CHAPTER 5

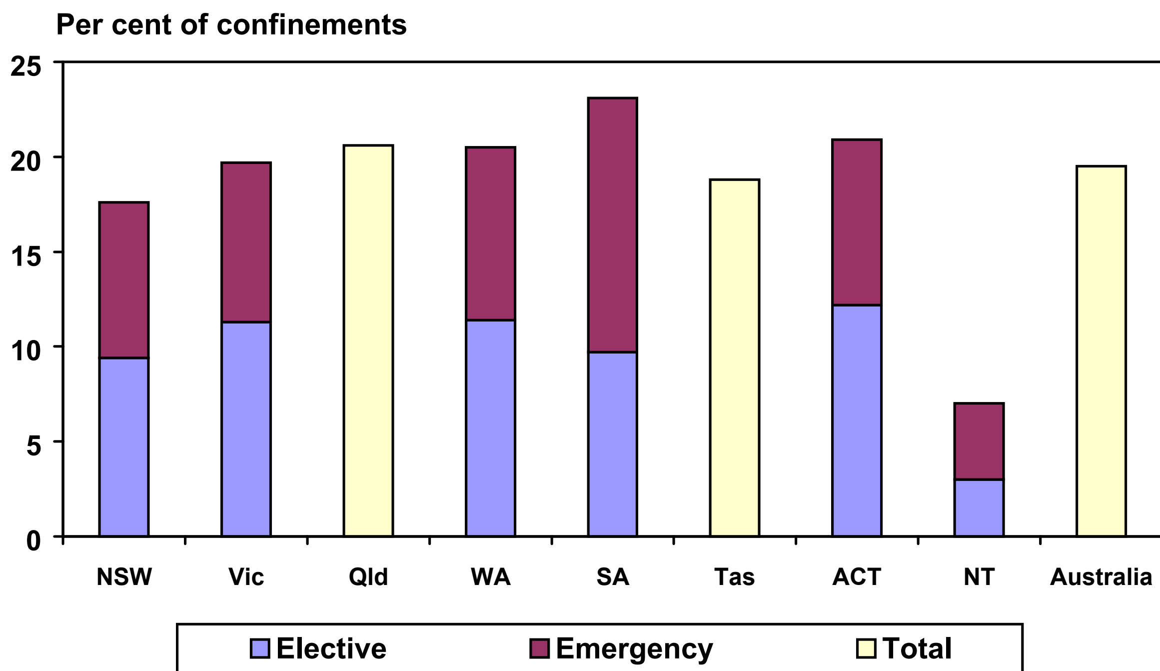
INTERVENTIONS IN CHILDBIRTH – CAESAREAN SECTION

5.1 The Committee is concerned to discover why intervention rates are generally higher in Australia than in most comparable countries, why practices are so variable between institutions and between public and private patients, whether they are justified by improved outcomes for mothers and babies or whether, indeed, they entail adverse consequences for either of these groups.

5.2 The Committee has examined each of the commonly performed childbirth interventions, beginning with Caesarean section, which has aroused the greatest interest and the greatest concern among some members of the general public and some health professionals, especially midwives.

Comparative Caesarean section rates

Caesarean rates, States and Territories, 1996



Note: Elective and emergency caesarean data for Queensland and Tasmania unavailable.

Source: AIHW, *Australia's mothers and babies 1996,* AIHW cat No.PER4, Figure 20, p.20

5.3 The most recent, comprehensive data on Caesarean section in Australia was published by the Australian Institute of Health and Welfare in 1999.[1] It indicated that in 1996 (the year to which its most recent figures apply) 19.5% of all births in

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1 Australian Institute of Health and Welfare. *Australia's mothers and babies, 1996,* Canberra, 1999.

Australia were by Caesarean section.[2] There has been a gradual but persistent increase in Caesarean sections over the last thirty years, although the rate of increase has slowed during the last decade.

> …we know that in the early to mid 1960s it was less than five per cent, that it rose to more than 10 per cent in the 1970s, to 15 per cent in the 1980s, and so on…The rate of increase has actually slowed down, if I can put it that way, in the 1990s. I would need to refer to the tables but it was about 16 per cent or 17 per cent in 1991, and it is now 19.5 per cent.[3]

5.4 However, more recent figures from the casemix data base operated by the Commonwealth Department of Health and Aged Care indicate a further increase during 1997-98 to a national rate of 21%.[4]

5.5 There are significant variations between States in the percentage of Caesareans performed. In 1996 the highest rate was in South Australia (23.1%) and the lowest was in New South Wales (17.6%).[5] The casemix data indicates an increase in New South Wales to 18.6% in 1997-98 and a very slight decrease in South Australia to 23%.[6]

5.6 While wide variations between States have historically been a feature of Caesarean rates in Australia, the States with the highest and lowest rates have changed over time. In all States however, the trend has been to increasing levels of Caesarean intervention.

> Caesarean rates varied considerably among the States and Territories – in 1985, the rates ranged between 12.9% in Tasmania and 18.2% in the Australian Capital Territory and, in 1990, between 14.7% in Tasmania and 21.4% in South Australia. Tasmania consistently had the lowest caesarean rate, while the highest rates occurred in South Australia, Queensland and the Australian Capital Territory.[7]

5.7 Australia now has one of the highest Caesarean rates in the world. For the first time it has exceeded the rate in the United States, long regarded by comparable countries (and by the United States itself) as unjustifiably high.

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2 Ibid, p.19.

3 *Committee Hansard,* 27.8.99, p.19 (Australian Institute of Health and Welfare).

4 National Hospital Morbidity (Casemix) Database 1997-98. The Department of Health and Aged Care cautions that the data 'has not yet been subjected to the extensive analysis that has been applied to the data from the AIHW'. See Submission No. 97, p.17 (Department of Health and Aged Care).

5 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* Canberra, 1999, p.19.

6 Submission No. 97, p.17 (Department of Health and Aged Care).

7 Lancaster Paul A L & Pedisich Elvis L. *Caesarean births in Australia, 1985-1990*, Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney 1993, pp.6-9.

> In fact we have now achieved – if that is the correct term to use – a caesarean rate that is higher than the caesarean rate in the United States…the United States…were very concerned nationally about caesarean rates of 24 or 25 per cent a decade or so ago. In the period since then the caesarean rate has declined to a level of 20.7 per cent, with the latest figures I saw for 1996 of 19 per cent and then slightly up again to 20.8 per cent in 1997 in the United States. But, as I say, on our preliminary figures, we have gone to 21 per cent[8]

5.8 By contrast, Caesarean rates in Holland are 6% and in the United Kingdom 12%.[9] However, in some countries they are much higher than in the United States.

> It is widely believed that the C/S rate should be reduced. However, no acceptable level has been agreed, and values in the developed world vary from 10% in Sweden to 38% in Chile. In some areas of Brazil C/S is considered a modern and acceptable way to have a baby, and 75% of mothers in some areas give birth this way.[10]

5.9 In Australia, Caesarean rates (and rates for some other interventions such as episiotomy) vary markedly between women with private health insurance and those without. There are more older women in the former group, which partly accounts for their higher Caesarean section rates but does not entirely explain it.

