M, *Chatelaine*, April 2003

*“The assault on normal birth: The OB disinformation campaign”*<sup>15</sup>

Goer H, *Midwifery Today*, 2002

*“what's good for the goose is good for the gander”*<sup>16</sup>

Fisk N, Grand Rounds, SWCH, 2003

When I first became involved in reviewing the literature, I was struck by how, in the midwifery and medical communities and in the public, this debate is very intense and emotional. The letters to the editor and the opinion pieces are often passionate, sometimes philosophical. Even those seeming to cite the evidence in a dispassionate manner often express a clear ideological position. In both the U.S. and Canada, protests have been held outside conferences discussing the issue.<sup>17,18</sup> Women's health groups and professional associations have put out press releases and position statements.<sup>19,20</sup> Feminist scholars have spoken out on (or been claimed by) both sides.<sup>21</sup>

Although there are many important differences, the intensity of the debate has similarities with other debates about choice: choice of birthplace and choice of abortion, for example.

Why is it that women making choices about their bodies and about reproduction generates such passion and anxiety? I would argue that it is this passion that attracts the media and fuels misinformation and mythologies. I would also pose that, like these other “choice” debates, the subject begins to represent issues far beyond the question at hand, representing world views, philosophies and political positions. Ironically but perhaps revealingly, in an age of evidence-based practice, we are caught up in discussions more dominated by ideology than evidence. Even the call for more evidence, often seen as a self-evident and neutral good, has political overtones. To understand and influence the debate, I think it is important to look at what else is being discussed under the surface of “too posh to push”.

## CHALLENGES FOR CAREGIVERS

One of the most challenging aspects of the debate for some midwives (and many other maternity care providers) is the way in which it can seem to raise a conflict about our underlying philosophies. Many midwives would define themselves as simultaneously advocates and guardians of normal birth and advocates and guardians of choice. Over the past few decades the childbirth movement, which gave birth to Canadian midwifery and many other childbirth reforms internationally, often assumed that choices in childbirth and normal birth were almost synonymous. For some, the question of choice of CS has challenged this assumption. Within what we call “woman-centred care”, choice and normal birth, although often aligned, exist in a kind of dynamic tension. The question of choosing CS highlights this tension between two deeply held midwifery philosophies and gives us an opportunity to talk about our role and our values. Being a guardian of choice is not as simple as it seemed when we first advocated “choices in childbirth”.

Prior to this debate I would have characterized myself as a very “choice” oriented kind of midwife. In some ways I think I had come to take physiologic birth almost for granted, having “grown up” as a midwife during a time when the movement for “natural

childbirth” and the “humanization” of birth had a strong influence on both popular and professional culture. In a context of popular demand to avoid the medicalization of birth, I had the security and luxury of being able to critique the limitations of seeing birth as a “natural” event. Given how problematic ideas of a universal or ideal “natural” can be, and how often the concept of the “natural” has been used against women, I saw the ideal midwifery philosophy as supportive of many different definitions of birth, supporting women to define birth for themselves.

The debate about CS by choice has pushed and challenged my thinking and forced me to reexamine the importance of the concepts of normal and natural birth, while continuing to critique how we construct these ideas. And although I had always viewed the concept of “choice” with a healthy suspicion, given its use in our culture to glorify consumerism and disguise what is often in fact a lack of choice, these problems are brought into sharper focus by the presentation of CS without medical indication as a choice.

As midwives we could decide to think through the choice side of our philosophy and see “CS on demand” as its advocates often portray it: as an issue of women's autonomy and as a right. Alternately, we could take up our role as defenders of physiologic birth and call for a kind of “pure” birth and midwifery untainted by technology. I hope that we refuse both of these appealing simple answers, and instead use this debate as an opportunity to challenge both our own assumptions and the often invisible social assumptions around us, in terms of how we think about choice, risk and normal birth. There are many thoughtful maternity care providers who are using this debate to explore the complicated spaces between these positions, to think more deeply about what we mean by our commitment to women, choice and normal birth and about how we understand risk.

I hope the debate about CS by choice will push maternity care providers to look again at the social and political context of birth and birth science, a perspective that may have been neglected in the past decade, in our enthusiasm for “evidence”. We have perhaps lost sight of a principle that was very important during the peak of the childbirth

movement: medical practice and the knowledge on which it is based, like all science, is always created, interpreted and applied inside history and politics. What gets counted as evidence, or as a risk or benefit, is not simply a “fact” but is understood within a particular moment in our culture and history.

### **A CHOICE FOR ALL WOMEN?**

One of the questions that has often been raised in the CS by choice debate is about whether *all* women should be offered choice of Caesarean section versus vaginal birth.<sup>22,23,24,25</sup> Or, should caregivers continue to assume that vaginal birth is the standard of care when there is no indication for surgery and discuss this option only when asked? The argument here is that with major improvements in practice over the last few decades, (particularly in anesthesia and post-operative infection), the risks of CS are much lower than in the past. Further, we are living in an era of patient choice and respect for women's autonomy; therefore, women should be able to weigh the risks and benefits for themselves. It follows that all women should be offered this choice.

Even the most passionate advocates of choice of CS agree that not all women would be good candidates for CS by choice. At the MIRU conference, Nicholas Fisk noted that while he was advocating the position that all women be offered CS, “if you are young, want to have more than one or two children, or may live while pregnant in an area without ready access to a tertiary care centre” the risks in subsequent pregnancies clearly outweigh potential benefits.<sup>9</sup> The politics of a debate are often best revealed by what is not stated. What is unstated here is that the above definition describes a very large proportion of the childbearing women on the planet. A discussion that ignores this while debating what “all” women should be offered is deeply flawed.

This leaves the question asked by Mary Hannah's recent article (and it is interesting to note how the question has evolved from the MIRU conference, which Hannah chaired): is CS a reasonable choice for some women?

### **APPROPRIATION OF CHOICE**

*It is time to reassess the practice of compulsory trial of labour in Canada, and ask whether our denial of patient choice in*

*mode of delivery is justified*<sup>23</sup>

Burnett M. *JOGC*, March 2002

Many of the advocates of CS on demand use, “feminist” language and arguments that they would see as supporting women's rights and autonomy.<sup>25,26</sup> The women's health movement used “choice” as a powerful slogan, particularly in relation to access to safe abortion and to “changing childbirth”. The CS on demand debate pushes us to examine how the concept of choice can be employed in ways that may be problematic. What are some of the dilemmas and problems with the choices in choice of CS? What distinguishes advocacy for women's autonomy and choices and the appropriation of these concepts?

In health care we are ethically and legally bound to consider our clients as individuals able to make autonomous choices. Although the construction of ethics that relies on both autonomous individuals and choice has many critics and limitations, it is widely accepted as a legal and ethical starting point. Thinking from within this perspective, and assuming equal safety (which is far from established), there is a problem with a system that would claim to offer women choice of “mode of birth”, but fails to address the need to ensure that *all choices of mode of birth* are offered. If we are to be guided as caregivers by respect for choice, then we would logically need to expect all practitioners to offer, and the system to support, choice of midwifery and family practice maternity care, birth centres and home birth, and for those in a rural or remote community the choice of birth in the community rather than mandatory evacuation to a distant centre with specialist care. Choice between the current norm (which as Mary Hannah's article in the *CMAJ* points out, is highly medicalized) and surgery may not turn out to be not much of choice at all.<sup>4,27</sup>

In an ideal world we would have good evidence about the risks and benefits of each option and systemic support for the full range of choices so that women could make informed choices free of coercion. In the reality of our less than ideal world this may be fantasy: the fantasy of health care choices as a shopping trip or a menu and the fantasy of all of us as equally empowered to choose.

