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Caesareans and authoritative knowledge (editorial)

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Caesareans and Authoritative Knowledge

I recently bought a copy of a new book *Delivery by Appointment: Caesarean Birth Today* by Michelle Hamer (2007). I was interested because the book is marketed to women in a culture where the rate of elective caesarean sections is increasing. Australia wide the rate has gone from 19% in 1993 to 27% in 2002 (Laws & Sullivan, 2005). There is a lively debate within Midwifery about how midwives should respond to the increased rate of caesareans. This is a particular challenge when working with a woman who, guided by her obstetrician, is booked for a caesarean section without a real medical indication. Unfortunately, this book provides no insight that might assist the midwife to know how to better respond to this dilemma. I thought, however, that it is important that midwives know what information is being offered to women on this topic and so I present my response to reading *Delivery by Appointment* (Hamer, 2007).

Hamer is an experienced journalist and newspaper editor. She has four children all of whom were caesarean deliveries. The purpose of her book is to inform women who are considering having a caesarean delivery about the culture of caesareans and what having a caesarean entails. It is also designed to help those women who go ahead with a caesarean, to feel better about themselves and their choices. *Delivery by Appointment* covers all the main topics that should be addressed in a book designed to provide pregnant women with information about caesareans. The book includes an historical and cultural perspective on caesareans. Women's stories and perspectives on how it feels to have a caesarean and recover afterwards make up a significant portion of the text. The book is strongest when it is giving women's experiences of having the operation and the post-operative period; including breastfeeding. The reasons that doctors and women give for having a caesarean are presented and discussed with alternative views also being presented.

The book uncritically presents the stories of about 20 women who have had caesarean sections to illustrate the various issues that the book addresses. The stories, for the most part, are positive or neutral in relation to caesareans as a way of birth. There are negative stories about complications, depression and difficulties bonding and breastfeeding. I say, 'uncritically' because the women often give the reason that they had to have a caesarean as 'failure to progress'. Often this diagnosis is iatrogenic (caused by medical intervention) and is not a 'real' or 'true' reason. Women with private health insurance are also the healthiest group of women in our society. In private hospitals, however, it is common for these healthy women to have caesareans. In New South Wales in 2004, for instance, 35% of women with private insurance had caesareans compared with 23% of women without insurance (Health, 2007). Where the doctor diagnoses that the baby's head is 'too big' to fit through the maternal pelvis, that is unlikely to be really true. By this I mean that if these same women were allowed to labour naturally, without interference and without being put into bed the vast majority would have normal births with healthy babies. I can make this claim confidently because in midwifery-led birthing services; including Ryde, Belmont and Wyong hospitals, healthy women, who book to birth there, have a 95% chance of having a normal birth (regardless of actual place of birth since some need to transfer to medical care). These differences are about the way in

which women and midwives prepare for and respond to labour and birth so that normal physiology is supported.

Hamer attempts to present herself as a professional 'objective' journalist. Journalists traditionally construct stories and books in a particular way: they seek out an expert and then someone who will provide a dissenting voice so as to present 'both sides of the story'. This supposedly lets the reader sort out for themselves what they believe or where the 'truth' lies. The trouble with this approach is that a lot of scientific knowledge is required in order to have an informed opinion of the causes and consequences of caesarean section and this is knowledge that Hamer lacks.

Journalistic 'objectivity' has been criticised for "creating passive dependency on powerful institutions and groups as 'accredited sources'. It fosters lazy journalism where journalists fail to ferret independently for information and evaluate truth from falsehood" (Curran, 1993). When the strategy of objective journalism was applied to caesarean delivery Hamer positioned the doctors as the experts and any other voice (midwives and maternity coalition) were positioned as 'non-expert' or dissenting voices. For example; it suits obstetric rhetoric to take credit (as Professor of Obstetrics James Walker does on p.55) for the improvements in maternal and neonatal outcomes that have been evident since the 1930s in developed countries. Hamer doesn't critique this ideology or any of the statements presented by the obstetricians she quotes. Neither does she seek an alternate view each time she quotes a medical expert as if as if what they say is 'the truth'. Midwives know, for instance, that the best evidence indicates that the improvements in maternal and neonatal morbidity since the 1930s actually came about mostly as a consequence of improvements in public health and the availability of antibiotics and not because of medical involvement in birth (Tew, 1990). I understand that journalists can't be expected to be able to determine the 'truth' or the best evidence. This is a reason to recognise the limits of one's expertise and therefore not produce a book that purports to give women information they can use for decision-making about caesarean deliveries.

The midwifery voice and the associated research evidence is downgraded by Hamer. She does this in part by under-representing midwives' voices throughout the book. A chapter by midwife Alison Shorten focuses on the concept of informed choice rather than the research evidence that is necessary for women to have in order to make an informed choice. Hamer most strongly downgrades midwives and research evidence when she places two, research rich, chapters by Professor Sally Tracy, a midwife of international standing, as appendices of the book. The research evidence that Tracy presents is essential to providing women with evidence and yet that information is relegated to the part that many readers never get to! Barb Vernon, of the Australian College of Midwives was quoted as saying "Personally, I don't think it's appropriate that women have the choice to have major surgery intervention when they are healthy – we don't let people have bowel surgery because they don't like going to the toilet" (p. 56). This comment and a few others like it are overwhelmed, however, by medicalised view that this book, wittingly or unwittingly, promotes.