> Caesarean section rates differ significantly between patients with public and private admission status. This cannot be entirely explained by the fact that older mothers (who are more likely to have an operative intervention) are also the most likely to have private health insurance.
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> - In 1997-98, 18% of public patient admissions were delivered by caesarean section against 27% for women with private status.[11]

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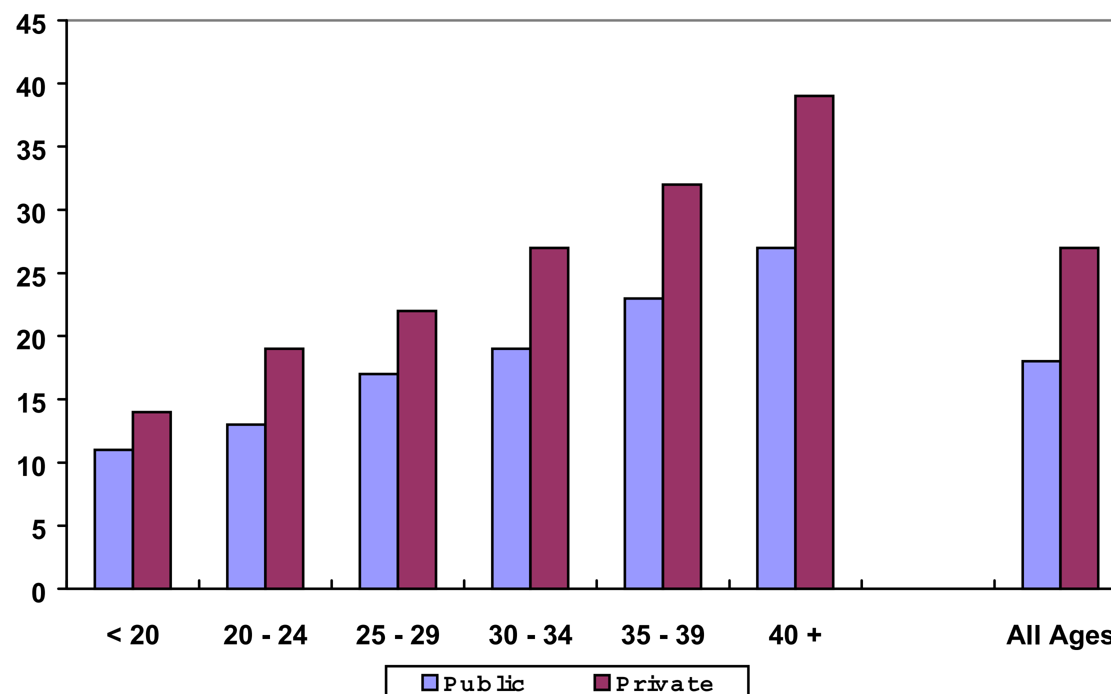
8 *Committee Hansard*, 27.8.99, p.19 (Australian Institute of Health and Welfare).

9 *Committee Hansard*, 6.9.99, p.92 (Dr Jane Fisher, University of Melbourne).

10 Cotzias C, Fisk N. *Patient demand for Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.9.

11 Submission No. 97, p.20 (Department of Health and Aged Care).

Caesarean rates by maternal age and accommodations status in hospital, selected States and Territories, 1996



Source: AIHW, *Australia's Mothers and Babies 1996,* (AIHW cat. No.PER 4), Figure 21, p.21.

5.10 This again is not a new phenomenon, although the generally declining rates of private insurance cover can be expected to have an effect on the numbers of Caesarean sections being performed in that sector.

> Mothers classified as private had caesarean rates about 40% higher than those classified as public. The greatest difference in rates was in Queensland where the caesarean rates for women admitted to hospital as private patients were 24% and 24.5% in 1989 and 1990, respectively, compared with 15.6% and 15.8%, respectively, for women admitted as public patients. The difference in caesarean rates between private and public patients was least pronounced in the Australian Capital Territory.[12]

5.11 The difference in Caesarean interventions between women with private insurance and women without it is particularly disturbing, given that women in the former group are likely to be healthier and generally at lower risk than those in the latter group.

12 Lancaster A. L. & Pedisich Elvis L. *Caesarean births in Australia, 1985-1990*. Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney, 1993, p.10.

> Private insurance is a very good marker of high socioeconomic status, and we know that high socioeconomic status is also linked with good health and in general with lower obstetric risk. The fact that the rates of use are so high among women who are privately insured is a matter of very serious concern.[13]

5.12 There are also significant variations between hospitals. Again, this can be partly explained by reference to their client group. Women at high risk are much more likely to have a Caesarean section and much more likely to give birth in major metropolitan hospitals with the specialists and equipment required to deal with difficult births. One would expect therefore that these major hospitals would have higher rates of Caesarean section than small country hospitals where clients are more likely to be healthy women at low risk of developing complications. This is in fact the case. But there are very significant differences between individual, large metropolitan hospitals with comparable client groups. At the Queen Elizabeth Hospital in Adelaide, for example, Caesarean section rates have been reduced to 16.6% through the implementation of guidelines by senior and junior staff. This compares with a rate of 25.4% at the Adelaide Women's and Children's Hospital during 1996.

> While caesarean rates for hospitals grouped by size were generally similar, there were still marked variations for individual hospitals. For example, among hospitals with more than 2,000 births per year, one hospital had a caesarean rate of only 9.8% [in 1996] but others had rates in excess of 30%. Such variations depend to some extent on the type of hospital and level of care, the proportion of public and private patients, and maternal age distribution, but policies within a particular hospital may also be a factor.[14]

5.13 Women's Hospitals Australia provided information on 17 of its hospitals (without identifiers) indicating that Caesarean section rates for 1998-99 varied from 15% to more than 30% in these institutions.[15]

5.14 There are also differences in intervention rates for public and private patients within the same hospital. At the Mercy Hospital for Women in Melbourne, for example, 22.03% of public patients had Caesarean sections during calendar year 1998. For privately insured patients the figure was 31.9%[16]. In North Gosford Private Hospital the Caesarean rate was 26.1% in 1997. In Gosford (public) Hospital the rate was 15.8%.[17]

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13 *Committee Hansard*, 6.6.99 p.85 (Dr Jane Fisher, University of Melbourne).

14 Submission No. 170, p. 6 (Australian Institute of Health and Welfare).

15 Additional information 27.8.99 (Women's Hospitals Australia).

16 Additional information 7.9.99 (Mercy Hospital for Women, Melbourne).

17 Submission No. 93. p.5 (Central Coast Midwives Association).

5.15 In these cases and others brought to the Committee's attention the differences were largely in **elective** Caesareans. The figures for **emergency** Caesareans were quite similar. This appears to be the case in all States and Territories.

5.16 Even in smaller hospitals with a predominantly low risk client group there are significant differences in intervention rates. The Caesarean rate at Lithgow for example, as noted earlier, was 27.1% in 1997. In Armidale, with a similar number of births, it was 10.3%.[18]

5.17 Caesarean rates vary according to the professional background of the principal carer. Rates are highest for specialist obstetricians, very much lower for general practitioners and lower again for midwives (who are not qualified to perform Caesarean sections themselves but must refer to medical staff any woman whose condition requires such a procedure). Again, these differences in practice can be largely explained by the client group of each of the professional practitioners. Almost all complex births (which are those most likely to require Caesarean section) are attended by a specialist obstetrician or registrar/general practitioner with obstetric qualifications. Midwives attend low risk births.

5.18 Even here however, there appear to be significant variations in practice between individual obstetricians or groups of obstetricians. This was certainly seen to be the case when individual practitioner rates could be determined through analysis of health insurance data. The data included a separate item for Caesarean section until the late 1980s.

> We do not have current information on practitioner variations in caesarean rates. Unfortunately, the item on caesarean section was taken out of the medical benefits schedule in the late 1980s…[Before that] we actually had access to health insurance data for individual practitioners. And, irrespective of the size of the obstetrician's practice, there were rather large variations in individual caesarean rates, a sixfold variation, say, from six percent to 35 per cent or 40 per cent.[19]

5.19 Some witnesses suggested a direct link between the number of specialist obstetricians and the number of Caesarean sections.

> …if you look at the rates across New South Wales, the places that have the largest numbers of obstetricians have the higher rates [of Caesarean section]…I should qualify that statement in that there are specific obstetricians who are very well versed in evidence based practice who have lower rates as well.[20]

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18 New South Wales Health Department. *New South Wales Mothers and Babies 1997,* Sydney, 1998, pp.88-89.

19 *Committee Hansard,* 27.8.99, p.8 (Australian Institute of Health and Welfare).

20 *Committee Hansard*, 14.9.99, p.397 (Professor M Chamberlain, University of Sydney).

5.20 One might expect that obstetricians who perform a large number of Caesarean sections for complex births and are therefore very skilled and knowledgeable about the procedures would attract as clients women who choose to birth by Caesarean section or those whose health status requires it. Since this information is not generally available it is difficult to determine the extent to which it accounts for the variations in practice between obstetricians.