*Consumer choice may make sense at the supermarket or car*

*salesroom. It is not a model for doctor-patient relationships. In some (increasing) circumstances, choice may actually be a risk to women's health and well-being. Constantly expanding a list of options for women is too often primarily to the benefit of the list-maker. This may apply to C-sections, too.*<sup>28</sup>

Lippman, *Globe and Mail* Editorial, 2004

## COMPLEXITIES OF CHOICE

If you look at choice from a wider perspective, most of us do not make choices as fully autonomous agents. Pressure and assistance may come from family, health care workers, social norms, and “fashion”. Choices are not made simply within the rational, scientific model. Attitudes, philosophies, life histories and relationships have profound influences on childbearing women and caregivers. Offering choice is not as neutral a process as our consumer choice obsessed society may assume at first glance. As Susan Bewley points out, advocates of CS on demand use the concept of autonomy “as some kind of trump card as if it were a simple linear and undisputed concept”.<sup>29</sup> The debate about CS demands that we ask: What conditions could operate to make this choice less than informed or autonomous?

Bewley is a British obstetrician who has written extensively about the “unfacts” and the “unethics” of choice of CS.<sup>29,30</sup> She stresses that the health care system does not normally offer surgery without medical indication and that patient autonomy allows refusal of treatment but not compliance with a demand for unnecessary treatment. This line of thinking leads some to the economic aspects: perhaps women should have to pay for unindicated surgery. The comparison here is often to cosmetic surgery.<sup>14,31</sup> This is a problematic comparison, as major abdominal surgery has some very different implications. And yet the cosmetic surgery analogy is commonly found in media coverage, with “too posh to push” being conflated with preserving youth and sexual appeal.

Maternity care providers are familiar with a long list of low intervention choices of “mode of delivery” that are supported by evidence (Table 1). The list is taken from Effective Care in Pregnancy and Childbirth's (ECPC) forms of care “shown to be effective” or that have no strong evidence to justify restricting choice.<sup>32</sup> These options are often not available to Canadian women. The fact that choice of CS is usually discussed

**TABLE 1:  
LOW INTERVENTION FORMS OF CARE  
SUPPORTED BY EVIDENCE** <sup>32</sup>

- Philosophy of birth as “normal”, physiological, social and cultural
- Supportive care in labour
- Intermittent auscultation
- Using upright positions in labour
- Eating and drinking in labour
- Choice of birth place – home birth, birth centres, birth in local communities
- Known caregiver
- Choice of VBAC and ECV
- Support for unrestricted breast-feeding
- Community-based care – midwifery and family practice
- Collaborative relationships between primary and secondary caregivers
- Care that respects women and provides non judgmental choices

without reference to other important birth choices reveals the politics underlying what appears to be a commitment to choice but may in fact reflect a commitment to technological intervention in birth rather than to choice. It is important to be critical of a cry for choice that centres only on CS and of a call for respect for women to make autonomous decisions about choosing surgery but not about home birth, or vaginal birth after Caesarean section (VBAC), or giving birth in a remote community. It is important to be critical of an approach to risk that highlights the risks of non-intervention and downplays the risks of intervention.

At the same time I think it is very important for midwives to note and take a very humble look at the fact that many of the ethical arguments used to support choice of CS are similar to the arguments used to support choice of home birth or birth in rural or remote communities. They centre on supporting women to weigh risks and benefits for themselves. It is also interesting to note that many of the motivations for CS and home birth can be seen as similar:

- Both are chosen by a minority of women
- Both choices may be seen as balancing risks to gain benefits especially in terms of avoiding morbidity and enhancing the “experience” of birth

- Both may relate to concerns about the quality of care and seeking known caregivers
- There is an opposite focus for fears and feelings of safety; i.e. the “natural” body experience vs. institutionalized medical care both may be strategies for seeking control
- Some women seeking home birth may prefer elective Caesarean section (ECS) to routine hospital care <sup>33</sup>

**WHO REQUESTS CAESAREAN SECTION?**

**CAREGIVER PREFERENCES**

There is a significant literature on the reasons why women choose Caesarean section, but it is important to note that the debate was for a time dominated by research into how often and why physicians would choose CS for themselves or their partners (Table 2). Nicholas Fisk discusses how his interest in the issue was sparked by requests from female medical students asking for CS without indication. Because physicians tended to get access to the procedure, Fisk asked himself why this “choice” was available to them and not to all women.<sup>9</sup>

*Obstetricians themselves are probably the most informed of consumer groups.*<sup>40</sup>

Al- Mufti et al, *Eur J Obstet Gynaecol Reprod Biol*, 1997

*Much more is made than is justified of the finding of a 17% choice of an ECS in an otherwise uncomplicated pregnancy by London obstetricians. . . . A request for ECS for fear of the consequences of a vaginal delivery does not necessarily mean that the fear is rational. It is hard to put risks into proper epidemiological perspective when one's daily work relates to disease and damage to the reproductive and sexual organs.*<sup>41</sup>

Bewley, *Lancet*, 1996

*. . . midwives are probably in a superior position when it comes to making an informed choice regarding mode of delivery; they overwhelmingly aim to have a vaginal delivery. . . . The discretionary practice of . . . female obstetricians is not to be confused with whether women ought to request a CS. . .*<sup>42</sup>

Dickson and Willett, *BMJ*, 1999

*Of course what is at stake here is not just what obstetricians might choose for themselves but whether their stated preferences might colour their willingness to agree to caesarean section in the absence of clinical indications.*<sup>27</sup>

Weaver, *MIDIRS*, 2001

**TABLE 2:  
CAREGIVER'S PREFERENCE FOR CAESAREAN SECTION  
VERSUS VAGINAL BIRTH**

London OBs - 17% (31% of women)	Al-Mufti et al, 1997 <sup>40</sup>
UK midwives - 4%	Dickson and Willet, 1999 <sup>42</sup>
Irish OBs - 7%	McGurgan P et al, 2001 <sup>34</sup>
UK trainee OBs - 16% men/15% women	Wright et al, 2001 <sup>35</sup>
Dutch OBs - 1.4%	van Roosmalen, 1999 <sup>36</sup>
Israeli OBs - 9%	Gonen et al, 2002 <sup>37</sup>
Australia/NZ OBs - 11%	Land et al, 2001 <sup>38</sup>
Danish OBs - 1%	Bergholt, 2004 <sup>39</sup>
Canadian OBs - 30%	Burnett, 2002 <sup>23</sup>

percent of women make this choice, with the notable exceptions of some South American countries.<sup>51</sup> Variations in the rates of women requesting CS without indication are dependent on definition of medical indications (in Sweden, for example, breech, previous CS or previous difficult shoulder dystocia were considered as “without medical indication”). According to a literature review by Gamble et al., few women chose CS with no current or previous indication. For multiparous women

The significant difference in obstetricians' reported preferences in different countries reveals the importance of cultural attitudes towards birth and how profoundly norms about rates of intervention influence caregiver attitudes. Although the importance of caregiver attitudes on rates of intervention has been studied, this is an area of the debate that needs more attention, given the potential for caregiver preferences to be transformed into women's “choices”.

