

As one highly respected health care analyst has written in *CMAJ*, “Canadians [should] re-embrace the core concept of a universal health care system in which the vast majority of services are provided by non-profit institutions with public accountability.”<sup>5</sup>

So yes, we should ban kickbacks and limit self-referrals. But if we really want to get to the root of the problem (and perhaps improve quality at the same time), we should encourage policy-makers to prohibit for-profit independent health facilities from providing medically necessary care.

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## Elective cesarean section

It was with utter dismay and surprise that I read Mary Hannah’s commentary on planned elective cesarean section.<sup>1</sup> Given that there has never been any scientific proof of benefit from unindicated surgery, how can the literature for indicated procedures be used to justify our willingness to acquiesce to the wishes of the consumer? And just because indicated procedures have low rates of complications and appear safe, we should not use those data to bend to

current trends in consumerism. Are we physicians so afraid of disappointing the consumer that we are willing to perform unnecessary procedures? I find it rather hypocritical that we misuse and contort the literature to justify this approach and then turn around and call ourselves scientists practising evidenced-based medicine. If we want to practise what amounts to cosmetic surgery, then by all means, let’s do so and bill patients for these services independently.

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1. Hannah ME. Planned elective cesarean section: A reasonable choice for some women? [editorial]. *CMAJ* 2004;170(5):813-4.

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Mary Hannah concludes her commentary on elective cesarean section<sup>1</sup> by suggesting that if, after appropriate counselling, a woman continues to perceive that the benefits of such a procedure outweigh the risks, her health and welfare “will be promoted by supporting her request.”

In this regard, it is important that all evidence on the benefits and harms be presented to the prospective mother. The UK’s National Institute of Clinical Excellence (NICE), which provides authoritative, robust and reliable guidance on current “best practice” to patients, health care professionals and the public,<sup>2</sup> is currently developing clinical guidelines on cesarean section,<sup>3</sup> expected to be released in April 2004 [the guidelines have now been published; see *CMAJ* 2004;170(12):1779.—Editor].

According to the draft document (page 27),<sup>3</sup> “maternal request is not on its [sic] own an indication for [cesarean section],” and “pregnant women should

be supported in whatever decision is made following these discussions.” The draft (pages 19–21) provides current evidence on length of stay, abdominal pain, perineal pain, postpartum hemorrhage, infection, breastfeeding, bladder and urinary tract injuries, need for further surgery, risk of thromboembolic disease and many other clinical outcomes, the majority of these data favouring vaginal birth over cesarean section.

Women should have a right to exercise their choice on the mode of delivery even when there are no clinical indications for cesarean section. However, providing this procedure in a publicly funded system such as the UK’s National Health Service would increase the overall cost, and the opportunity cost thus incurred might deny services that would be of benefit to other users of the service.

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I was disturbed to read Mary Hannah’s commentary<sup>1</sup> outlining the possibility of the Society of Obstetricians and Gynaecologists of Canada (SOGC) supporting the option of medically unnecessary cesarean sections. I am disappointed that cesarean section would be offered when little consideration is given to options at the other end of the spectrum.

Proponents of cesarean section on demand contend that a patient has the right to choose the course of care that best suits her situation. While this is entirely true, the fact remains that such choice has not always been the case. Personally, I was denied my preference of a vaginal birth after cesarean by 3 different physicians. My second choice was to give birth under the care of a midwife, a choice that the Alberta government forced me to pay for. If women are given the option to choose a cesarean section when it is medically unnecessary, they should also have to pay for this form of care. It is an outrage that cesarean section on demand — a medically unnecessary, costly procedure — is covered by Alberta health care while midwifery — a proven, safe, economical option — continues to be excluded.

If the SOGC truly wants to allow women to choose their course of maternity care, they have to fully support and champion the entire range of options available. This includes unmedicated physiologic birth attended by a midwife. If you are concerned about a patient's choice, work to ensure that we all have access to the services we choose.

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**M**ary Hannah's commentary<sup>1</sup> arrives at a time when women are losing confidence in their ability to give birth vaginally. To suggest, as Hannah does, the equivalence of maternal and newborn outcomes for cesarean and vaginal birth in the face of confusing science is to contribute to fear and an increase in cesarean procedures.

Hannah concludes that cesarean section is more dangerous in current and future pregnancies, but then discusses pelvic floor issues, reporting that the

risk of urinary incontinence is higher for vaginal births.<sup>1</sup> However, most studies of urinary incontinence are flawed by follow-up limited to 3 to 6 months<sup>2-5</sup> and fail to specify the difference between minor and severe incontinence. Population-based studies report either no difference in urinary incontinence by route of birth<sup>6</sup> or a baseline rate that is high and only somewhat improved by cesarean section.<sup>7</sup> Notably, even nuns have a high rate of urinary incontinence.<sup>8</sup> We need to concentrate on nonsurgical and lifestyle improvements to prevent this important problem.

Hannah also states that cesarean section is safer for the fetus and the newborn,<sup>1</sup> and this is true for certain entities. For example, one subarachnoid hemorrhage can be prevented with every 7000 cesarean procedures, and one brachial plexus injury can be prevented with every 2200 procedures. But for every 333 cesarean sections, one newborn will experience a significant feeding problem, for every 69 cesareans there will be a respiratory problem resulting in separation of the mother and newborn, and for every 317 cesareans one newborn will require a respirator for more than 24 hours.<sup>9-11</sup>

Hannah muses that contemporary birth, which involves inductions, long periods of labour, continuous electronic fetal monitoring, augmentation, epidurals, forceps, episiotomy and multiple caregivers, can hardly be considered "natural." Good point! But who is responsible for this unnatural environment? Hannah's own study of post-term pregnancy<sup>12</sup> is the bedrock upon which our current epidemic of post-term inductions is based, leading in my institution to a rate of cesarean sections among first births in excess of 40% (the rate is about 8% for women in spontaneous labour). It may take between 500 and 2000 post-term inductions to avoid one stillbirth, but, in the process, a cascade of accepted "side effects" ensues. This situation needs fixing, but cesarean section is not the appropriate mode of repair.

Hannah uses her Term Breech Trial<sup>13</sup> to make the point that cesarean section is safer. However, it is not ap-

propriate to extrapolate data from subjects whose fetuses are in breech position to a population of women whose fetuses are in vertex position.

Hannah supports informed choice, but the process of informing the patient well, covering the complex and ambiguous literature about maternal and newborn morbidity and mortality, and bowel, bladder and sexual functioning, as well as the joy, power and transformative nature of vaginal birth, is likely to take more than an hour. And the person doing the informing, usually the surgeon, is in a position of conflict of interest, because cesarean section allows the physician some control over his or her life. If the consent does not cover this detail, as well as a sensitive exploration of the values, fears and hopes of the woman requesting the procedure, informed consent is a sham.

To appropriate the word "choice" in today's chaotic and industrialized birth environment is unjustified. Better to work on improving that environment by providing optimal support to pregnant women, making doula care the norm, reserving birth technology for those who need it, reconsidering the role of induction timing for the post-term fetus and making birth a truly woman-centred event, rather than a professional- and institution-focused process.

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