5.21 Many factors influence elective Caesarean rates at the macro level. The nature of the client group is a major determinant. But anecdotal evidence to the Committee suggests that other factors also have an influence. One of these is the 'institutional culture' of a hospital, which is normally established by a few leading professionals within that organisation. Another is peer pressure.

> …back in the 1980s and into the early 1990s, Tasmania had a lower caesarean rate than all the other states. The perinatal collection in Tasmania was set up by a professor of obstetrics, with a view to obstetric audit of what was going on in the state. He regularly fed the information back for the whole state of Tasmania to individual practitioners. I would like to think that that was a factor in keeping the caesarean section rate down in that state – although I cannot prove it; it is my hypothesis. Since he retired the caesarean rate…has caught up with the national figure.[21]

5.22 In an isolated area the philosophy and practice of an individual specialist or general practitioner/obstetrician can make a difference, as the Committee was advised in Western Australia. In the Geraldton region the Caesarean rate halved (from 16.5% to 7.3%) between 1994-5 and 1998-9 after the appointment of a specialist obstetrician, working with a team of general practitioners and midwives. The number of births remained fairly constant during this period (659-699).[22]

Reasons for growth in rates of Caesarean section

5.23 Many factors may contribute to a woman's decision to undergo a Caesarean section and a doctor's decision to perform one. These may be social/cultural as well as medical. The decision to operate may be made before the onset of labour, in which case it is known as an **elective** Caesarean, or after the onset of labour, in which case it is known as an **emergency** Caesarean section.

5.24 The following paragraphs describe some of the factors contributing to the decision to undergo or to perform a Caesarean section.

(i) Safety

5.25 Caesarean section is now a very safe operation. In the period 1991-93, for example, 14 maternal deaths were directly attributable to Caesarean section and 3 to

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21 *Committee Hansard,* 27.8.99, p.29 (Australian Institute of Health and Welfare).

22 *Committee Hansard*, 8.9.99, pp.321-22 (Royal Australian College of General Practitioners).

anaesthetic. There was a total of 84 maternal deaths for 769,253 confinements.[23] Although it is a major operation with significant adverse consequences for the mother in the short term, such as pain and reduced mobility for up to six weeks following the operation, it has few long term adverse effects on the baby. In the short term it increases the risk of respiratory distress to the newborn but it may improve outcomes for some babies at particular risk, such as those with very small birth weight. It may also reduce the number of unexpected intrauterine deaths. These occur in about 1 in 600 pregnancies which progress beyond 41 weeks gestation.[24]

5.26 Because of its relative safety, Caesarean section is now an option for many births where previously it would never have been considered. However, it remains more risky than vaginal birth, with a maternal mortality rate two to four times higher than for vaginal delivery (although the figures are very low in both cases). Elective Caesarean section is safer for the mother than emergency Caesarean section.

(ii) Availability

5.27 Almost all women in Australia deemed to be at risk of developing complications are advised and assisted to birth in major hospitals where Caesarean section is available at short notice if required. This includes women in rural areas who, as noted, are encouraged to move to urban centres to give birth.

5.28 Healthy women in major centres of population who develop unsuspected complications during labour are usually transported quickly to hospital where they can be operated upon if necessary. The situation is much more difficult in country areas. Healthy women who develop unexpected complications there may have difficulty in obtaining rapid access to Caesarean section and other medical support. The fact that this situation rarely arises is testimony to the skills of the general practitioners and midwives in screening women for possible complications and ensuring that their births take place close to necessary facilities.

5.29 In situations in which a range of other options was likely to have been considered in the first instance, for example in a breech position, the widespread availability of Caesarean section increases the likelihood of its use.

(iii) Increasing age of mothers

5.30 The age of mothers giving birth to their first babies is increasing in Australia. In 1996 the estimated mean age nationally was 28.6. In 1991 it was 27.9. The percentage of older mothers (aged 35 or over) giving birth for the first time increased

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23 National Health and Medical Research Council. *Report on Maternal Deaths in Australia 1991-1993,* Canberra 1998, p.9 and p.68.

24 Hilder L et al. *Prolonged pregnancy: evaluating gestation specific risks of fetal and infant mortality.* British Journal of Obstetrics and Gynaecology, 1998;105: pp.169-173.

from 10.6% in 1991 to 14.3% in 1996.[25] This situation is also occurring in other comparable countries.

5.31 Rates of Caesarean section are considerably higher among older women. The older they are when their first baby is born, the more likely they are to give birth via Caesarean section.

> In 1996, the caesarean rate among mothers in their early 30s was double that of teenage mothers, while for mothers aged 40 years and over the rate was almost three times higher. The national caesarean rates by maternal age were as follows: less than 20 years – 11.1%; 20-24 years – 14.0%; 25-29 years – 18.3%; 30-34 years – 22.0%; 35-39 years – 26.2%; and 40 years and over – 31.8%.[26]

5.32 In addition, Caesarean rates are generally higher for women having their first baby than for others. The comparable figures in 1996 were 20.7% for first time mothers and 18.7% for others.[27]

5.33 There are a number of reasons for this, both medical and social. Older women have a slightly enhanced risk of carrying a baby with foetal abnormalities and a slightly higher risk of developing complications during labour and delivery. They are more likely to be privately insured and more likely to be attended during their antenatal period and during birth by a specialist obstetrician. All of these factors enhance the likelihood of Caesarean section.

5.34 The Committee was told that older women are more likely to be highly educated and assertive. Some of them have careers which they do not want to disrupt. They are therefore said to be disproportionately represented among the group of women 'demanding' Caesarean section (as discussed in the following paragraphs).

5.35 It is impossible to ascertain the importance of each of these factors in contributing to the high Caesarean rate among older mothers but the high rate itself cannot be disputed.

(iv) Medical indications for elective Caesarean section

5.36 Some conditions of the mother or foetus during pregnancy predispose doctors and mothers to the use of Caesarean section. They do not of themselves necessitate this approach and years ago would have been generally managed through vaginal delivery. The major predisposing factors are:

(a) Caesarean section following a previous Caesarean section;

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25 Figures are from Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, Sydney 1999, p.7.

26 Submission No. 170, p.3 (Australian Institute of Health and Welfare).

27 Ibid, p.3.

(b) breech presentation of the foetus;

(c) multiple birth;

(d) low birth weight of the baby; and

(e) large size of the baby, especially where the mother is small.

5.37 This is an area of some disagreement between midwives and some medical specialists. Midwives consider that many, but not all, of these conditions could be managed by vaginal delivery without adverse consequences for the mother or baby. This was particularly the case when Caesarean section was less routinely resorted to, so that specialists developed skills in, for example, delivering breech babies and in assisting women to deliver vaginally after a previous Caesarean section.

5.38 Now, obstetricians are much more likely to resort to Caesarean section before the labour starts that is, elective Caesarean. This limits their opportunities to develop skills in vaginal delivery of complex births.

5.39 Each of the predisposing factors listed above is briefly discussed below.

<u>(a) Caesarean section following an earlier Caesarean section</u>

5.40 A woman who has given birth by Caesarean section may have difficulty in giving birth vaginally on subsequent occasions. This is because the scar from the original procedure may reopen during labour. For this reason many women who are pregnant for the second time, and whose first birth was by Caesarean section, are advised to be delivered again by Caesarean section.

5.41 Some midwives and medical specialists dispute the necessity for this approach. They suggest that if vaginal labour is allowed to proceed and carefully monitored then a majority of women in this group will be able to give birth by this method without harm to themselves or their babies. In the minority of cases where the previous scar tissue is in danger of rupturing there is sufficient time to perform a Caesarean section.

5.42 Evidence shows that up to 70% of women who opt for vaginal labour in these circumstances (technically described as a 'trial of scar') are successfully delivered without recourse to Caesarean section.[28]

5.43 However, a recently published West Australian study indicated that when women with a previous Caesarean section were advised of the risks and benefits of a

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28 See de Costa Caroline M. *Caesarean section: a matter of choice?* Medical Journal of Australia 23.5.99, 170, pp.572-573.

trial of scar as opposed to Caesarean section for a second birth the majority opted for a second Caesarean section.[29]

5.44 As a result of the increase in the number of women delivering their first babies by Caesarean section the number delivering subsequent children by the same method is also increasing. This group constitutes a significant proportion of total Caesarean sections and is continuing to contribute to the rise in rates. Casemix data for 1997-98 showed previous Caesarean section as the principal reason for Caesarean delivery in 23.26% of cases. It was the secondary reason in a further 12.55% of cases.