### **WOMEN'S PREFERENCES AND MOTIVATIONS**

The literature about the reasons why women ask for CS with no medical indication shows that the request is overwhelmingly related to fear and trauma.<sup>43</sup> This is important to note, given the media coverage that focuses on fashion and convenience or a seemingly superficial desire to avoid the unpredictability, challenge and messiness of birth. This finding should lead us to ask serious questions about the way that we care for women in labour. It also leads us to understand that part of the problem with the debate about “choice” of CS is not that it might not be an appropriate choice for some women. The problem is that the focus on choosing CS as a woman's right has failed to focus on the need to improve our care of the majority of women who choose vaginal birth. The focus on CS may in fact undermine efforts to improve care for vaginal birth.

After taking into consideration the need for similar definitions of “indication”, it seems that less than one

who request CS there is a very strong association with previous negative birth experience, especially emergency CS. In nulliparous women, fear of birth (especially crowning) since childhood and history of sexual abuse are the strongest indicators.<sup>37</sup>

Women report fear of being alone, helpless, and in uncontrollable pain. Some are motivated by fear for the baby's safety. Most lack information about the risks of CS and often have the impression there are no potential complications for themselves or the baby. Many do not understand the implications of recovering from surgery. Many do not understand that they have requested the surgery without medical indication, but thought that it was recommended by their doctor.<sup>52</sup> The literature on Brazil indicates a preference for “surgery from above” vs. “surgery from below”.<sup>53</sup> Caesarean may be associated with good care and vaginal birth with poor care and medical neglect. Body image issues may also influence preferences, with fear of damage to pelvic floor or of being cut or torn associated with a desire to maintain sexual attractiveness.<sup>54,55</sup> In some countries CS may be one of the only ways to access tubal ligation.<sup>34</sup>

Despite these compelling findings, convenience and fashion continue to be the dominant motivations reported in the media. How often does fear and anxiety underlie concerns expressed as fashion and convenience? Some women state that they want to be able to plan their (or their partner's or mother's) work lives. Others report a strong desire for a known caregiver (or support person) and perceive CS as the

**TABLE 3:  
HOW MANY WOMEN REQUEST CAESAREAN SECTION  
WITHOUT INDICATION?**

Ireland - 1.5%	Geary et al, Euro J Perinat Med, 1997 <sup>44</sup>
Australia - 2%	Quinlivan, Aust NZ J Obst Gynaecol, 1999 <sup>45</sup>
Lit Review >1%	Gamble et al, Birth, 2000 <sup>43</sup>
Australia - .3 - 6.5%	Gamble et al, Birth, 2001 <sup>46</sup>
London, UK - 7.6%	Eftekhar and Steer, BMJ, 2000 <sup>47</sup>
Sweden - 8.5%	Hildingson, ICM, 2002 <sup>48</sup>
Norway - 1.9%	Nyhus, ICM, 2002 <sup>49</sup>
UK - 1-5%	National Audit, 2001 <sup>34</sup>
Italy - 4%	(Italian law mandates choice of CS) <sup>50</sup>
Latin America - 30/75% (public/private)	Belizan et al <sup>51</sup>

trend is significant, especially when contrasted with the coverage of the Salt Lake City woman who refused CS. (see illustration 3) It is not hard to see who is a more attractive role model for young women. I was recently invited to speak to staff at Jessie's Centre for Teens in Toronto about the CS debate, as young women who have absorbed the media messages increasingly expect that they can avoid labour by choosing CS.

In this context, the challenge to those of us hoping to preserve

only way to give birth on their physician's on call day, or during their mother's holiday.<sup>14</sup> We may be missing something in taking a superficial view of concerns about being able to “plan” the birth and the postpartum period. An interesting area to explore would be whether women are afraid of being without support either in labour or postpartum, given the lack of systemic support in these stressful times, unless they plan birth around the needs of family members. Work pressures are also significant as childbearing women (or their partners or relatives) struggle to compete in workplaces that have a culture demanding as little time off as possible. Is it easier for our society to offer surgery than support?

normal birth must be to ask ourselves how we can create a culture that respects and honours not just the beauty and the challenge of vaginal birth, but more deeply the beauty and strength of the female reproductive body.

Fashion trends set by the rich and famous relate to fears about body image and sexual attractiveness and again, tend to conflate CS with cosmetic surgery. CS plays into expectations for perfection; women may be seeking the perfect baby, the perfect body or even the perfect doctor. The term “too posh to push” was coined when Victoria Beckham a.k.a. Posh Spice was reported to have had a CS on demand. Interestingly, Beckham and British actress Elizabeth Hurley, the “poster girls” of choice of CS, were recently featured in a *Toronto Sun* article on sex and relationships. “Girls wanna be Posh” reported on research indicating that they would swap “their equality and their job” to be “kept by a man, preferably a rich sports star”.<sup>56</sup> (see illustration 1 and 2) Young women following the lead of these stars do not seem to be using them as models of autonomous decision-making.

The impact that media coverage of CS as a fashion

### ILLUSTRATION 1

#### SEX & RELATIONSHIPS

## Girls wanna be Posh

### ILLUSTRATION 2



**A high percentage (of young women) said they would ... swap their equality and their job any day for being kept by a man — preferably a rich sports star.**

### ILLUSTRATION 3

## Refused to have C-section, woman faces murder charge

Case refuels U.S. debate over competing rights of pregnant women and fetuses

**BY KAREN GREENBERG**  
A woman in Utah is facing a murder charge after refusing to undergo a cesarean section, delivery in a case that has reignited the U.S. debate over competing rights of pregnant women and fetuses.

on the issue, and that in fact the case had been decided by state courts. “I’ve never related a C-section, against a pregnant individual’s wishes.”

He, however, said the law has children who live with their grandmothers in Utah. “I’ve never seen the woman in Salt Lake City with a C-section,” he said. “I’ve never seen her in Utah.”

The case has become the most prominent in a national debate over the rights of pregnant women and fetuses. “I’ve never seen the woman in Utah with a C-section,” he said. “I’ve never seen her in Utah.”

“I’ve never seen the woman in Utah with a C-section,” he said. “I’ve never seen her in Utah.”



## ADDRESSING FEAR ABOUT CHILDBIRTH

Research findings providing information and counseling to women who request CS indicate that a majority will choose vaginal birth when their fears are addressed by a skilled informed counselor and they understand the risks and benefits. Ryding looked at all of the women in one hospital in Sweden who requested CS<sup>57</sup>:

*When a pregnant woman asks for an obstetrically unmotivated CS, counselling is necessary. . . . Women who need and accept short term psychotherapy with an obstetrically well-informed therapist stand a good chance of an uncomplicated vaginal delivery.*

Ryding, Acta Obstet Gynecol Scand, 1993

In a randomized controlled trial (RCT) by Saisto et al examining the treatment of anxiety about birth, 62% of those requesting CS chose vaginal birth after counselling. The counseling group reported lower birth concerns, lower anxiety levels and shorter labours (6.8 vs 8.5 hours).<sup>58</sup> It seems clear that CS should not be offered as a substitute for reassurance, accurate information, counseling, supportive care in labour and/or pain relief. Is the request for ECS symptomatic of failing to provide quality, compassionate care for vaginal birth? We need to examine our systems of care, especially in regard to prenatal anxieties and care during and after difficult labours. The recent SOGC and AOM statements on CS on demand advocate for appropriate resources to be allocated to ensure continuous support in labour.

