

CAESAREAN SECTION: THE UNDERPINNING CHOICE?

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Abstract

Caesarean section rate is rising the last years in Greece. Although it is a common operation, it is evident that it has the most significant long-term consequences for women of childbearing age. Since, the rising Caesarean Section rate affects perinatal outcomes; it is also a major public health issue. Therefore, it is necessary the clinicians to consider the reasons of this fact and to inform pregnant women. Moreover, strategies should be developed by the government in order to reduce the rate of Caesarean Section.

Keywords: Caesarean Section, counseling, women's health, midwifery, birth

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Introduction

According to the conclusion of research by Graham et al (1999) "...women are not homogenous in their requirements for information nor their desire to be involved, and the challenge to providers is to be responsive to this variability...". But what about the midwives and the obstetricians who will take care of them? Are they a homogenous group? If not does this variability of health providers improve or detract from the care of women?

Aaronson (1987) argues that "women with similar demographic characteristics, perceived the care they receive from obstetricians and nurse-midwives to be different in terms of the different health practitioners' feelings about certain health behaviours and their supportiveness to the women". Bryar (1995) suggests, "that these differences reflect the differences in models of care held" by the two different groups

midwives and obstetricians. According to a study by Dickson et al (1999) midwives would choose a vaginal delivery rather than a Cesarean Section (129 from the 135 who replied). By contrast other studies (e.g. Geary et al 1998, Al Mufti et al 1996, Gabbe et al 2001, Cotzias et al 2001, Groom et al 2001) found that there was a trend for obstetricians and doctors to choose elective Caesarean Section as a mode of delivery for themselves (female) or their partners (male). On examining the literature, published about Cesarean Section it is rare to find obstetric studies, which refer to midwifery research or vice versa. Usually, both of the groups referred to their own particular lobby.

The Midwifery 'Lobby'

Rooks (1999) argues "the midwifery model establishes the pregnant woman as an active partner in her own care and recognizes her

as the primary actor and decision maker." Although, as underlined "some midwives have incorporated some aspects of medical management into their practices" (Rooks, 1999), Bryar (1995) argues that "the majority of midwives work within organizations that are based on a medical-model of care and may themselves hold a medical model approach to care." Similarly, Kitzinger (2001) argues that: "midwives are put under pressure to care for women with epidurals and those having Cesarean Sections. They are caught between their duty to the employing authority and to the woman whom they are committed to serve." On the other hand, "women are told they are being selfish to expect midwives to leave the hospital for a homebirth and that they will be denying other women adequate care" (Kitzinger 2001)

The Obstetric 'Lobby'

Murphy- Lawless (1998) emphasizes "obstetrics argues that its power to determine what ought to be done in childbirth is founded on its authority as a form of scientific rationality and it is not amenable to accepting as expert any voice from outside that community."

It is essential to consider the autonomy of the obstetric profession and the effect of this upon the organization and effectiveness of maternity care. "Of all the professions, medicine has been among the most successful in achieving autonomy and establishing the freedom to work without regulation from outside its own community. Consumers have a very small voice in policies that regulate the terms of health care delivery and only physicians' control the content of medical work and the education of recruits. This autonomy means that it is only physicians, who are in a position to monitor each other's behavior and performance" (Scully 1994). Recent events within the NHS (e.g. in Bristol) have challenged some of this power and autonomy. The dominant model is the obstetric one and this has profound implications for the women and for society. The Caesarean Section rate is influenced by

the dominant medical model and its philosophy.