(b) Breech presentation of the foetus

5.45 Breech presentation of the foetus before birth occurs in approximately 4% of pregnancies.[30] While it is a complicating factor, vaginally delivered breech babies have only marginally worse outcomes than do vaginally delivered babies of normally presented foetuses. A recent study of maternal and neonatal outcomes of 846 single breech deliveries concluded that 'available data was not sufficiently conclusive to justify Caesarean section for the singleton breech infant at term'.[31]

5.46 A multinational, randomised trial of planned Caesarean section versus planned vaginal delivery of breech babies, begun in 1997 and due to conclude in 2000, should provide more definitive answers on the relative safety of each of the methods for both mothers and babies. The trial is being conducted by the University of Toronto in Canada.

5.47 Before Caesarean section was such a safe procedure, almost all breech babies were delivered vaginally. Midwives and medical specialists would develop skills in external rotation of the baby to the head down position before labour commenced and were successful in doing so in about 70% of cases. Where this was not possible, or where the baby returned to its original position before labour began, they would develop skills in assisting during labour and birth and in minimising trauma to the mother and baby. If trial of a breech by vaginal labour were unsuccessful they could resort to Caesarean section at that point.

5.48 Today, specialists are much more likely to resort to Caesarean section before labour begins. Vaginal delivery is now performed in only 13% of cases of breech presentation. There are a number of reasons for this. One, as noted, is that Caesarean section is a relatively safe alternative. Another reason is that young specialists have less practice in managing breech births vaginally and so are more nervous about undertaking them. They may also be concerned about the possibility of litigation if

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29 Quinlivan J. Peterson R. and 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. Australian and New Zealand Journal of Obstetric Gynaecology,* 1999, 392, pp. 207-214.

30 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* Sydney 1999, p.18.

31 See Schiff et al. *Maternal and Neonatal Outcomes of 846 Singleton Breech Deliveries.* American Journal of Obstetrics and Gynaecology 1996, 175, pp.18-23.

they do not opt for Caesarean section and there is subsequently a less than optimal outcome. Women themselves may be ill informed about the high success rate for vaginal delivery of breech babies and may exert pressure on obstetricians to perform a Caesarean section. As specialists and midwives become less experienced in performing vaginal delivery for breech presentations they become less skilled at doing so, more reluctant to undertake them and more likely to resort to Caesarean section.

5.49 Breech presentation makes a significant contribution to Australia's high Caesarean rate. It was the principal reason for performing Caesarean sections in 11.06% of cases in 1997-98 and the secondary reason in 4.13% of cases.

(c) Multiple births

5.50 Multiple births are inherently more risky for the babies than single births. The greater the number of babies involved, the greater the risk, especially for the second and subsequent babies born. For this reason Caesarean section rates are higher for multiple births than for single births, and the greater the number of babies the greater the likelihood of Caesarean section. All quadruplets are now born by Caesarean section, as are 75% of all triplets. For twins the rate is 35%.

5.51 For twins the perinatal death rate was 3.7 times higher in 1994-96 than for singleton births. For other multiple births it was 8.6 times higher.[32] Some midwives and obstetricians suggest vaginal delivery of twins where there are no other risk factors. But, through lack of experience, fear of litigation and women's concerns about the safety of the babies, an increasing number prefer to perform a Caesarean section.

5.52 There has been an increase in the number of multiple births associated with IVF and other assisted conception programs. In turn, this has contributed to an increase in the number of Caesarean sections. The casemix data does not include information on multiple births greater than two babies. In 1997-98 it did not show the delivery of twins as a principal reason for Caesarean section although it was cited as the secondary reason in 3.08% of cases.

(d) Low birth weight of the infant

5.53 There is some conflicting evidence that pre term and low birth weight infants have a greater chance of survival and suffer fewer adverse effects if delivered by Caesarean section. In these circumstances therefore birth by Caesarean section may be indicated. However, recent evidence casts doubt on the value of Caesarean sections for low birth weight babies and intervention rates on these grounds have begun to fall during the 1990s.

32 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* pp.43-44.

5.54 The position is reversed for babies of normal weight and gestational age. They are more likely to suffer from respiratory complications when delivered by Caesarean section than when delivered vaginally.

5.55 The number of live births of pre term babies and babies of very low birth weight is increasing, as are their survival rates. The increase in live births is partly a result of the more widespread adoption of assisted conception programs (which result in a disproportionate number of pre term births). The increase in survival rates is a direct result of advances in medical knowledge and medical technology.

(e) Large size of the infant, when the mother is small

5.56 The Committee heard conflicting evidence on the extent to which Caesarean sections are performed in these circumstances, and the desirability of performing them for these reasons. One witness suggested this was a particular problem among some ethnic groups.

> If you come to a hospital in any capital city…you will find that at least 47 per cent, and in some hospitals up to 60 per cent, of the women are first generation migrants. Particularly if they marry outside their racial group, they grow babies with body habitus which is different to that of babies born in Vietnam, Somalia or Ethiopia.[33]

5.57 Others suggested that the high Caesarean rate among some ethnic groups was more likely to reflect the distress of mothers during labour in an unfamiliar environment surrounded by strangers with whom they were unable to communicate.

5.58 There are certainly variations in Caesarean rates between ethic groups.

> High caesarean rates occurred among mothers born in the Philippines (27.4%), Malaysia (23.6%) and India (23.2%) and relatively low rates among mothers from Vietnam (14.3%), Lebanon (13.1%) and New Zealand (16.4%).[34]

5.59 These figures do not differentiate maternal age, health or insurance status, which might also have an effect on Caesarean section rates. Nor do they provide information on the ethnic and health backgrounds of the fathers.

5.60 There appears to be only anecdotal evidence to support the claim that some practitioners see these circumstances (large size of baby when the mother is small) as warranting the performance of Caesarean sections. Indeed, the Committee received evidence of some births in which these circumstances prevailed and vaginal delivery was allowed to proceed despite significant distress to the mother and the baby.

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33 *Committee Hansard,* 6.9.99, p.172 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

34 Submission No. 170, p.5 (Australian Institute of Health and Welfare).

5.61 The Committee is therefore unable to ascertain the extent to which these factors have contributed to an increase in the Caesarean section rate, or indeed if they have made any such contribution. This is an area requiring further research and data against which the conflicting claims can be assessed.

(v) Indications for emergency Caesarean section

5.62 Emergency Caesarean sections are those in which the decision to operate is made after the onset of labour. It includes those cases of trial of scar and trial of breech delivery (discussed earlier) which cannot be sustained. The major medical reasons for emergency Caesarean sections are:

(a) foetal distress;

(b) failure to progress in labour; and

(c) placenta praevia.

5.63 Each of these is discussed below.

(a) Foetal distress

5.64 The Committee heard conflicting evidence on the appropriateness of Caesarean section as a response to foetal distress. Some witnesses claimed that continuous foetal monitoring of low risk infants, which is the norm in some hospitals, had adverse consequences for the mother and the baby. It restricted a woman's mobility during labour, confining her to a prone position on the bed, which was not the optimal position for labour or delivery. These witnesses also claimed that it exaggerated the extent of foetal distress, (through high false positive rates for the detection of foetal hypoxia or acidosis) resulting in the performance of Caesarean sections when in fact the baby's condition did not warrant it.

5.65 Obviously, there are circumstances in which foetal distress is such as to warrant prompt resort to Caesarean section. But it is impossible for the Committee to judge whether it is used in circumstances where it is not medically necessary. Again, fear of litigation in the event of an adverse outcome may influence practitioners' decisions here. Women's concern to avoid any risk of foetal damage is another major factor.

5.66 Certainly, foetal distress was said by doctors to be a major reason for the performance of Caesarean section. It was cited as the principal reason for it in 10.71% of cases in the 1997-98 casemix data set and as the secondary reason in 9.09% of cases.

