Vaginal birth comes with risks too – so should it really be the default option?

July 26 2016, by Mairead Black

Some women want to experience labour, but for others the risks aren't worth it. Credit: Ollyy/Shutterstick

When it comes to childbirth, vaginal delivery is often assumed to be the best thing – women have, after all, done it for thousands of years. But

natural birth actually comes with risks, including tearing, haemorrhage and incontinence for the mother and injuries to the baby during labour. So why is it that the vast majority of pregnant women are only being warned about the risks of caesarean sections?

This could now change, as the Royal College of Obstetricians and Gynaecologists are to discuss the current view of vaginal birth as the default option for childbirth in the UK. They will consider whether there's merit in routinely discussing the relative risks and benefits of vaginal birth and caesarean section with pregnant women. Such an approach would ideally provide balanced information for women to inform their birth plans.

The move follows an unprecedented UK Supreme Court ruling in 2015 that changed the legal landscape of informed consent in healthcare. The Montgomery vs Lanarkshire Health Board case ruled in favour of a complainant who had not been informed of a childbirth risk they encountered, despite voicing concerns during pregnancy. The baby's shoulder got stuck during delivery, resulting in brain injury due to a lack of oxygen – a problem which would have been avoided if a prelabour caesarean section had been performed.

The ruling means health professionals counselling patients about procedures should no longer limit discussion of risks to those which they themselves think are important – they must instead discuss those risks a "reasonable patient" would consider to be significant.

The concept of asking women to "consent" to vaginal birth may seem absurd to some, but it has been discussed in obstetric circles over at least two generations. This is partly due to key changes in childbirth, such as caesarean section becoming safer. Women also have children later, which means that the risk for problems during labour and birth are higher.

Weighing up the evidence

While both caesarean section and vaginal birth are considered to be relatively safe in high-income countries, each features its own set of risks. How such risks are perceived and valued may vary considerably between health professionals and women themselves.

UK hospitals still treat vaginal birth as the default birth mode for most women, despite its risks and the fact that the National Institute of Health and Care Excellence (NICE) has recommended that there should be some room for choice. Studies from other high-income countries suggest that risks due to natural birth may be poorly appreciated by women and health professionals. While up to 95% of UK women aim for a vaginal birth in their first pregnancy, only around 75% achieve this. Some 21% experience an emergency caesarean section during labour, which is not as safe as a planned one.

A further substantial proportion of women experience important complications of vaginal birth. These include an 8% postpartum haemorrhage rate, 1% blood transfusion rate, and a 5-6% third-degree tear rate (40% suffer some degree of tearing). One in six (15%) women end up having an operative vaginal birth, such as use of forceps, which is associated with faecal incontinence and pelvic organ prolapse in later life. Also, it's important to realise that long labours, complications and interventions are associated with maternal distress, postnatal depression and intense anxiety in future pregnancies.

This leaves little more than half of first-time mothers experiencing an uncomplicated spontaneous vaginal birth. This is a considerable number which illustrates why women aiming for a natural birth may need to know that such attempts could involve a medical intervention or complications.

In this light, the alternative of a planned caesarean section may be tempting. While not risk-free, it appears to be similar to that of of a planned vaginal birth in the short term and – with a slightly higher risk of respiratory problems at birth – may be even safer for the baby. However, the scarring from a section will make each future pregnancy more risky as it can affect the development of the placenta, resulting in increased risks for the mother of developing major bleeding and hysterectomy, although this is rare. There is also some concern that babies born by caesarean could be at higher risk of developing asthma.

The importance of patient choice

Since women will value these risks differently, informing them of the merits of both options would empower them to decide what matters most to them. For some that will be the opportunity to experience labour and the benefits of vaginal birth, for others it will be the option of a more controlled and predictable caesarean birth.

But in reality things are more complicated. If potential risks of vaginal birth are routinely discussed with all women, caesarean section rates in UK hospitals are likely to rise further. The NICE report estimates that normal births cost an average of £1,512, planned Caesareans cost £2,369 and emergency C-sections cost £3,042. This may generate a timebomb effect for the future as the number of repeat caesareans will also rise, bringing with it a high cost in terms of both medical services and health consequences. However, such costs may be deemed acceptable if these reflect women's informed choices based on realistic expectations, and a lower number of emergency procedures.

But even if we do decide to be more open about the risks of natural birth, we'll have to first work out which risks should be communicated – and how. How is a doctor or midwife to know what a "reasonable patient" would want to know, and will their communication skills be

sufficient to ensure that women feel able to voice their personal fears? How will they tackle the fact that women may value positive outcomes of a single pregnancy more than the combined outcomes of two or more future pregnancies? Others have argued that too much focus on risk will only generate unnecessary maternal anxiety.

A simpler option may therefore be to communicate the risks of vaginal birth only to women over an accepted risk threshold for complications – such as all women aged over 35 years in their first pregnancy or those with a combination of age over 30 years and BMI over 30.

Ultimately, a woman's birth plan should reflect her values. If this means having a planned caesarean section, then such informed choices should be respected and health services developed to accommodate such plans.

This article was originally published on The Conversation. *Read the* original article.

Source: The Conversation