Hamer, in spite of her journalistic efforts, isn't and can't be disinterested; she has a view and a position that becomes clear. For instance, she presents the thinking that is underpinning the epidemic of caesareans: the notion that a caesarean allows a woman to have a vaginal by-pass and that this is 'good' and 'valuable' to women. In a section headed "Keeping Yourself Nice", Hamer writes: women are "unwilling to offer this part of their anatomy up to the mauling of a vaginal birth". ... "We have just started on the path to sexual empowerment" she writes "and owning our own orgasms and we want to maintain the equipment that can get us there" (p. 58). These two statements are based on ignorance and fear and they are not supported by evidence. Yet it is these fears that are driving many women to have caesareans. Hamer claims that a caesarean section will deliver predictability but the only predictability it delivers is the day and time of birth. This can be very useful for a doctor who needs to schedule other operations and attend patients at his rooms but is isn't generally highly desired by women. Everything else, including birth outcomes remains unpredictable with a caesarean. According to the available research evidence, having a caesarean section will not reduce the risk of the baby dying (Bell et al., 2001). It will not reduce the risk of cerebral palsy (Foley et al., 2005). A caesarean will not prevent incontinence in the later years of a woman's life (Chaliha, Khullar, & Stanton, 2002).

Hamer writes "It doesn't matter how a child comes into the world. All that matters" she says "is that you love them no matter what" (p.221). Her belief, that the process of birth doesn't matter is at odds with a huge amount of research evidence (See Walsh (2007) for succinct account and extensive research references). Drawing on the appendices by Sally Tracy (2007a; 2007b) and the book by Denis Walsh (2007) we can say that a caesarean section, including an elective caesarean, when compared with a normal birth is associated with higher rates of the following negative outcomes:

- Maternal death
- Post-natal pain and lethargy
- Short to medium term post-operative complications
- Respiratory distress of the newborn
- Baby admission to the nursery
- Difficulties with bonding
- Difficulties with breastfeeding
- Postnatal depression
- Major increase in postpartum haemorrhage in subsequent pregnancies
- Doubling of stillbirths in subsequent pregnancies.

Where does this leave the midwife who is working with a woman whose doctor has advised a caesarean section that the midwife believes isn't needed? The best response will be individual and contextual. The duration and quality of the midwife's relationship with the woman is of central importance. If you don't have a relationship you are in a shaky position trying to start a dialogue on the benefits and dangers of caesareans. The woman probably has a relationship of trust with her doctor which you would generally be

wise to respect. The timing of the possible discussion is also important as a confronting approach might be appropriate in the antenatal period prior to admission but not when you are preparing the woman for surgery. If asked about *Delivery by Appointment* I suggest that you advise her that this book does not authoritative knowledge upon which to base informed decision-making.

Once a woman has actually had the operation it is clearly the midwife's role to help the woman feel good about herself and her decision. This is the time to focus on the positives that have come out of the situation. Still later, when the woman returns for care in a subsequent pregnancy it may be a good time to more fully explore the issues and to give the woman access to sources of information which assist her to find evidence based answers to her questions. A good place to start is at <http://www.vbac.com/> which is a consumer organisation that aims to be woman-centred and evidence-based. Alison Shorten has produced a decision-aid *Birth Choices: What is best for you ... vaginal or caesarean birth?* This decision-aid is available by emailing ashorten@uow.edu.au.

References

- Bell, J., Campbell, D., Graham, W., Penney, G., Ryan, M., & Hall, M. (2001). Can obstetric complications explain the high levels of obstetric interventions and maternity service use among older women? A retrospective analysis of routinely collected data. *BJOG*, *108*(9), 910-918.
- Chaliha, C., Khullar, V., & Stanton, S. (2002). Urinary symptoms in pregnancy: are they useful for diagnosis. *British Journal of Obstetrics and Gynaecology*, *109*, 1181-1183.
- Curran, J. (1993). Rethinking the media as a public sphere. In P. Dahlgren (Ed.), *Communication and citizenship: journalism and the public sphere*. (pp. 27-57). London: Routledge.
- Foley, M., Alarab, M., Daly, L., Keane, D., Macquillan, K., & O'Herlihy, C. (2005). Term neonatal asphyxial seizures and peripartum deaths: lack of correlation with a rising cesarean delivery rate. *American Journal of Obstetrics and Gynaecology*, *191*(1), 102-108.
- Hamer, M. (2007). *Delivery by appointment: caesarean birth today*. Sydney: New Holland.
- Health, N. (2007). *South Wales mothers and babies 2005*. Sydney: Centre for Epidemiology and Research. NSW Public Health Bull 2007; 18 (S-1).
- Laws, P., & Sullivan, E. (2005). *Australian Mothers and babies 2003*. Canberra: Australian Institute of Health and Welfare. Perinatal Statistics Series No. 16).
- Tew, M. (1990). *Safer Childbirth*. Melbourne: Chapman and Hall.
- Tracy, S. (2007a). Appedix 1 A midwife's view of caesarean. In M. Hamer (Ed.), *Delivery by appointment: caesarean birth today* (pp. 235-239). Sydney: New Holland.
- Tracy, S. (2007b). Appendix 2: The risks of ceasarens. In M. Hamer (Ed.), *Delivery by appointment: caesarean section today* (pp. 240-246). Sydney: New Holland.
- Walsh, D. (2007). *Evidence-based care for normal labour and birth: a guide for midwives*. London: Routledge.