The Technocratic Body Mythology

Richards (1993) points out that "our western cultural attitude toward birth is fear based" (Murphy-Lawless 1998) According, to Davis-Floyd (1996) "the technocratic paradigm metaphorizes the female body as a defective machine unable to produce a healthy baby without technological assistance. In contrast, the holistic paradigm interprets the female body as an organic system, and birth as an ecological process that can only be harmed by dissection and intervention. (Sargent & Brettell 1996)" Maybe in the future, Caesarean Sections will be thought as a very brutal intervention on the woman's body. Scully (1994) argues that 'The records can be used to show how theories relevant to "female problems" were postulated on culturally patterned attitudes about the nature and purpose of women and how these beliefs provided the justification for some surgical practices' and continues 'many popular theories were not rational or scientific, but because gynaecologists were (and still are) the uncontested medical experts, they were able to exert social control over women.' Similarly, Davis-Floyd argue that "the technocratic paradigm is hegemonic, pervading medical practice and guiding almost all reproductive research ...". The modern woman surrounded by the technology everywhere and the research that justifies the need to be monitored by technology finds her body ruled by a very well organized technocratic system. The mythology that surrounds this technocratic world emphasizes the need to use more technology.

When the obstetrician wields the knife due to litigation'

Fear of litigation may affect obstetricians' attitudes to Caesarean Section. "Obstetricians here like in the United States, often explain the rise in cesareans as due to the threat of litigation. If something bad happens to a baby, it is safer to show that you did something rather than nothing, and deciding on caesarean section is an

obvious way to demonstrate concern" (Kitzinger 1998).

Experts accept that Caesarean Section carries higher risks of mortality and morbidity than vaginal delivery for both mother and the baby (Minkoff & Schwarz 1980, O'Driscoll & Foley 1983, Pearson 1984). In 1995, the World Health Organization issued a consensus statement suggesting that there were no additional health benefits associated with Caesarean Section above 10-15%. (Royal College of Obstetricians and Gynaecologists et al 2001)

'The underpinning choice'

Many London obstetricians have a favorable attitude towards Caesarean Section, and some consider it the best option for themselves or their spouses (Al Mufti et al 1997). The above study identified Elective Caesarean Section in uncomplicated pregnancies as a frequent choice (17%) of those who have the 'authoritative' knowledge. Hemminki (1997) argues "If this view of Cesarean Section as a good alternative to vaginal birth rather than an undesired consequence of obstetric problems spreads to lay people, the demand for caesarean deliveries is likely to explode at this time of emphasizing patient choice." As Karl Marx once noted, the ruling ideas of any society are the ideas of the ruling class. Considering the roles of midwives and obstetricians, we can conclude that the medical model is the ruling model of care, the one that obstetricians support. If the obstetricians, as the 'ruling class' in childbirth, have favorable attitude to Caesarean Section, what are the consequences for the women? Hemminki (1997) argues "If experts advocate cesarean section as the method of choice in normal situations, then special courage is required from a woman to choose vaginal delivery, where there are possible problems, even she is given the final decision. An intriguing question is what has created this favorable attitude of London obstetricians towards Cesarean Sections, a view in contradiction with scientific literature. If obstetricians have opinions that lack scientific basis, informed choice by a patient is impossible." (Hemminki, 1997) Kirby & Hanlon-Lundberg

(1999) argue that this favorable attitude towards Caesarean Section is a result of a philosophy that supports that nature can be improved with our actions: "it is our nature to "do something" rather than "do nothing". In this context, a "timely" Cesarean Section is frequently considered an improvement over nature, leading to the adage "when in doubt, cut it out." Graham & Oakley (1981) argue that the struggle between women and doctors is between two contrasting frames of reference, where the concept 'normal' has a different meaning for women from the meaning it has for doctors. "Normal for doctors is about a successful measured pregnancy in terms of whether a well mother and a live baby emerge at the end of it. For women normal conveys the sense of their individual bodies.."

Who is informed - who gives the information and whose decision is it really?

Graham et al (1999) argue that "medical and midwifery staff do not often document discussions with the women regarding the reasons for their Cesarean Section and its implications for future childbirth." Similarly, Wilkinson et al (1998) acknowledge that: "We did not collect information about how well informed each woman was before requesting operative delivery. We also did not record how anxious her informant was that she should be delivered by section ... further research is required" (Wilkinson et al 1998).

