

Home » National » Article

Fatal flaws in steady rise of caesareans

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The increasing number of women who opt for surgical deliveries is causing serious problems for them and their health teams, writes Ruth Pollard.

At a closed-door meeting of the state's top maternity specialists an increasingly common, life-threatening complication was laid bare.

Linked to the rising rate of caesarean deliveries, the condition known as placenta accreta has gone from being a rare event to one frequent enough for hospitals to implement comprehensive plans to treat women who experience the massive haemorrhaging it can cause.

Caused by the placenta sticking to the scars of previous caesareans, sometimes penetrating the wall of the uterus, bladder or bowel, it can take a team of surgeons to remove it and can result in an emergency hysterectomy.

Death from placenta accreta is rare, but what is worrying specialists - from obstetricians to midwives, gynaecologists and anaesthetists - is that so many of these cases turn into full-scale medical emergencies in a matter of minutes. And the risk rises with every subsequent caesarean.

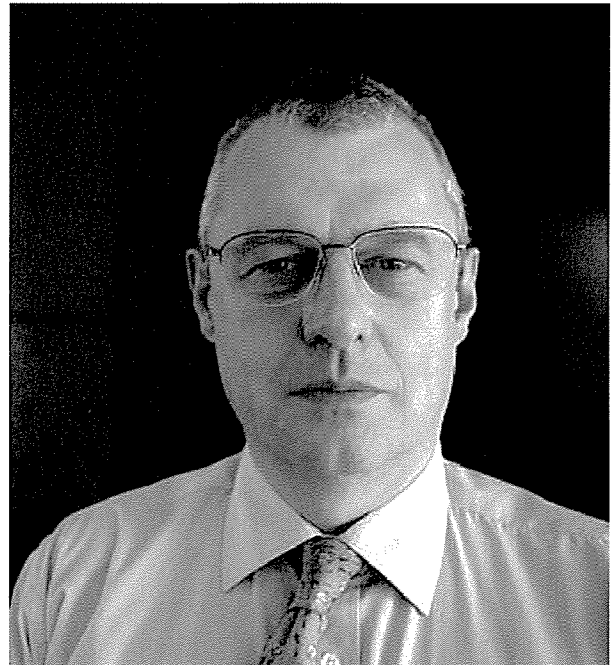
It is only a matter of time, they say, before the death rate starts to rise.

This is the other side of a procedure that women are told is safe - often safer than vaginal birth - and a procedure that is progressively rising, now hovering at about 30 per cent of all deliveries.

Complications following caesarean section are well known, but the meeting at the Royal Hospital for Women on June 22 last year was indicative of an undercurrent of change.

There is, many specialists have told the *Herald*, an increasing desire to reduce the number of elective, surgical births and increase vaginal deliveries, not just to reduce dangerous complications but also to ease pressure on public hospitals and improve recovery time for women and babies.

At that meeting, convened by NSW Health, officials presented a nightmare scenario: based on current trends a rise in the number of caesarean sections from 30 to 39 per cent of births would mean more than 1000 extra operations a year, diverting resources from other services.



Nightmare scenario: When things go wrong
Photo: Steven Siewert

Compare that with the 1970s, when the rate of caesarean sections was about 5 per cent.

By the 1980s caesareans made up about 10 to 15 per cent of all births.

But then came a dangerous combination: medical advances made anaesthesia safer as society moved towards the quick, clean and convenient over the potentially long, drawn out and messy. The result: a significant shift towards elective caesarean sections. The rate reached 19 per cent in 1994, 27 per cent in 2002 and 28.5 per cent in 2003. Now it makes up nearly one-third of all births.

William Walters has been delivering babies for more than 40 years. Based at the Royal Hospital for Women in Randwick, he says it is vital the number of elective caesareans is reduced.

"There is ongoing discussions looking at how normal birth can be encouraged with the view to reducing the rate of caesarean sections, because there are more complications from caesareans - some that even result in maternal death - and clearly we must do everything we can to prevent those."

Being better prepared through the use of increasingly sophisticated screening techniques does not necessarily alter the outcome, Professor Walters says.

"In many cases we can still be confronted with great difficulties at the time of delivery which will not prevent that terrible hemorrhage problem or prevent the emergency hysterectomy being necessary.

Also, the logistics of organising the increasing number of elective caesarean sections have forced the profession to reappraise the surgery it does, says Greg Davis, the director of obstetrics at St George Hospital.

"We organise an extra elective caesarean-section list per week but lose an elective gynaecological list per week. All these women in the public system waiting on gynaecological surgery are sacrificed for the women who want to have elective caesars.

