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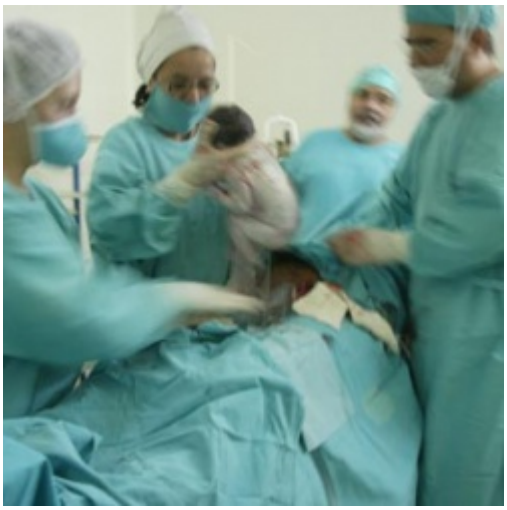
Choosing Caesarian Sections Is About Risks

By Chuck Dinerstein — September 12, 2018



Courtesy tifhermom [1]

The rate of Caesarian sections (C-Section) continues to increase globally despite efforts to standardize their use through education and guidelines. A recent meta-analysis of 34 studies, global in scope, identified three explanatory themes; a clinician's personal beliefs, health care system issues and characteristics of the involved clinicians. I would humbly disagree and argue that the choice of vaginal birth or C-section is like many decision one of risk and benefit. Issues of convenience, for physician or mother, do exist but are secondary nudges more than decision points.

C-Sections are Unique

I can think of no other instance where two lives are at risk, both entwined and sometimes with disparate needs. Leave aside all the issues of "natural" birth, a mother's overriding concern is the welfare of her baby; her well-being is a secondary issue. For physicians, entrusted with the protection of both mother and child, who to attend to is based on who is in greatest need. Neither vaginal birth nor C-sections are without complications, but again they differ for mother and baby.

From a maternal view, vaginal births have short-term risks primarily inordinate pain, more significant are the long-term risks of injury to the muscles of the pelvic floor, that suspend the uterus and bladder in their proper position; and those injuries can result in later urinary or fecal incontinence. The current literature suggests that vaginal births may confer some additional protection to the baby concerning exposure to vaginal bacteria, etc. C-sections come with more short-term, rather than long-term concerns; bleeding, wound infections and so on; sections confer no special protection to the baby. As you might expect, C-sections done emergently, rather than electively, may be more disorganized and complications more likely.

There are absolute reasons to proceed with a C-section; primarily when the baby cannot physically fit through the birth canal or when there is fetal distress and the baby's life is at risk. The rising rate of sections, in part, reflects, both of these concerns; our ability to know in advance that the baby will "not fit" or that they are in distress from our advances in imaging and fetal monitoring accounts for some numbers. The concern about the increasing number of C-sections is about the uncertain, more ambiguous instances – circumstances that require judgment and allow for more "backseat driving." Let me summarize; the natural approach is best until it is not. Knowing when it is not is a judgment call, in no small measure a function of training, experience and the resources at hand. [1]

Litigation

Consider first, the elephant in the room, the risk of malpractice litigation. The meta-analysis indicates this is a global concern, although a more prominent concern in highly developed countries. When you are making a judgment call, the problem is the uncertainty of risk, coupled with the greater certainty of litigation should you err incorrectly. And we are considering two lives, with differing needs. A wound problem is far more easily forgiven and remunerated than a hypoxic child with lifelong brain damage – and when I say forgiven, I mean not merely by the patient but by yourself. So whether its effect is truly large or not, the fear of litigation nudges physicians toward sections.

You might think health system or hospital guidelines for care could resolve some of this fear providing a defense of your judgment. But guidelines are clear and useful for the situations where they are needed the least. They offer no real help when the way forward is ambiguous. Guidelines can provide direction, and they serve as a defense in litigation pointing out that the physician acted reasonably, following standards of care and not acting through negligence.

Another contextual concern that like litigation is present but not foremost are the resources on hand; a concern for both less developed and highly developed systems. In the former, the worries are about infrastructure, the nuts and bolts of care – can you quickly put together the necessities of an emergency C-section? It is harder to "sit on your hands" when you know that it will take a half hour or more to set up a room and staff for an emergency section. You need a buffer. It is harder to wait when you need older heads to settle you down, and there are no experienced elders. In our more highly developed systems, these concerns about infrastructure are largely satisfied; our issues revolve around workers and lifestyle. A trial of labor is time intensive and that time is far more scarce and taxing in the underserved and rural settings where there is only one or two physicians/midwives available. All else being equal, resource deficiencies, real or ambiguous, nudge physicians towards sections.

A mother's concern

Physicians cite a maternal preference for C-sections as another factor despite studies showing the actual ask rate is about 15%. These requests imply anxiety or exhaustion; they reflect patient concerns, I do not need to characterize them beyond that. It takes more effort when you patient is anxious or "just wants the baby out" – to sit, calm, hold their hand, talk them through a difficult labor. Like many other things, advocates can spin our response to these requests. Am I empowering my patient, sharing decision making? Am I opting for less work on my part? It is

another factor in weighing the decision.

A physician's experience

Experience and its cognitive companion judgment are often poorly characterized by numbers. Every delivery is different. Experience reflects with whom and where and when. Any of these factors can contribute support or unease. When a physician is uncomfortable, we move towards our comfort zone, just as everyone might. I would argue that experience reflects just how large or small that comfort zone can be.

The study also alluded to financial concerns. Both the hospital and physicians are paid more for a C-section than vaginal birth; sections are more resource intensive. While cynics argue that the additional income from performing a section is a consideration, and it may be for an immoral few, that is not the real calculation. The few hundred dollars difference even multiplied over a lifetime of cases, pales compared to the cost financially and spiritually for having an adverse outcome for a baby. Post-traumatic distress is not confined to the patient's and their families.

It is hard to identify intent in the hospital record let alone in the administrative coding that most studies utilize in understanding how these decisions are made. As it turns out, like most of medicine, it is more complicated than the sound bites, or the clever phrases suggest.

[1] There are a number of complications and concerns I am leaving out this general discussion. I am trying to explain the thought process, not training the reader to make medical decisions.

Source: Clinician's views of factors influencing decision-making for caesarian section PLOS One DOI: 10.1371/journal.pone.0200941

Links
[1] https://www.flickr.com/photos/tifwarmowski/11236147