(b) Failure to progress in labour

5.67 Evidence to the Committee suggested that failure to progress was the most common cause of emergency Caesarean section. Its incidence is not evident in

casemix data, which does not include this among the possible reasons for Caesarean interventions.

5.68 The reasons for failure to progress in labour were a matter of dispute in evidence to the Committee. Some evidence suggested that failure to progress was directly linked to induction of labour.

> The high epidural rate in some hospitals is undoubtedly related to the high rates of induction and labour augmentation (more painful labour). The use of epidural analgesia also results in an increased use of interventions such as forceps and/or caesarean section (due to failure to progress in labour). The use of medical interventions in labour often leads to other interventions becoming necessary, thus increasing maternity care costs.[35]

5.69 Other evidence suggested that it was a more general reaction to the medicalisation of the birth process.

> Where there is an emphasis on time limits, on ongoing monitoring, on the time constraints of the medical staff, such as shift changes and obstetrician's rosters, and on bright lights and technology, women become stressed, hormone levels alter, and the birthing process slows down or stops, leading to an intervention domino effect and more caesarean sections.[36]

5.70 The number of emergency Caesarean sections performed as a result of the mother's failure to progress in labour is impossible to determine. This is another area requiring research on which to assess the appropriateness of current practice. However, evidence to the Committee suggests that it is widely perceived as a significant contributor to Australia's high Caesarean section rate.

> The main [reason for the increase in the Caesarean section rate] – and it has been going on since the mid-1970s – has been the so called failure to progress in labour situations with the first baby. The cervix does not reach full dilation within a certain time and the patients and the doctors are concerned about the foetal wellbeing.[37]

<u>(c) Placenta praevia</u>

5.71 This is a condition in which the placenta covers the cervix, partially or completely blocking it. It causes sudden and severe bleeding in the mother, possibly resulting in her death. In these circumstances therefore Caesarean section is always indicated.

5.72 Caesarean section necessitated by placenta praevia accounts for a very small proportion of the total number of Caesarean sections performed. It was cited as the

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35 Submission No. 154, p.4 (Professor Marie Chamberlain and Ms Jannine van der Klei).

36 Submission No.184, p.2 (Birth Support, Bendigo).

37 *Committee Hansard*, 6.9.99, p.175 (National Association of Specialist Obstetricians and Gynaecologists).

principal reason for 1.54% of the Caesarean sections performed in 1997-98. It was never cited as a secondary reason.

5.73 In addition to the medical reasons for Caesarean section discussed above, a range of other medical conditions are also indicators for Caesarean intervention. These include sideways lie of the foetus, cord prolapse and eclampsia. They occur in a relatively small number of cases and so have not been included in this discussion.

5.74 Medical indications for elective and emergency Caesarean section have not changed significantly in many years, except for the flow on effect of Caesarean sections in women who have had an earlier birth by this method. The increasing Caesarean rate appears to reflect a readiness for earlier Caesarean intervention rather than any change in the medical indications for its use.

(vi) Patient demand

5.75 Patient demand is said to be a significant factor in Australia's escalating Caesarean rate. This is certainly a widely held perception in the community, although advice to the Committee suggested that patient request for Caesarean section was a determining factor in only about 5% of (mainly elective) Caesarean sections in cases where there was no medical justification for such a procedure.

5.76 The perception is fostered by the media, with its television serials portraying birth as a life threatening event from which woman and child can be saved only by emergency surgery following a high speed dash to hospital.

5.77 The print media too tends to portray Caesarean sections as the preferred alternative to vaginal birth – less mess and more convenient. The following excerpts have been selected at random from recent articles.

> …'it was good having a caesarean because it was over and done with, and there was no pain'.[38]

* * *

> 'I went in at 8 am and came out at 8.30, signed, sealed and delivered… It came down to my age, and the pain and the convenience. I had to fit in with my husband's holidays.'[39]

5.78 Some witnesses pointed to the increase in the Caesarean section rate as reflecting society's preoccupation with technological solutions to problems.

> …we have increasingly a technological perspective in our culture as a whole and this is reflected in the birth process. In all aspects of our life, we think technology is good and more technology is better and we take this into the

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38 *Removing the uncertainty*. Adelaide Advertiser, 6.9.99.

39 *Caesareans – Just what the Mother-to-be Ordered.* Australian, 28.8.99, p.3.

> birth area where we think technology is good and most technology – caesarean section – must be better.[40]

5.79 Women were reported by witnesses as requesting Caesarean section for reasons of convenience. This was said to be especially the case for 'career' women, but was not restricted to that group.

> I do not like to put people in pigeon holes, but a lot of the more career oriented women are very in control people and do not like to not be in control. I really do believe that that is a driving force. I have no evidence for that; that is just an anecdotal thing, but I do see that quite often amongst the women that I look after.[41]

5.80 Women may request Caesarean section before the onset of labour because they want to avoid the pain of vaginal childbirth. They may also request it during labour, if they consider the pain is excessive.

5.81 The Committee heard some suggestion that partners are more likely than the woman giving birth to favour Caesarean section for pain avoidance or pain relief, but again, the 'evidence' was anecdotal. Some recent studies lend weight to this view however. Questionnaires completed by 278 women who gave birth by Caesarean section at the Women's and Children's Hospital in Adelaide in 1996 indicated that in a majority of cases (61%) partners' reaction during labour was one of the factors influencing the decision to undergo an emergency Caesarean section.[42]

5.82 An important reason for a woman's decision to choose a Caesarean section is concern to avoid some of the claimed long term ill effects of vaginal delivery, chiefly the risk of faecal or urinary incontinence resulting from damage to the pelvic floor or anal sphincter muscles during vaginal labour. Although these risks are not widely discussed they are well documented. The conditions are embarrassing and debilitating and may themselves require surgery in time.

> Women who deliver by C/S suffer less from urinary incontinence compared with those delivering vaginally. Of women without stress incontinence before or during pregnancy, none delivering by C/S had urinary incontinence in the puerperium compared with 13% of those delivering vaginally.
>
> Four per cent of women with no clinically obvious sphincter rupture begin experiencing faecal incontinence after childbirth. The incidence of faecal incontinence increases with the number of vaginal deliveries. Women who

40 *Committee Hansard,* 15.9.99, p.526 (Dr Sarah Buckley).

41 *Committee Hansard,* 7.9.99, p.269 (Sister Edith Reddin).

42 See Turnbull Deborah A et al. *Women's role and satisfaction in the decision to have a caesarean section. Medical Journal of Australia* 1999; 170, pp.580-583.

deliver by C/S have significantly less frequent faecal incontinence years later than women delivering vaginally.[43]

* * *

Childbirth was found to be associated with a variety of muscular and neuromuscular injuries of the pelvic floor that are linked to the development of anal incontinence, urinary incontinence, and pelvic organ prolapse. Risk factors for pelvic floor injury include forceps delivery, episiotomy, prolonged second-stage of labour, and increased fetal size.[44]

5.83 One submission to the Committee suggested that the adverse consequences of vaginal delivery, especially operative vaginal delivery, were not appreciated by midwives because they were often not apparent in the immediate post natal period. This influenced midwives' views of the comparative benefits of vaginal as opposed to Caesarean delivery.

It is my belief that the general public are only beginning to realise how common and debilitating these conditions [urinary incontinence and genital prolapse] can be. **Most midwives are largely ignorant about prolapse and incontinence and their relation to childbirth because they do not deal with these problems in their professional lives.**

This colours their view of the childbirth process and leads them to see a "natural delivery" with as little intervention (eg caesarean section) as possible as being the ideal. The terms of reference of your enquiry even legitimise this view and have the stated aim of minimising intervention.[45]

5.84 Other possible long term effects of vaginal delivery less frequently cited as reasons for choosing Caesarean section include dyspareunia (pain during intercourse) and perineal pain.

Three months after vaginal delivery, 20% of women have dyspareunia and 12% seek medical advice because of perineal problems which may persist for years. Morbidity after operative vaginal delivery is greater and longer lasting than that after C/S. Perineal pain is a particular problem and leads to a higher incidence of sexual difficulties in this group.[46]

5.85 Women are concerned above all about the safety of the baby. Many state that their decision to opt for a Caesarean section is prompted by the belief that a Caesarean birth is safer for the baby than a vaginal birth.