## QUESTIONS ABOUT CHANGING SOCIAL ATTITUDES TOWARDS BODIES AND TECHNOLOGY

The CS and cosmetic surgery analogy is just the tip of an iceberg. We live in a world of information technology, organ donation, transgender transformation and a pop culture fascination with medical miracles. In this changing world is our role as midwives and as advocates and guardians of normal birth changing its shape? We live in a world where prominent feminist theorist/biologist Donna Haraway, counsels the need to integrate and not separate the animal, human and machine. Her statement "I'd rather be a cyborg than a goddess" was meant to poke fun at what she would

characterize as an unexamined "earth-mother" feminism. She challenges those of us who might romanticize the "natural" to take responsibility for how we are all integrating technology into our lives and bodies.<sup>59</sup>

In this world, is giving birth with the body, like many other ways of life, going to become a "lifestyle" choice that some value but is no longer the assumed or the "natural" choice? In this case, vaginal birth, instead of being the expected way to enter the world, would become the choice for those who want to take the risks and experience the joys of using their bodies to give birth. Will midwives become ecotourism hostesses or even extreme sports adventure guides and obstetricians cosmetic surgeons? In this context, is there "an ecology" of vaginal birth that needs protection? Are we in danger of losing the beauty of birth to our love of technology? The art and science of obstetrics could become an "endangered species", with no need for more than a cesarean technician, no decisions to be made and cesarean the answer to everything. In seeking to avoid the messiness and uncertainty of birth with surgery are we as a society giving up on continuing to develop knowledge and skills to determine which women and babies need interventions? Are we giving up on supporting women to find power and dignity in the work of giving birth?

## PART II: THINKING ABOUT RISK

### RISKS AND BENEFITS TO THE FETUS AND NEWBORN

At the 2002 MIRU conference, neonatologist Michael Dunn titled his presentation "What would the baby choose?". He, like many looking at potential benefits of Caesarean section versus vaginal birth, argued that CS at 37-38 weeks could lead to a reduction in rates of intra-uterine death in late pregnancy and an avoidance of hypoxia in labour, and therefore, birth-related asphyxial injuries and death. He noted that the risks of CS for the baby include increased rates of transient tachypnea of the newborn (TTN) and respiratory distress syndrome (RDS) and therefore the need for increased neonatal intensive care.<sup>60</sup> Although the risks of TTN are often seen as minimal, they involve increased admissions to neonatal intensive care units and

separation of mother and baby, raising concerns about the consequences of disruption to early contact and breastfeeding. According to Dunn there would be some increase in serious cases of RDS and a rare but very serious increase in persistent pulmonary hypertension (PPH) of the newborn.

More recent literature notes that it is important to consider increased risk to the fetus in subsequent pregnancies. The increased risk of placental problems and uterine rupture in future pregnancies is also a risk to the fetus. A 2003 study in the *Lancet* reported a small but significant increase in the rate of stillbirth in subsequent pregnancies.<sup>61</sup>

Dunn posed that, based on avoiding the risks of late pregnancy and labour, if all pregnant Canadian women (260,000) had CS rather than vaginal births it would lead to saving the lives of 200 babies per year. This means that it would take 1300 CS to avoid one perinatal death. Note how the debate shifts in this argument. We are now analyzing the benefits and risks of all women *having* Caesarean surgery, not just the choice of surgery. Grobman, arguing against elective CS in an analysis of elective repeat CS vs vaginal birth after Caesarean, suggests that prevention of one major adverse outcome (death or permanent neurologic sequelae) would require 1591 Caesareans and cost 2.4 million dollars.<sup>62</sup> Applying an analysis based on all women to the question of choice of CS is of limited value.<sup>29,30</sup>

The discussion of potential benefit to babies is often posed without reference to risks to mothers. A characteristic of much of the literature about CS without medical indication is a failure to straightforwardly mention, let alone thoroughly discuss, the risks of morbidity and mortality to the woman. "CS is much safer" is often the closest advocates get to a discussion of risk.<sup>9,23,25</sup> This is very problematic in a society where expectations of maternal altruism are powerful and often invisible.

Dunn based his estimations on Canadian rates of perinatal mortality. What is striking when examining this data is that rates of both stillbirth and neonatal death are greatest in northern and aboriginal communities.<sup>63</sup> CS by choice is not an option in this population, where pregnant women are likely to be

young, have larger families and be far from tertiary care. CS is not the right solution to the higher rates of perinatal mortality in northern communities. The risk/benefit ratio of CS in eligible populations (women planning to have only one child and living in a large urban centre) with a much lower risk would be even less convincing.

The discussion of CS as a way to save Canadian babies' lives is good example of the medicalization and depoliticization of socio-economic issues. We fail to note the unequal distribution of perinatal death in our society and end up by posing CS as a surgical fix to deep social problems. This kind of approach looks rational when presented as a mathematical model without the social context, but in fact might be exactly the wrong answer.

For decades, many of the countries with the lowest perinatal mortality rates (PMR) have been the countries with the lowest CS rates (and also the countries with extensive social welfare systems). High rates of CS are not associated with lower perinatal mortality. Social class is a much better predictor of high PMR than rates of CS. Notably, rates of cerebral palsy have not been shown to fall as a result of increased use of CS.<sup>29,21</sup>

## **RISKS AND BENEFITS TO THE MOTHER**

Although many advocates of choice of CS avoid the issue of maternal death, when it is addressed there is a lack of clarity about the extent of the risk for CS without indication. A clear understanding of this issue is complicated by lack of separate data on elective CS for medical complications and CS without complications. According to Effective Care in Pregnancy and Childbirth (ECPC) and the United Kingdom (UK) data, the risk of maternal mortality is increased two to four times with elective CS vs vaginal birth.<sup>32,64</sup> To understand the long-term impact of CS, risks in subsequent pregnancies also need to be taken into account. According to ECPC, elective repeat CS has a maternal mortality of 17.9 per 100,000 as compared to 4.9 for vaginal birth (the UK data cites 2.1 for vaginal birth<sup>51</sup>), so clearly the woman who has a second child and who would have had a normal second birth is at even greater proportional risk. Some private clinics in Brazil report mortality rates as high as 1-2 per 1000.<sup>65</sup>

It is important for advocates of vaginal birth to look honestly at the fact that elective CS seems to be safer than emergency CS and that when considering the risks of vaginal birth we need to incorporate the risks of emergency CS. For the minority of women who avoid an emergency procedure, elective Caesarean section (ECS) may be two to three times safer.<sup>4,32</sup> One of the arguments driving the push for choice of CS is that women should be able to choose for themselves whether or not they want to avoid the risk of emergency section that is inherent in the risk of vaginal birth. What this approach can obscure is the fact that, overwhelmingly, the safest birth is the normal vaginal birth. For the vast majority of women, a system that supports and increases rates of normal, spontaneous vaginal deliveries (NSVD) is the safest system and the choice of vaginal birth is the safest choice. The recent SOGC and AOM statements are quite clear on this point. What was also eloquently pointed out in the letters to the editor following the CMAJ article is that complications following unindicated surgery are always unnecessary complications. It would seem apparent that increasing our ability to select which women need CS and avoiding unnecessary surgery would be a more desirable goal (and one advocated for a decade by the World Health Organization).<sup>66</sup>