Gamble and Creedy (2000) conclude that "without the assurance that women are fully informed about the risks and benefits of Cesarean Section, statements about their contribution or request for caesarean delivery are questionable." Questions are raised to this point about which woman should be called informed and who is her informant. Kitzinger (1998) states: "What women do not know is that the risks to the mother are higher with cesarean than vaginal birth. That includes the risk of dying, as well as pelvic infection, the side effects of anesthesia, operative injury, hemorrhage, later uterine rupture, and the psychological consequences of surgery."

Even if this information is provided there are many questions raised regarding the extent to which this choice is influenced by other factors including the personal opinion of the physician. Scully (1994) argues that “the monopoly over medical knowledge, which is considered too difficult and technical for the average lay person to understand, places the consumer at a decided disadvantage. Even the average, well-informed individual is handicapped in evaluating a physician advice or performance, because the information needed to make an informed decision is with-held or unavailable” (p11). Similarly, Hillan (2000) asks, “If a doctor explains the necessity or usefulness of Caesarean delivery to a woman and sympathetically listens and answers her questions and the woman subsequently agrees to the operation - is this a maternal request?”

Choices are also influenced by gender roles in society. Kitzinger (2001) argues, “The most vulnerable women are those who look to experts to tell them what to do. They do not feel happy about questioning authority. They are frightened that if they disobey they will be punished or their babies will suffer. For them the cultural feminine ideal is one of submissiveness or experience has taught them that resistance has dangerous consequences ... we need education for choice... choice is questionable unless women can obtain accurate information, and free to give not only ‘informed consent’ but ‘informed refusal’.” Hemminki (1997) argues that “It is certainly conceivable that patients’ pressure or willingness is a cause for high Cesarean delivery rate. It is not an unlikely, possibility in our Western medicalized birth culture, with its mechanical view of health problems. If this is so, one should ask what the contribution of health professionals has been forming these opinions, and what their role should be changing them.”

Frightened Women - a consequence of the technocratic medical model

According to Jolly et al (1999) “Cesarean Section or vaginal instrumental delivery leaves many mothers frightened about future childbirth and as a result of this fear is voluntary infertility.” The medical term

for this situation is tokophobia, which comes from greek synthetic word from tokos and phobia. Tokos in greek means birth and phobia means fear. Frightened women are the products of a technocratic medical system. As ‘obedient’ consumers they are likely to choose intervention, distrusting the capacity of their own bodies to give birth normally. Thanks to influence of the media and possibly significant others who have been through the technocratic birth system, this may be the case even before they have themselves experienced birth.

Kitzinger (2001) argues “They are convinced that vaginal birth will distort and mutilate their bodies and leave them gaping and incontinent, or they are simply frightened about what doctors will do to them, and believe that Cesarean Section offers the safest birth for the baby and is a way of avoiding pain. They see vaginal birth as ugly, agonizing - a form of torture- and enlist a surgeon to avoid this.” Kirby & Hanlon - Lundberg (1999) argue that: “The ‘Holy Grail’ health practitioners seek is made more elusive by its iridescent nature, depending on the individual and societal perspectives by which it is viewed. As long as caesarean delivery is perceived as an improvement over nature, ‘cold steel and sunshine’ will be the birth mode of choice with minimal provocation for many women, willingly delivered by concurring practitioners”.

Gamble & Creedy (2000) conclude “the current debate surrounding women’s request for Cesarean Section has the capacity to create a sense that women have choice and control in childbirth without legitimately and adequately addressing these issues.” Ussher (1995) suggests that “Discussion can challenge the images of women contained within the present discourse and open the arena for a new understanding of the psychology of the female body, whilst silence can only maintain oppression”. Moreover, as Churchill (1997) concludes, women need to be aware of their rights, that their own knowledge and feelings about childbirth are valuable, and more importantly, that the doctor does not always know best”.

Conclusion

Although Cesarean Section is a common operation with the most significant long-term consequences for women of childbearing age, the caesarean section rate in Greece is rising and this fact indicates a significant health issue for our country. The rising Caesarean Section rate is a public health problem that is associated with long term effects for the mother and the newborn. Therefore, the need for developing further, or reorganizing the health education antenatal services in primary care in order to meet pregnant information needs regarding Caesarean Section and all related perinatal health issues, is evident

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