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43 Cotzias C. Fisk N. *Patient demand for a Caesarean section.* Advances in Obstetrics and Gynaecology. Issue 15, pp.11-12.

44 Handa V. L. et al. *Protecting the pelvic floor; obstetric management to prevent incontinence and pelvic floor prolapse.* Obstetrics and Gynaecology 1996, September: 88 (3), pp.470-478.

45 Submission No. 188, p.1 (Dr Glen Barker, Vic).

46 Ibid, p.12.

> On balance, when we interviewed the women, both in a quantitative and qualitative sense, they very much talked about or thought about caesarean section as being less risky for the baby. They very much couched their reason in terms of safety to the baby.[47]

5.86 Some, privately insured women, it is suggested, see Caesarean section as a service they have purchased with their insurance.

> The perception I get is that when women are paying good money to have a doctor look after them, they want the doctor to look after them. If they want a certain thing – for instance, a caesarean – they feel that they are paying him or her and he or she ought to do it. I think they put as much pressure on the doctors perhaps as the doctors put on them, in some cases.[48]

5.87 Those in the community and the professions who are concerned about the numbers of women requesting (or demanding, as some witnesses claimed) Caesarean section without any medical indication see education as the key to reducing demand. They argue that women are ill informed about the relative advantages and disadvantages of Caesarean versus vaginal birth and that if they were fully aware of the consequences of each approach then fewer of them would chose Caesarean section. Some of the popular misconceptions which, in this view, need to be addressed are:

Caesarean birth is painless

5.88 Women need to be advised that Caesarean sections are not painless. They are major operations and post operative pain is a major factor to be considered. In addition, some women who opt for Caesarean sections to escape the pain of childbirth may not be aware of the techniques available to manage the pain of vaginal delivery.

Caesarean birth has no long term ill effects

5.89 Caesarean section limits mobility for up to six weeks, at a time when a woman has great demands placed upon her.

5.90 There is also increasing evidence that women giving birth by Caesarean section are more likely to suffer long term psycho social problems than are women giving birth naturally. They are more likely to have difficulty in breastfeeding, for example, and are more prone to post natal depression.

> As health professionals, we are becoming increasingly aware of the damage done to women, and therefore to their babies, through the misuse of intervention in birth. The latest evidence highlights the link between

47 *Committee Hansard,* 7.9.99, p.265 (Dr Deborah Turnbull, University of Adelaide). Referring to study by Turnbull, Deborah A. *Women's role and satisfaction in the decision to have a Caesarean section.* Medical Journal of Australia 1999, 170: pp.580-583.

48 *Committee Hansard,* 7.9.99, p.269 (Sister Edith Reddin).

> obstetric intervention and post-traumatic stress disorder (PTSD) in childbearing women.[49]

5.91 Caesarean sections also entail an enhanced though small risk of subsequent ectopic pregnancy, placenta praevia, placenta accreta and emergency hysterectomy.

> Although peripartum emergency hysterectomy is an uncommon complication…it is 18 times more likely in women with a history of C/S compared with those who had a vaginal delivery. Previous C/S is also a risk factor for major obstetric haemorrhage in a subsequent pregnancy.[50]

Caesarean birth is safer for the baby

5.92 Babies delivered by Caesarean section have a higher risk of respiratory distress in the period immediately after birth, although for babies of normal gestational age, mortality and long term morbidity outcomes are similar whether they are delivered vaginally or by Caesarean section.

Caesarean section has a lower risk of maternal mortality

5.93 Maternal mortality rates are two to four times higher for Caesarean section.

Caesarean section is the only option where a previous Caesarean section has been performed, or where the baby is in a breech position

5.94 As discussed, breech presentation and previous Caesarean section do not preclude the possibility of vaginal birth. In both cases the majority of women can deliver vaginally without any risk to themselves or their babies.

5.95 Supporters of natural childbirth also point out that women who choose Caesarean section deprive themselves of one of life's great experiences. They claim that although vaginal birth may be hard work and is sometimes painful it is also empowering and uplifting (especially where there is minimal intervention), so that women who have experienced it begin their maternal role from a position of strength, viz a viz those who have not.

> Birth is very much a psychological process which is easily fractured if mishandled. Our society's expectations have in many cases shifted from where women empowered, educated and supported the birthing woman to a model where a professionally trained doctor is deemed to have the

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49 Submission No. 57, p.2 (Brisbane Independent Midwives). The research referred to is by D Creedy, and was published as *Birthing and the development of trauma symptoms: incidence and contributing factors.* Griffith University, Brisbane 1999.

50 Cotzias C. Fisk N. *Patient demand for a Caesarean section.* Advances in Obstetrics and Gynaecology. Issue 15. p13. Article refers to a number of studies on this issue including Greene R et al. *Long-term implications of caesarean section.* American Journal of Obstetrical Gynaecology 1997, 176, pp.254-256 and Coulter- Smith S et al. *Previous caesarean section: a risk factor for major obstetric haemorrhage,* Journal of Obstetrics and Gynaecology, 1996, 16, pp. 349-352.

> knowledge and the control over the birthing process. This has disempowered women, rendering them vulnerable, lacking in confidence and willing to 'hand over their bodies' to the professionals.[51]

5.96 There appears to be a link between women's education levels and the likelihood of their giving birth by Caesarean section. The available evidence suggests that those with the very best information – female obstetricians – are among the most likely to opt for Caesarean section.

> …when obstetricians were asked which mode of delivery they preferred for their own uncomplicated pregnancy at term, 31% chose elective C/S. The reasons cited were fear of pelvic damage, fetal safety and electively timed delivery.[52]

5.97 Other factors are obviously at work here. At a very general level, it might be assumed that poorly educated women are less likely to have private insurance and less likely to be attended by a specialist obstetrician, both factors associated with higher rates of intervention. More importantly, less educated women may be less likely to assert their 'right' to Caesarean section in the face of medical advice to the contrary and obstetricians may be less likely to accede to their requests.

5.98 A Victorian study suggested that obstetricians may see litigation as more likely to be instigated by better educated women than by others, and that this might influence their approach to intervention.[53]

> It is possible that confident, articulate, well pregnancy-educated women and their husbands may arouse greater anxieties about malpractice litigation in their treating physicians than those who are less articulate or well-educated. Obstetricians may then be less willing to risk a natural outcome of delivery in this group.[54]

5.99 However, some of the other limited evidence available on this issue suggests that there is no difference in terms of class or education between the women who opt for Caesarean section and those who do not.

> Our study [the Turnbull questionnaire] showed that women who seem to have a preference for caesarean section are no different from those who do not. I know that a lot of individual clinicians talk about articulate middle-class women having stronger preferences, wanting to plan the event and, therefore, demanding it more. Our research with a consecutive group of

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51 Submission No. 184, pp. 1-2 (Birth Support Bendigo).

52 Cotzias C. Fisk N. *Patient demand for a Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.10.

53 This was a Melbourne study conducted by Dr Jane Fisher in 1993. It analysed questionnaires sent to 242 nulliparous pregnant women in the late stages of pregnancy and again six weeks after birth.

54 Fisher J et al. *Private health insurance and a healthy personality: new risk factors for obstetric intervention?* Journal of Psychosomatic Obstetrics and Gynaecology, 16, 1995, p.6.

> women, sampled in a systematic manner, does not indicate that that is so. The women who have preferences for section are no more likely to be educated women, they are no more likely to be older women, they are no more likely to be English speaking women.[55]

5.100 This witness hypothesised that the general view that it is middle class women who 'demand' Caesarean section has arisen because this is the group whom specialist obstetricians are most likely to treat, and on which, therefore, they base their assumptions about the type of women requesting elective Caesarean sections.