The risks of morbidity to the mother, especially following a repeat CS, are often insufficiently discussed. The increasingly serious problems with morbidity in subsequent pregnancies are side stepped by the questionable assumption that the population that would choose this option is a population that would only have one or, at most, two children. Risks of cesarean are widely accepted to include:

- Operative and post operative complications,
- Increased postpartum recovery,
- Ectopic pregnancy,
- Placental abruption
- Placenta accreta,
- Placenta percreta,
- Infertility,
- Uterine rupture,
- Hysterectomy,
- Increased risks with increased parity.<sup>67</sup>

## THE PELVIC FLOOR

I could not leave this discussion without reference to

the debate about whether elective CS would help prevent significant damage to the pelvic floor. Claims that CS is an appropriate strategy to reduce damage to the pelvic floor are not well established, but there is a wide-ranging medical and non-medical discussion of the topic.<sup>68</sup> In a Google search I found 3,840 hits when I entered childbirth and pelvic floor damage. The surge of interest in the pelvic floor is a fascinating social phenomenon. Extremes on both sides are somewhat breathtaking in both the anti-medical and anti-natural birth direction. There is certainly lots of potential for a pregnant woman surfing the net to get very upset and confused about this topic. At the same time, there is some real scope for social analysis, as some authors seem to feel that our very humanity and civilization are resting on the pelvic floor.

*functioning sphincters are the basis of civilization*<sup>69</sup>

Murphy, , *OBGYN NET*, 2003

*we should leave vaginal birth to the animals*<sup>9</sup>

Fisk, *MIRU*, Nov 2002

Alternately, it is medico-legal liability at stake:

*we believe it is imperative to reevaluate modern obstetric practices both for the patients benefit and for our medicolegal protection*<sup>70</sup>

O'Boyle et al. *Am J Obstet Gynecol* 2002

There are clearly many things going on in the pelvic floor debate other than science. Bewley worries about how the claim that CS can protect the pelvic floor generates fears about “morbidity of mythological proportions”, but is not based in fact. An overemphasis on pelvic floor damage raises anxieties for women and caregivers and threatens to undermine confidence in vaginal birth.<sup>29</sup>

There is growing evidence that episiotomy, forceps, long second stages, third and fourth degree tears and inadequate repair of tears can contribute to long term pelvic floor trauma.<sup>71</sup> There is evidence that childbirth may not be the only determining factor: pregnancy, parity, lifestyle, aging, fitness, body size and genetics may be as important.<sup>72</sup> Some authors link pelvic floor damage with the pelvic floor relaxation associated with epidural anesthesia.<sup>73</sup>

There is conflicting evidence about the effectiveness of pelvic floor exercises, but there are indications their use in prevention and treatment of pelvic floor problems could be improved.<sup>74</sup> Evidence that perineal massage helps primiparous women avoid tearing is largely ignored.<sup>29</sup> There seems to be a growing number of experts who agree that we can improve care of the pelvic floor during birth and that we may need to change some obstetric practices, but that CS is not the answer.

*It is true that the pelvic floor may be damaged during vaginal delivery. Rather than stimulate ever more ready recourse to Caesarean section, however, our first concern should surely be to review aspects of the modern management of labour that may contribute to it for example, maternal posture and mobility, the use of epidural anaesthesia, the length of the second stage of labour and the liberal use of episiotomy.*<sup>75</sup>

Stirrat and Dunn, *BMJ*, 1999

*There is no doubt that both morbidity and mortality are higher following a caesarean section and therefore extreme caution needs to be exercised when consenting to caesarean section. . . It is a matter of concern that 35% of primigravid women sustain occult anal sphincter damage during vaginal delivery and that less than 20% of doctors feel adequately trained to recognize and repair perineal trauma. However the solution lies not in by passing natural childbirth but aiming to make vaginal delivery safe.*<sup>75</sup>

Sultan, *BMJ*, 1999

Micheal Klein, whose research on episiotomy helped lower its use as a routine procedure, makes the case that much of the research that shows benefit to CS versus vaginal birth is short term and that studies which follow women beyond three months show little difference.<sup>76</sup> He also argues that taking a second look at his research on pelvic floor outcomes shows that a vaginal birth with an intact perineum is equally as beneficial as CS. In his view, avoiding damage to the pelvic floor is not a reason to choose CS in advance. A discussion of pelvic floor outcomes should be part of making decisions about forceps versus CS.<sup>77</sup> Many experts argue that selecting women at high risk for long-term pelvic floor damage (for example those with pre-existing incontinence, obese women at high parity or those with previous third or fourth degree tears) is much more rational than offering CS “for all”.<sup>29,73,75</sup>

## RISKS AND BENEFITS TO CAREPROVIDERS AND THE HEALTH CARE SYSTEM

### COST AND CONVENIENCE

One of the subplots of CS on demand has inevitably been a debate about the cost of allowing women to have surgery “on request”: whether the cost would be greater or lesser, or whether women themselves should pay for unnecessary surgery.<sup>78,79</sup> Some argue that the higher the CS rate, the more cost-effective and efficient the procedure becomes, calling up a picture of the labour floor as an assembly line of planned procedures.<sup>25</sup> One of the factors making the economics of Caesarean by choice more viable is a general decrease in the routine length of stay post surgery that has occurred in the last decade.<sup>49</sup> This vision of what would seem to be a “birth factory”, points out that the perceived benefits of convenience may not be for the woman only.

*What would the motivations be for caregivers to recommend elective cesarean section before labour? . . . We would all get more sleep! We could lay off all of the labour nurses and fire all the midwives. We would not need obstetricians; we could simply use general surgeons . . .*<sup>13</sup>

DeMott, *Birth* 2000

There is a risk to the system when resources used for unnecessary procedures not only diverts funds needed for other services, but strains staff and facilities to the point that care is not only less humane but also less safe for those choosing vaginal birth or needing high risk care. Bewley worries about undermining the development of evidence-based high risk care.<sup>29</sup> And as witnessed in many countries in the wake of the Term Breech Trial, but already a factor in “even marginally difficult vaginal deliveries” in Brazil, a move to higher rates of CS may both reflect and consolidate a lack of skills in managing labour and vaginal birth.<sup>39,80,81,89</sup> A new generation of obstetricians has learned in an environment comfortable with a high Caesarean rate. There is also a risk of polarization between a highly technologized system of care and an “alternative” system that values physiologic approaches, rather than a collaborative approach that respects the place for both approaches. In this situation decisions about birth may be based more on opposing ideology than

evidence or indication.

