

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

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

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Mary Hannah's commentary¹ arrives at a time when women are losing confidence in their ability to give birth vaginally. To suggest, as Hannah does, the equivalence of maternal and newborn outcomes for cesarean and vaginal birth in the face of confusing science is to contribute to fear and an increase in cesarean procedures.

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

risk of urinary incontinence is higher for vaginal births.¹ However, most studies of urinary incontinence are flawed by follow-up limited to 3 to 6 months²⁻⁵ and fail to specify the difference between minor and severe incontinence. Population-based studies report either no difference in urinary incontinence by route of birth⁶ or a baseline rate that is high and only somewhat improved by cesarean section.⁷ Notably, even nuns have a high rate of urinary incontinence.⁸ We need to concentrate on nonsurgical and lifestyle improvements to prevent this important problem.

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

Hannah muses that contemporary birth, which involves inductions, long periods of labour, continuous electronic fetal monitoring, augmentation, epidurals, forceps, episiotomy and multiple caregivers, can hardly be considered "natural." Good point! But who is responsible for this unnatural environment? Hannah's own study of post-term pregnancy¹² is the bedrock upon which our current epidemic of post-term inductions is based, leading in my institution to a rate of cesarean sections among first births in excess of 40% (the rate is about 8% for women in spontaneous labour). It may take between 500 and 2000 post-term inductions to avoid one stillbirth, but, in the process, a cascade of accepted "side effects" ensues. This situation needs fixing, but cesarean section is not the appropriate mode of repair.

Hannah uses her Term Breech Trial¹³ to make the point that cesarean section is safer. However, it is not ap-

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

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

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

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Le débat actuel entourant la possibilité pour les femmes d'obtenir de leur obstétricien une césarienne sur demande a fait l'objet d'un article paru dans votre journal en mars 2004¹. Dans cet article, Hannah nous informe du fait que seule une nouvelle étude randomisée contrôlée pourrait permettre d'évaluer les risques et les avantages d'une césarienne programmée par opposition à un accouchement vaginal planifié. Afin d'illustrer certains avantages de la césarienne élective, Hannah introduit plusieurs résultats statistiques reliés en particulier aux taux d'incontinence urinaire.

Or, dans cet article, le terme d'accouchement vaginal spontané mériterait d'être mieux défini. Quand Hannah fait référence au taux d'incontinence urinaire suivant un accouchement vaginal spontané, on est en droit de se demander, par exemple, si dans l'étude citée les femmes mettant au monde leur bébé

ont fait l'expérience d'une poussée physiologique involontaire, non dirigée, faisant intervenir le réflexe de poussée. Ou plutôt, s'il s'est agit d'un accouchement vaginal spontané, sous péridurale par exemple, durant lequel à dilatation complète la femme s'est vu encouragée à inspirer, bloquer, pousser. Les résultats et les conséquences sur le périnée féminin sont-ils les mêmes d'une manière ou de l'autre?

Ceci nous amène à questionner l'autorité que l'on doit accorder à Hannah dès lors qu'elle fait référence à la notion d'accouchement vaginal spontané. Lorsqu'on parle de spontané cela veut dire que l'accouchement s'est déroulé spontanément, c'est-à-dire physiologiquement. Si c'est le cas, l'induction, la stimulation, le monitoring, la restriction des positions pour la poussée, la péridurale, le «coaching» de la poussée, l'épisiotomie, les ventouses, les pressions abdominales, les forceps, seraient tous des éléments qui excluraient ces accouchements de la catégorie accouchement vaginal spontané.

Il est évident pour ceux qui en ont été témoins qu'il existe une distinction fondamentale entre accouchement vaginal (c'est-à-dire naissance par les voies naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé). Le milieu hospitalier est reconnu comme un milieu où les comportements sont fortement codifiés et structurés. Une femme qui y accouche aujourd'hui ne devrait trop espérer y être soutenue dans sa «spontanéité». L'accouchement vaginal spontané observé en milieu hospitalier comporte un biais énorme, celui-là même d'avoir lieu dans un espace, l'hôpital, où le processus physiologique normal de la mise au monde d'un bébé est quasiment toujours perturbé. L'hôpital est un biais systématique important introduit dans toutes les études sur l'accouchement, sans jamais être mentionné comme une des limites des études.

L'accouchement vaginal spontané devrait être clairement défini dans les futures études scientifiques, incluant celles dirigées par Hannah. Si l'on souhaite vraiment comparer les césari-

ennes sur demande avec l'accouchement vaginal spontané, on devrait le faire en se concentrant sur l'espace le plus propice à un accouchement spontané et physiologique, c'est-à-dire l'accouchement à la maison.

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Référence

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[The author responds:]

Although generalizing evidence for a planned cesarean from one indication to another is problematic, we do this when evidence is lacking. For example, some use the results of the Term Breech Trial, which found better outcomes with planned cesarean for singleton breech fetuses at term, to justify planned cesarean section for twins if one of the twins is in breech position.¹ Contrary to the suggestion of John Fernandes, the issue is not consumerism, cost or cosmetic surgery; rather, it is a woman's choice after discussion of the risks and benefits of all reasonable alternatives.²

Padmanabhan Badrinath and Penny Lindballe agree that a woman should be able to choose how she will deliver her baby. Badrinath raises concerns that planned cesarean sections will add to the cost of health care. However, planned cesareans may actually be associated with lower costs.³ Lindballe suggests that women should be able to choose midwifery care and that health care plans should cover this option too. I agree. Planning for a vaginal birth might be a more attractive option for Canadian women if midwifery care were more readily available and affordable.

Planned cesarean and planned vaginal birth are not associated with equiva-