> It is an issue of selection bias. They [specialist obstetricians] are seeing a select group of women so they have no points of comparison.[56]

5.101 The dynamics of the relationship between doctor and patient must certainly be an important consideration in the final decision reached on whether or not to perform a Caesarean section. But this is an area about which very little is known. Deborah Turnbull's study reported that 61% of patients felt they had been included in the decision to have a Caesarean. Half 'strongly agreed' that they were satisfied with the decision to have a Caesarean and 40% 'agreed'.[57] However, 20 % reported they needed more information on other options and only 28% felt they had been given good information on the issues. In this study more than 25% of patients indicated that they 'had insisted on' or were 'keen to have' a Caesarean delivery. Similar percentages have been reported in recent studies in Scotland and Western Australia.[58]

5.102 It is impossible to ascertain the proportion of Caesarean sections performed at the patient's request where there is no medical reason. This is a particularly difficult area to examine given that few doctors are likely to admit to performing operations for which there is no sound medical justification. (Indeed, this is one of the few areas of medical practice where such an approach is even contemplated.)

5.103 Most evidence to the Committee suggested that the popular view of large numbers of women demanding Caesarean sections was grossly exaggerated.

> The majority of women come in [to an obstetrician] saying, "I want a natural birth without any intervention if possible". The group wanting caesarean sections is very small, but they are women who have thought

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55 *Committee Hansard*, 7.9.99, p.265 (Dr D Turnbull, University of Adelaide).

56 *Committee Hansard*, 7.9.99, pp. 266-7 (Dr D Turnbull, University of Adelaide).

57 Turnbull Deborah A. et al. *Women's role and satisfaction in the decision to have a caesarean section.* Medical Journal of Australia 1999; 170: pp.580-583.

58 See Wilkinson C, et al. *Is a rising caesarean section rate inevitable?* British Journal of Obstetrics and Gynaecology 1998, vol. 105, pp.45-52 and Quinlivan J et al. *Patient Preference the Leading Indication for Elective Caesarean Section in Public Patients – Results of a 2-year prospective audit in a teaching hospital.* Australian and New Zealand Journal of Obstetrics and Gynaecology, 1999, vol. 392, pp. 207-214.

> about what they want. They have thought about their choices, and this is what they want.[59]
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> * * *
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> The usual rationale provided by the clinicians who provide this care is that women are demanding these procedures. To my knowledge, there is very little evidence to support this assertion…[60]

5.104 Most doctors providing evidence to the Committee on this issue tended to the view that patient request/demand might account for 5% of Caesarean sections performed.[61] Those who discussed it said that where a healthy woman requested Caesarean section they would try to dissuade her by explaining the disadvantages of Caesarean section, as well as its advantages, in comparison to vaginal delivery. However, where a woman persisted in her request, despite full awareness of the consequences, most said that they would accede to the request.

> …the patient's input to any clinical management decision cannot and must not be overlooked. It must be as well informed as possible, but in the end it becomes a clinical decision. There are a number of reasons…why denying a patient a caesarean section may in fact be causing her, then and subsequently, an enormous amount of grief in various ways. But we would not simply give a blanket yes to a caesarean section request.[62]
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> * * *
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> …I would say a minority would request a caesarean…It is usually not big, but it is very real. Some of them will choose a caesarean for that reason [difficult previous birth]. I must say, when they do, I would go along with that. In a particular situation like that, I would not be too insistent on trying to change their minds. In other situations, I would.[63]

5.105 There appears to have been a change in medical practice in this respect over the last ten years. In 1987, for example, the British Medical Journal advised readers in an editorial that 'a woman's request for caesarean section in an uncomplicated pregnancy should be refused'.[64] Yet recently, when 300 obstetricians at a conference in Adelaide were asked if they would perform a Caesarean section on a patient who demanded it, all said that they would do so.[65]

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59 *Committee Hansard*, 6.9.99, p.174 (National Association of Specialist Obstetricians and Gynaecologists).

60 *Committee Hansard,* 6.9.99, p.85 (Dr Jane Fisher, University of Melbourne).

61 *Committee Hansard*, 7.9.99, p.200 (Professor M Keirse, Flinders Medical Centre).

62 *Committee Hansard,* 27.8.99, p.68 (Women's Hospitals Australia).

63 *Committee Hansard*, 7.9.99, p.195 (Professor M Keirse, Flinders Medical Centre).

64 Hall M H. *When a woman asks for a caesarean section.* British Medical Journal 1987; 294: pp.201-202.

65 *Committee Hansard*, 6.9.99, p.170 (National Association of Specialist Obstetricians and Gynaecologists).

5.106 So what has changed in this 12 year period? Two major factors appear to account for this difference. The first is changing attitudes on the part of clinicians and some consumers to the balance of benefit versus harm between Caesarean sections and vaginal deliveries.

> …on the basis of the available evidence the concept of a prophylactic caesarean section being outrageous has been shattered by the fact that almost a third of female obstetricians would choose it for themselves. Prophylactic caesarean section can no longer be considered clinically unjustifiable, and it now forms part of accepted medical practice.[66]

5.107 While most commentators do not go so far as to agree that elective Caesarean section for non medical reasons 'forms part of accepted medical practice' there appears to be more general agreement that the balance is shifting in that direction.

> The trend for increasing use of caesarean section, coupled with a greater emphasis on patients' autonomy in medical decision making, has clearly progressed too far for a return to paternalistic directions to women on how they should give birth.[67]

(vii) Litigation

5.108 The second major factor is the threat of litigation in the event of a less than optimal outcome following refusal to perform a Caesarean.

5.109 Many doctors advised the Committee that litigation was very rare when a Caesarean had been performed, even when there was an adverse outcome. The patients' and lawyers' perception was that if a Caesarean had been performed then everything possible had been done. If a Caesarean had not been performed then this was interpreted as negligence on the part of the doctor, even in cases where there was absolutely no medical evidence to suggest that a Caesarean was either necessary or might have changed the outcome.

> The Obstetrician like the patient is striving for the perfect result but in the current climate he is seen to be giving of his best only when he performs a Caesarean. Then, though the result be unfavourable, blame is rarely apportioned by either the patient or a Court of Law.[68]

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66 Paterson-Brown S. *Should doctors perform an elective caesarean section on request?* British Medical Journal, vol. 317, 15 August 1998, p.463.

67 Olubusola Amu et al. *Maternal choice alone should not determine method of delivery.* British Medical Journal, vol. 317, 15 August 1998, pp. 462-463.

68 Additional Information 7.9.99 (Mercy Hospital for Women, Melbourne).

> …in the major court cases on obstetrics and litigation nobody has been sued for doing a caesarean section. Many people have been sued for failing – in the eyes of the plaintiff and her defence – to do a caesarean.[69]

5.110 Some witnesses suggested that the threat of litigation is more perception than reality. This view is supported by the findings of the Review of Professional Indemnity Arrangements, discussed in chapter 10, which concluded that:

> The statement that an obstetrician might cease delivering babies because of fear of being sued for a damaged baby shows a degree of fear out of all proportion to the real risk of such legal action occurring. While there are no comprehensive data available for the public and private sectors, it seems unlikely that the total number of claims made of this kind each year is more than 20, and the total number of claims paid out between five and ten. This gives a rate of "brain-damaged" baby claims of between 1 in 13 000 to 1 in 18 000 births, and a successful claims rate of between 1 in 26 000 and 1 in 52 000. If fear of being caught up in litigation were the motivating factor for practice change, then claims data would support a move out of gynaecological practice, rather than obstetrics.[70]

5.111 Nevertheless, there is no doubt that the fear of litigation exerts a powerful influence on obstetrical practice. Many doctors practice defensive medicine to avoid the threat of litigation. It is the conjunction of the threat of litigation and patients' unrealistic expectations of a perfect baby and a pain free birth every time by Caesarean section that explain doctors' propensity to perform a surgical operation for which there is no medical justification, in contradiction to medical best practice and ethics.

5.112 Both of these factors have been discussed by Dr Brian Roberman of King Edward Memorial Hospital, Perth who sees obstetricians as victims of their own success. Medical advances have made childbirth so safe that anything less than a perfect outcome is deemed a failure on the part of clinicians, and a cause for litigation.

> The penalty of success is increased expectations.
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> […Dr Roberman] said it was ironic that it had never been safer for a mother to have a baby, yet it had never been more risky for an obstetrician to deliver one.[71]

5.113 The impact of litigation on medical practice is discussed in greater detail in chapter 10.

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69 *Committee Hansard*, 6.9.99, p.170 (National Association of Specialist Obstetricians and Gynaecologists).