In some systems, physicians directly benefit from higher fees for CS, which was seen to be a direct motivator in several countries including the U.S., Australia and Brazil, leading some government and third party insurers to make changes in payment to a global fee for all births, in an effort to lower the CS rate. More research is needed on the impact of financial incentives on birth interventions, but to date a strong effect has not been demonstrated.<sup>82</sup> Many authors worry there may be indirect motivations, with CS seen as the quicker, more predictable and less work intensive option.<sup>63,83,84</sup>

### CAREGIVER MOTIVATIONS

Caregiver motivations to support a more liberal attitude towards CS seem to be complex. Most systems with a private/public split show a clear pattern of high Caesarean rates in private patients. An Australian chairman of the obstetric association told the media that “because they (private patients) are paying extra money they expect extra service”.<sup>79</sup> Caregivers, like women, may value “personal” care from a known caregiver and schedule a CS on their “on call” day so that they can attend the births of the women they have seen for prenatal care. Many critics of the professional motivations that may be fueling the push to allow CS on demand cite the overwhelming belief that technologic procedures must be superior to a physiologic process as the underlying factor. Susan Bewley worries that cutbacks, poor pay and devaluing of the job has led to a shortage of midwives and lack of quality care that can prevent overuse of surgery.

*An insufficient number of midwives is a dismal indication for cesarean section but may be part of the explanation as to why this debate has come from the capital.*<sup>29</sup>

Bewley, *BMJ*, 2002

Has failure to lower the CS rate, despite substantial efforts in the 80s and 90s, led to an “easy out” in maternal request? Is support for CS often a simple response to the growing professional acceptance of “partnership” and “consumer choice”? Or are we witnessing a kind of backlash to gains made by the women's health and childbirth movements – a kind of “you wanted choice so we will give you choice”

reaction? Is this redefinition of a physiologic process as abnormal a familiar strategy for reassertion of “turf”, a strategy that has been played out many times in the history of medicine and midwifery?

Some have linked CS on demand with the feminization of medicine, as some of the research points to higher proportions of young, female obstetricians more likely to prefer CS to vaginal birth for their own births.<sup>34</sup> Others see the preference for CS on the part of both women and physicians as participation in a culture that sees women's genitals as sexual rather than reproductive. They suggest the struggle over CS is similar to the move to artificial feeding, supported by medicine but based in culture and economics rather than science.<sup>67</sup> Others more philosophically muse that we are witnessing a very human struggle with uncertainty and control and the fact that errors of omission may be harder to live with, and defend, than errors of commission, in a medical culture and social context that values action over trusting nature.<sup>64,85</sup>

It is important to take medico-legal factors into account. It has become almost a truism that physicians never get sued for doing a CS but may well get sued for trying to avoid one. In the question period after the MIRU debate Nicholas Fisk was very honest about the fact that CS is possibly better for the baby, possibly better for the woman but clearly better for the obstetric care provider medico-legally. Fisk would pose CS as a cheaper alternative to maintaining liability protection for physicians.<sup>9</sup> The reality of medico-legal pressures makes it imperative that we find solutions to the litigation crisis other than more and more ready recourse to surgery. The risk here is that medico-legal forces have an untoward influence on practice and lead to a decrease in choices (and, over time, of services and skills) for both women and caregivers.

It is also vital to see the costs and proposed benefits and risks of CS by choice in a global context. Much of the discussion of increased safety of CS or its cost-effectiveness is assuming a standard of care and a resource base that is not the norm all over the planet, which raises concerns about what the SOGC called an “tremendous international disaster”.<sup>6</sup>

*Making substantial progress towards improving the quality of maternal health care is urgent: while we continue to discuss unnecessary surgical interventions, millions of women that require these procedures do not have access to them and risk their own and their children's lives.*<sup>86</sup>

Langer and Villar, *BMJ*, 2002

## **SURGICAL FIX FOR A NON-SURGICAL PROBLEM?**

*For a medical community and society that brings women to the point of preferring major surgery to childbirth, serious questions need to be asked – preferably before women start paying with their lives.*<sup>87</sup>

Bastian, *BMJ*, 2002

In pursuing the path of choice of CS without medical indication are we as a society seeking a surgical fix for a non-surgical problem? Are we trying to attend to fear with surgery, moving to surgery rather than what seems to be a more difficult task: providing compassionate care and implementing evidence-based practices that support normal birth? We need to find other ways to listen to women's fears and concerns about vaginal birth and try to improve the ways we are caring for them. Intermittent auscultation and one to one care are examples of practices that have been lost in the pursuit of technology and have been very challenging to re-implement. They are both essential to supporting vaginal birth.

It is vital that midwives take part in the debate about choosing CS and in policy making around this issue. Although currently most women seeking this choice would not seek midwifery care, midwives need to be informed and ready to discuss CS on demand. Ongoing media coverage is normalizing the idea and the debate within the medical and midwifery community continues. It is important to rekindle popular discussion about what matters about physiologic birth, about the evidence and more than the evidence, since in the words of Murray Enkin “what matters most may be what is the most difficult to measure”.<sup>88</sup> Midwives can emphasize the importance of care that explores women's fears and concerns and put forward the position that there are ways to address these concerns other than surgery. Midwives have an important role in helping to keep in perspective that the safest birth is a vaginal birth and

the safest policy would support the maximum number of physiologic births.

I hope that as midwives we will approach the issue as an opportunity to be strong advocates for physiologic birth *and* to respect individual women's diverse choices at the same time. I hope we will work for a maternity care system that respects low intervention birth choices not just the technological ones, a system that will listen not only to those who wish to choose CS but also those who wish to avoid it. At the same time, I hope we will acknowledge that both “demands” may stem from a demand for control and safety, and reflect different views of the world and what constitutes safety and risk, views that should be respected, explored and challenged.

Our analysis cannot stop with a simple view of choice as a neutral and objective process, or of risks or benefits as uncontested “facts”, especially in the context of a society dominated by a “culture of fear” and a “risk epidemic”.<sup>89</sup> We need to look at what kind of cultural support women in our society need in order to find birth “with their bodies” as a viable and rewarding choice. We may need new and creative ways to show the potential to find joy and power in physiologic birth.<sup>ii</sup> We need ways to counter the cultural dominance of television representations of bodies perfected by technology (e.g. Nip and Tuck) and birth as a technologic procedure to which birthing women as well as the audience are spectators (e.g. Maternity Ward).

I hope we will take up the challenge to learn to talk openly about risks in childbirth, while resisting the culture of fear and nurturing confidence in both birth itself and in women's abilities. There is some important work yet to be done in learning how best to inform women about risk, how to put risks in perspective with other life events and avoid the risk of harm that may result from an overemphasis on risk in childbirth. To adapt the framework of social anthropologist Mary Douglas, when we make choices about CS by choice, we are not just discussing individual risks and choices, we are choosing what kind of a society we want to live in.

## FOOTNOTES

<sup>i</sup> There are some important issues of language and terminology to be considered in this debate. The phenomenon has been called Caesarean “by choice”, “on demand”, “on request” or “without medical indication”. Each of these have their own shades of meaning and I will use all in this article as seems appropriate. Some authors also use the term “elective” Caesarean, the term traditionally used for, but perhaps better called, a planned Caesarean which is medically indicated. The second issue of language is about what to call Caesarean section. Some would suggest Caesarean birth, to humanize the experience of giving birth by section. Others would advocate Caesarean surgery to clarify what can be taken too casually: that Caesarean section is major abdominal surgery.