"It increases your length of stay, beds get blocked up, it stresses everybody - the more caesars we have the more women the residents have to see rather than working in the ante-natal clinic. It is more work for the whole unit."

The only practical solution is to decrease the number of first caesareans and increase the number of vaginal births after caesarean, Dr Davis says. VBAC - vaginal birth after caesarean - is safe in about 70-80 per cent of cases, and it is where the most can be done to reduce the rate of elective surgical birth, he says.

"The other thing you have got to realise is that we are bulging at the seams. If you want to start up a new initiative like focusing on VBACs you have actually got to get the people with enough energy and time - and that is the problem: nobody has any time to do anything; you are chasing your tail all the time.

"We are designed for 2200 to 2400 births, and we were coping well - but another 300 births is another six per week. That may not seem like a lot, but when the system is already chugging along at full tilt it is difficult."

Davis says that, on average, a vaginal birth is easier to look after than a caesarean.

Yet in a moment of startling honesty, he describes the dismay he has felt when a birth starts to go badly.

"All obstetricians can tell you of times when you are standing there at the end of the bed, delivering a baby, things are going wrong, and you are thinking, "God I wish I was somewhere else. I wish I had have done a caesarean section'.

"It is easy to be critical when it is not you ... but if the baby is going to be damaged for the rest of its life and it is all because of a decision you made, it is like little scars on your soul. They are there forever."

The rise in surgical birth is also a reflection of society, where the desire for order and predictability are paramount, and where fear of childbirth, the pain and the process, is growing.

"Fear has become more prevalent, there has been a lot more written about it, high-profile women are talking about it - they say they wanted to have their elective caesarean section, wanted to be in control, wanted to avoid prolapse or pelvic floor problems," Davis says. "It also reflects our society; with an elective caesarean section you have a date, a time and you can plan your life around that."

The secretary of the NSW Midwives Association, Hannah Dahlen, says women have been conned into thinking that caesarean deliveries are safer for babies. "That is a myth. At the rate of caesareans we have now, we are creating problems for both mums and babies. We have tipped the balance: we know there is a certain level of caesarean sections that improves our maternal and baby mortality rate, maybe around 15 per cent, but developed countries are starting to see maternal death rates going up."

In the US, maternal deaths have risen two years in a row, and in Britain the death rate is running at 14 per 100,000, the highest it has been for decades, Ms Dahlen says.

"That our maternal death rate has not risen is great, but let's learn from what is happening around us and make sure it doesn't happen. People are thinking that caesarean is an easy way out of labour, but what they have got to realise is that it is a hard way into motherhood and an even harder way into any future pregnancy and birth."

Dahlen and others are calling on state and federal governments to rethink the way they fund maternity services, bringing the focus back to preventative health and low-intervention deliveries where possible.

Priorities should be increasing the midwifery workforce and providing Medicare funding and medical indemnity insurance for midwife services, allowing them to work to the full scope of their practice, she says.

"We need to move birth away from being a medical emergency and provide women with full midwifery care and obstetric care. Currently there is a great Grand Canyon that runs between the two professions, and women fall down that canyon."

David Ellwood, an obstetrician at Canberra Hospital and professor of obstetrics and gynaecology at ANU Medical School, is blunt in his assessment of the point our society has reached with

childbirth.

"Litigation and the fact that people expect perfection in everything they do these days has driven people to think that the more intervention the better, and maybe that isn't true.

"There is a climate of fear that has been generated about childbirth, and for things to switch around it will require some real champions, who are obstetricians, to come out and say, 'We do not have to do it this way; there are safe alternatives without intervention'."

He acknowledges there is, to some degree, a turf war being fought between midwives and obstetricians - partly over professional status and partly over professional practice - that has prevented a timely resolution to the growing problem. But the time to act is now, he says.

But other obstetricians say the stress on a woman's body caused by a vaginal delivery - from tears and other tissue damage to incontinence and prolapse later in life - should be avoided.

Another uses the emotive analogy of women "pushing out cannonballs" to describe vaginal birth, focusing most of his attention on "educating" women about the pelvic floor trauma caused by a normal birth and lamenting the difficulties of arguing against supporters of non-surgical deliveries.

Such is the passion attached to this debate that, until now, change has seemed impossible.

Yet, as one Melbourne doctor has warned, maternal deaths represent the tip of the iceberg of the harm caused by caesareans.

"For every case of mortality directly or indirectly caused by pregnancy or its management, there are probably 50 women who experience a life-threatening complication but survive with varying degrees of short- and long-term [health problems]."

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