70 Commonwealth Department of Human Services and Health. *Compensation and Professional Indemnity in Health Care. A Final Report,* Canberra 1995, p.281. The same Report noted (p.10) that '80% of the cases numerically made against obstetricians and gynaecologists related to their gynaecological practice'.

71 The West Australian. *Doctors pay a price for medical progress,* 27 January 1994, p.11.

(viii) Doctor convenience

5.114 Some evidence to the Committee suggested that some doctors may perform Caesarean sections for their own convenience. (This charge was made also in connection with other interventions, notably induction, and will be discussed in the next chapter.) This was said to be particularly the case for obstetricians tending women in more than one hospital. Since they obviously could not supervise births in more than one place at the same time, they tended to perform Caesarean sections which were quickly completed, thus allowing them to move to their next case.

> I think part of the problem is that private practitioners have their rooms and deliver women at various hospitals. If they were made to stay in one and the same spot they would be able to look after them more properly and they would not have to just end it quickly so that they could rush back to their rooms. If I had anything to say I would make it illegal to practice in two positions, but I must say I am not too popular when I say that to my colleagues.[72]

5.115 This was said to happen to a lesser extent where obstetricians were responsible for a number of births proceeding at the same time in the same hospital. Certainly there is evidence to suggest that the length of labour of privately insured women is significantly shorter than that of women without it, presumably because these labours have a greater likelihood of ending in Caesarean section.

5.116 A number of witnesses pointed out that obstetricians' training emphasises the unusual and potentially serious aspects of childbirth. This is appropriate if obstetricians are attending high risk births. It is not appropriate for the majority of normal births. When obstetricians do attend such births it is suggested that their training has not equipped them to stay in the background and let nature take its course, intervening only when things go wrong. They are trained to act and do so, it was suggested to the Committee, even when there is no medical justification for doing so and when labour could have proceeded without adverse consequences for the mother and baby.

> There is this great tension that the profession is highly trained surgically. It is suggested that they get more gratification from action than expectancy… the profession is highly trained surgically and, therefore, they have a strong urge to act. Their perception of danger is probably heightened. Their perception of risk is probably heightened. Their sense of achievement professionally comes from acting and intervening in this circumstance.[73]

5.117 If true, this is a further reason for encouraging midwives to attend normal births, with specialists concentrating on complex births but available to assist where normal births develop complications.

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72 *Committee Hansard,* 7.9.99, p.194 (Professor M Keirse, Flinders Medical Centre).

73 *Committee Hansard*, 6.9.99 p.92 (Dr Jane Fisher, University of Melbourne).

(ix) Financial incentives

5.118 There are no direct financial incentives in current funding arrangements which might encourage individual practitioners to perform Caesarean sections rather than vaginal deliveries. It is unlikely that casemix funding would have this effect at the hospital level. At the national level certainly, unnecessary Caesarean sections are a drain upon taxpayers, with the average Caesarean section costing about twice as much as the average vaginal delivery.[74]

5.119 These issues are discussed in greater detail in chapter 9 of this Report.

What is the optimal rate for Caesarean section?

5.120 No witnesses before the Committee were prepared to state an optimal rate for Caesarean section. Most agreed that current rates were too high (at least for elective interventions) and supported a reduction on the grounds that:

- some are now performed without any medical justification;
- many are now performed without adequate medical justification;
- there is generally higher maternal morbidity and mortality associated with Caesarean sections; and
- Caesarean sections are more costly.

5.121 This is not a universal view however. Overseas commentators in particular are questioning the preoccupation with rising Caesarean rates. The [British] Lancet, for example, recently stated that 'the uptake of caesarean sections in informed women is more appropriate than any target to reduce the Caesarean section rate'.[75]

> Obstetricians have assumed for too long that the indications for C/S are absolute. However, by considering the cumulative risk of abnormalities arising during the labour process, and given the poor predictive value of current fetal monitoring tests, and our ability to predict adverse fetal outcome, the risk-benefit ratio of C/S is altering.[76]
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> * * *
>
> The [British] reports *Health Committee Maternity Services* and *Changing Childbirth* suggested that women should have a pivotal role in their obstetric care yet some are now being criticised for the choices they are making. These choices should not be discredited simply because they are not the

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74 The West Australian Health Department, for example, advised that in a West Australian tertiary hospital an uncomplicated vaginal delivery costs $1776 and an uncomplicated Caesarean section costs $2640. The cost of each is significantly lower in non teaching hospitals. Additional information 21.10.99.

75 *What is the right number of caesarean sections?* Lancet editorial 1997; 348, p. 815.

76 Cotzias C. Fisk N. *Patient demand for Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.13.

> ones that were expected. We should respect a woman's view and choice if it is fully informed, if she expresses a logical reason for wanting a caesarean section, and if she can demonstrate an understanding of the implications of the procedure. We should not be dictating to women what they should think, nor should we be judgmental of their values, if they happen to differ from our own.[77]

5.122 In the United States, concerns about the high Caesarean rate prompted the promulgation, in 1995, of a national goal to reduce the rate to 15% (it was then 25%) by the year 2000. This approach has been widely criticised both within the United States and overseas as being unachievable and arbitrary.

5.123 The figure of 15% was adopted following the World Health Organisation's definition of that figure as constituting a reasonable rate for Caesarean section.[78]

The Committee's conclusions

5.124 The Committee is concerned by Australia's high Caesarean section rate. As noted, Australia has one of the highest rates in the developed world. The Committee is also concerned by the significant variation in rates between States, between hospitals and between women with public insurance and those without it.

5.125 Evidence to the Committee during the course of this Inquiry provides some explanation for this high rate and for the wide variations in practice described but does not fully account for it.

5.126 The variations relate almost entirely to elective rather than to emergency Caesarean section. The Committee is not persuaded that patient demand is a major contributor to the high rates of elective Caesarean section, despite the widespread publicity given to this view. Nor does it believe that patient request is an adequate reason for performing a major surgical procedure.

5.127 In condemning the current high rate of elective Caesarean section the Committee acknowledges that examples of excellent obstetrical practice were brought to its attention during the course of the Inquiry. It was advised, for example, of many instances in which a single obstetrician had reduced the Caesarean rate at the institution at which they worked.

5.128 To ensure that best practice is more widely adopted the Committee believes that guidelines should be developed by the relevant professional bodies. A number of recent State and national reports have come to the same conclusions and made recommendations to this effect. None has been implemented. The Committee believes therefore that it is entirely appropriate for the Commonwealth Government, through

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77 Paterson-Brown S. *Should doctors perform an elective caesarean section on request?* British Medical Journal vol. 317, 15 August 1998, p.463.

78 World Health Organisation. *Appropriate Technology for Birth.* 1985. Sometimes referred to as the Fortelesa Declaration.

the National Health and Medical Research Council (NHMRC), to take the lead in addressing this issue.

5.129 The Committee believes that the NHMRC should work with the relevant professional bodies to develop best practice guidelines. It believes that a body such as the proposed Maternity Services Committee should monitor the implementation of the guidelines and the extent to which individual hospitals conform to a proposed target for Caesarean section. The Committee considers such a target should be set at 15%, as recommended by the World Health Organisation.

5.130 The Committee believes that a reduction in Caesarean rates will also be assisted through dissemination of recent research findings on Caesarean section, through encouragement of existing best practice and through peer review and persuasion. Greater consumer awareness and education will assist. The Committee considers that enhanced consumer awareness of the advantages and disadvantages of various forms of intervention, including Caesarean section, and of the hospitals at which they are most frequently performed will be achieved through implementation of other recommendations in this Report.

Recommendation

The Committee RECOMMENDS that the National Health and Medical Research Council work with the relevant professional bodies to develop best practice guidelines for elective Caesarean sections.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to decide a target rate for Caesarean sections, moving towards the target of 15% recommended by the World Health Organisation.

Recommendation

The Committee RECOMMENDS that the Joint Maternity Services Committee monitor the implementation of best practice guidelines for Caesarean sections and report upon the extent to which individual hospitals meet the proposed target for Caesarean sections of 15%.