<sup>ii</sup> A significant scholarly and public literature exists that addresses the meaning, challenge and joy that women can find in childbirth. See for example the scholarly work of Coslett, Klassen and Kahn.<sup>90,91,92</sup> Hawkins and Knox *The Midwifery Option* and Brabant's *Une Naissance Heureuse* are Canadian examples aimed at childbearing women and families.<sup>93,94</sup>

## REFERENCES

1. Kirkey S. Canadian doctors agree to offer caesarean sections for women 'too push to push'. Ottawa Citizen 2004 March 2:1.
2. Kirkey S. C-sections to be available on demand, CMA says. Vancouver Sun 2004 March 2:1.
3. Carey E. C-section? You'll soon get to choose. Toronto Star 2004 March 2:1.
4. Hannah M. Planned elective cesarean: a reasonable choice for some women? CMAJ 2004;170(5) 813-4.
5. Morier D. SOGC still debating on the topic of elective C-sections. SOGC Media Advisory. 2002 March 2. Available at: [www.sogc.ca](http://www.sogc.ca).
6. Moier D. Caesarian section on demand - SOGC's position. 2004 March 10. Available at: [www.sogc.ca](http://www.sogc.ca).
7. ACOG Office of Communications. New ACOG opinion addresses elective cesarean controversy. 2003 Oct 31. Available at URL: [http://agoc.org/from\\_home/publications/press\\_releases/nr10-31-03-1.cfm](http://agoc.org/from_home/publications/press_releases/nr10-31-03-1.cfm).
8. Stein R. Elective Caesareans judged ethical. Washington Post 2003 Oct 31:A02.
9. Fisk N. Caesarean section: just for fun. Proceedings of MIRU conference. Choosing delivery by Caesarean: has its time come? 2002 Nov 7; Toronto, Canada.
10. Editor's choice. Politically incorrect surgery. BMJ 1999;319.
11. FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical aspects regarding caesarean delivery for non-medical reasons. Int J Obs Gynecol 1999;64:317-22.
12. Cole D. Highlights in obstetrics from the 50<sup>th</sup> annual meeting of ACOG. Medscape Ob/Gyn & Women's Health 2002;7(1).
13. DeMott RK. Commentary: A blatant misuse of power? Birth 2000;27(4):264-5.
14. Armstrong S. The cutting edge. Chatelaine. 2003 Apr:93-100.
15. Goer H. The assault on normal birth: the ob disinformation campaign. Midwifery Today 2002;63. Available from: URL: <http://www.midwiferytoday.com/articles/disinformation.asp>
16. Fisk N. Cesareans for all. Grand rounds, Sunnybrook and Women's College Hospital. March 2003.
17. Young D. Confrontation in Kansas City. Birth 2000 Sept: 27(3): 153-7.
18. Annis B. Mothers protest unnecessary surgery. ICAN Press Release 2002 Nov 5.
19. The American College of Nurse-Midwives. US women not getting the whole story on cesarean sections. Press release 2000 Sept 6.
20. Association of Ontario Midwives. Press Release: Elective c-sections a concern for Ontario midwives. 2004 Mar 10.
21. Wagner M. Choosing caesarean section. Midwifery Today 2001 Spring:26-9.
22. Choosing delivery by Caesarean: has its time come? University of Toronto Maternal and Infant Research Unit conference. 2002 Nov 7; Toronto, Canada.
23. Burnett M. Optional Caesarean: what do some Canadian physicians say? JOGC 2002;219-20.
24. Jibodu O, Arulkumaran S. Caesarean section on request. Journal SOGC 2000 Sept:684-9.
25. Paterson-Brown S, Fisk NM. Caesarean section: every woman's right to choose? Curr Opin Obstet Gynecol 1997;9:351-5.
26. Somerville M. Whose delivery is it anyway?: the ethics and law of obstetric decision-making. Proceedings of the MIRU Conference: Choosing Delivery by Caesarean: Has its time come? 2002 Nov 7; Toronto, Canada.
27. Weaver J. Thoughts on caesarean section. MIDIRS 2001;11(4):517-8.
28. Lippman A. C-section fight does a U-turn: optional cesarean sections are under serious consideration by doctors, a move that would reverse the long battle to limit surgical intervention in maternity care. Globe and Mail 2004 Mar 3.
29. Bewley S. The unethics of 'request' caesarean section. Br J Obstet Gynaecol 2002;109:593-6.
30. Bewley S. The unfacts of 'request' caesarean section. Br J Obstet Gynaecol 2002;109:597-605.
31. Fernandes JR. Elective Caesarian??? Is there such a thing? CMAJ e-letters to editor. 2004 Mar. Available at URL <http://www.cmaj.ca/cgi/eletters/170/5/813>.
32. Enkin M, et al. A guide to effective care in pregnancy and childbirth. Oxford, New York. Oxford University Press, 2000.
33. Anderson T. Commentary. MIDIRS 2001;11(3):368-70.
34. McGurgan P, Coulter Smith S, O'Donovan PJ. A national confidential survey of obstetricians' personal preferences regarding mode of delivery. Eur J Obstet Gynecol Reprod Biol 2001;97(1):17-9.
35. Wright JB, et al. A survey of trainee obstetricians' preferences for childbirth. Eur J Obstet Gynecol Reprod Biol 2001;97(1):23-5.
36. van Roosmalen J. Unnecessary caesarean sections should be avoided [retraction of Patterson-Brown S, Amu O, Rajendran S. Bolaji I. BMJ 1998;317:462-5]. BMJ 1999;318:121.
37. Gonen R, Taniert A, Degani S. Obstetricians' opinions regarding patient choices in caesarean delivery. Obset Gynecol 2002;99:577-8.
38. Land R, Parry E, Rane A, Wilson D. Personal preferences of obstetricians towards childbirth. Aust N.Z., J Obstet Gynaecol 2001;41:249-51.

39. Bergholt T, Ostberg, B, Legarth J, Weber, T. Danish obstetricians' personal preference and general attitude to elective cesarean section on maternal request: a nation-wide postal survey. *Acta Obstet Gynecol Scand* 2004;83(3):262-6.
40. Al-Mufti R, McCarthy A, Fisk N. Survey of obstetricians' personal preference and discretionary practice. *Eur J Obstet Gynecol Reprod Biol* 1997;73:1-4.
41. Bewley S. Obstetrician's views on caesarean section versus vaginal birth. *Lancet* 1996;347:1189.
42. Dickson M, Willett M. Midwives would prefer a vaginal delivery. *BMJ* 1999;319:1008.
43. Gamble J, Heath M, Creedy D. Women's request for cesarean section: a critique of the literature. *Birth* 2000;27:256-63.
44. Geary M, Fanagan M, Boylan P. Maternal satisfaction with management in labour and preference for mode of delivery. *J Perinat Med* 1997;25:433-9.
45. Quinlivan J, Petersen R, Nichols C. Patient preference the leading indication for elective Caesarean section in public patients results of a 2 year prospective audit in a teaching hospital. *Aust N.Z., J Obstet Gynaecol* 1999;39:207-14.
46. Gamble J, Heath M, Creedy D. Women's preference for a cesarean section: incidence and associated factors. *Birth* 2000;28(2):101-10.
47. Eftekhari K, Steer P. Women choose caesarean section. *BMJ* 2000;320:1073.
48. Hildingsson. Reasons for request for cesarean section in Sweden. *Proceedings of the International Confederation of Midwives 2002; Vienna, Austria.*
49. Nyhus. Choice of cesarean section in Norway. *Proceedings of the International Confederation of Midwives 2002; Vienna, Austria.*
50. Donati S, Grandolfo M, Andreozzi S. Do Italian mothers prefer cesarean delivery? *Birth* 2003;30(2):89.
51. Belizan J, Althabe F, Barros F, Alexander S. Rates and implications of cesarean in Latin America: an ecological study. *BMJ* 1999;319:1397-400.
52. Turnbull D, Wilkinson C, Yaser A, Carty V, Svigos J, Robinson J. Women's role and satisfaction in the decision to have a caesarean section. *Med J Aust* 1999;170:580-3.
53. De Mello e Souza C. C-sections as ideal births: The cultural construction of beneficence and patient's rights in Brazil. *Cambridge Q Healthcare Ethics* 1994;3:358-366.
54. Behague D, Victoria C, Barros F. Consumer demand for caesarean sections in Brazil: informed decision making, patient choice, or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods. Available from: URL:<http://bmj.com/cgi/content/full/324/7343/942>
55. Belizan J, Althabe F, Barros F, Alexander S. Rates and implications of cesarean in Latin America: an ecological study. *BMJ* 1999;319:1397-400.
56. Gibson V. Girls wanna be Posh. *Toronto Sun* 2004 Mar 14.
57. Ryding EL. Investigation of 33 women who demanded a cesarean section for personal reasons. *Acta Obstet Gynecol Scand* 1993;72:280-5.
58. Saisto T, Samela- Aro K, Nurmi JE, Kononen T, Halmesmaki E. A randomized controlled trial of intervention in fear of childbirth. *Obstet Gynecol* 2001;98:820-6.
59. Haraway, D. Simians, cyborgs and women: the reinvention of nature. New York Routledge, 1991.
60. Dunn MS. Planned elective caesarian section: would the baby choose it? *Proceedings of the MIRU Conference: choosing delivery by Caesarean: has its time come?* 2002 Nov 7; Toronto, Canada.
61. Smith GC, Pell JP, Dobbie R. Caesarean section and risk of unexplained stillbirth in subsequent pregnancy. *Lancet* 2003;362(9398):1179-84.
62. Grobman WA. Cost effectiveness of elective cesarean delivery. *Obstet Gynecol* 2000;95(5):745-51.
63. Canadian Perinatal Surveillance System. Stillbirth and infant mortality. Available from: URL:[http://www.hc-sc.gc.ca/pphb-dgspss/rhs-ssg/factshts/mort\\_e.html](http://www.hc-sc.gc.ca/pphb-dgspss/rhs-ssg/factshts/mort_e.html).
64. Hall MH, Bewley S. Maternal mortality and mode of delivery. *Lancet* 1999;354(9180):776.
65. Jibodu O, Arulkumaran S. Caesarean section on request. *JOGC* 2000 Sept:684-9.
66. World Health Organization. Appropriate technology for birth. *Lancet* 1985;2:436-7.
67. Hemminki E, Merilainen J. Long term effects of cesarean section: ectopic pregnancy and placental problems. *Am J Obstet Gynaecol* 1996;174:1569-74.
68. Farrell S. Childbirth and the pelvic floor: quality and implications of the evidence. *Proceedings of the the MIRU Conference: choosing delivery by Caesarean: has its time come?* 2002 Nov 7; Toronto, Canada.
69. Murphy M. Choosing cesarean birth: an alternative to today's crisis in natural birth. *OBGYN NET*. 2003.
70. O'Boyle AL, Davis GD, Calhoun BC. Informed consent and birth: protecting the pelvic floor and protecting ourselves. *Am J Obstet Gynecol* 2002;187:982-3.
71. Bernstein P. Elective cesarean section: an acceptable alternative to vaginal delivery? *Medscape Ob/Gyn & Women's Health* 2002;7(2):1-3.
72. Buchsbaum GM, Chin M, Glantz C, Guzick D. Prevalence of urinary incontinence and associated risk factors in a cohort of nuns. *Obstet Gynecol* 2002;100(2):226-9.
73. Stirrat G, Dunn P. Obstetricians are more than technicians [retraction of Patterson-Brown S, Amu O, Rajendran S. *Bolaji I. BMJ* 1998;317:462-5]. *BMJ* 1999;318:120-1.
74. Dannecker C, Anthuber C. The effects of childbirth on the pelvic-floor. *J Perinat Med*. 2000;28:175-84.
75. Sultan A. Editor's commentary. *BMJ* 1999;(7222):319.
76. Klein M. Woman-centred care not promotion of elective Caesarean section. E-letters to editor *CMAJ*. 2004 Mar 12. Available at URL <http://www.cmaj.ca/cgi/eletters/170/5/813>.
77. Klein M. Personal communication 2003 Dec.
78. Zulueta P. Patients do not have right to impose their wishes at all cost [retraction of Patterson-Brown S, Amu O, Rajendran S. *Bolaji I. BMJ* 1998;317:462-5] *BMJ* 1999;318:120.
79. Malkin J. Not as much as you think: toward a truer estimate of the difference in direct medical costs between vaginal and cesarean deliveries. *Birth* 2001;28(3):208-9.
80. Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. Term Breech Trial Collaborative Group. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomized multicentre trial. *Lancet* 2000;356(9239):1375-83.
81. Nutall C. The caesarean culture of Brazil. *BMJ*

2000;320:1072.

82. American Academy of Family Physicians. Financial costs of elective repeat cesarean section compared to vaginal birth after cesarean section in trial of labor versus elective repeat cesarean section for the woman with a previous cesarean section. AAFP Clinical Recommendations. 2000 Aug.

83. King J. Obstetric intervention and economic imperative. Br J Obstet Gynaecol 1993;100:303-6.

84. Bettiol H. Caesarean section (CS) and patient's demand. [retraction of Behague D, Victoria C, Barros F. Consumer demand for caesarean sections in Brazil: informed decision making, patient choice, or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods. BMJ 2002;324:942.] BMJ 2002 May 20.

85. Hall P. The metastatic mythology of risk. The Accoucher 1999 June:1-2.

86. Langer A, Villar J. Promoting evidence based practice in maternal care: would keep the knife away. BMJ 2002;324:928-9.

87. Bastian H. Commentary: health has become secondary to a sexually attractive body. BMJ 1999;(7222):319.

88. Enkin M. Evidence based practice: utopia, dystopia and oxymoron. Ryerson University speaker series. 2003 Oct.

89. Skolbekken JA. The risk epidemic in medical journals. Soc Sci Med 1995;40(3):291-305.

90. Closett T. Women Writing Childbirth. Manchester. Manchester University Press, 1994.

91. Klassen, Pamela. Blessed Events: Religion and Homebirth in America. Princeton, NJ. Princeton University Press, 2001.

92. Kahn, RP. Bearing meaning. Chicago. University of Illinois, 1995.

93. Hawkins, M. Knox S. The midwifery option: a Canadian guide to the birth experience. Toronto. Harper Collins, 2003.

94. Brabant, I. Une naissance heuresse. Montreal. Saint-Martin, 1995.

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