IN THE LITERATURE

COMMENTARY ON:

Smith J, Plaat F, Fisk NM. The natural caesarean: A woman-centred technique. *BJOG* 2008;115:1037–1042.

How Natural Can Major Surgery Really Be? A Critique of "The Natural Caesarean" Technique

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Although we welcome the suggestion of improving women's experiences and the process of their cesarean section, we believe more practices could be improved than those proposed by Smith, Plaat, and Fisk. We also have major concerns about the authors' use of the key phrase "natural caesarean" and what it could imply to the general public, particularly at a time when research evidence of the adverse effects of cesarean section is increasing and professional interest is growing to reduce the currently high (and often still rising) cesarean section rates around the world.

What Does the Article Say?

The authors rightly state that in recent years the focus on natural and normal birth in maternity service provision has increased in some developed countries. Some innovations have appeared, such as birth centers and midwifery-led care, but also changes have been implemented in some traditional labor ward settings. More generally in recent years, particularly in the United Kingdom and Australia, an effort has been made to introduce greater choice in models of care, which has included promoting "normal" birth to reduce high obstetrical intervention rates. Maternity staff in some institutions have endeavored to support natural physiological processes rather than using medical interventions as a first resort, and to enable parents to take a more active role in decision-making and care processes. The authors also note that postnatal practices after vaginal birth that contribute to greater maternal satisfaction have been implemented for quite some time, such as early skin-to-skin contact, breastfeeding soon after birth, "rooming-in," "feeding on demand," and opportunities for emotional bonding.

Despite this focus on vaginal birth, Smith and colleagues point out that cesarean section is the most commonly performed operation worldwide and little has changed in professional practice related to cesarean surgery that could provide women with more satisfying experiences. The authors therefore propose what they have termed a "natural" approach to cesarean section. This "alternative" enables parents to actively participate—the assumption is that this involvement does not usually happen during a cesarean section. In addition, the baby is transferred to the mother for immediate skin-to-skin contact after a slow removal from the incision with what the authors refer to as "physiological autoresuscitation." This alternative approach "mimics" the situation with vaginal birth, according to the authors.

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So What's Wrong with the Idea of a "Natural Caesarean"?

In light of developments to make maternity care more "woman-centered," particularly in relation to vaginal birth, it is laudable of the authors to want to find ways of improving women's experiences of cesarean surgery. Birth with obstetrical intervention has been shown in Australia and the UK to be associated with higher levels of dissatisfaction and psychological distress than vaginal birth, with a quarter to a third of women recording acute emotional trauma symptoms (1,2). Priest et al (3) also found that approximately one third of Australian women are dissatisfied with their birth experience in general, representing 80,000 women per year (4).

Consumer information and web sites suggest that women can have a less traumatic experience of cesarean section if they are better prepared, are more involved in the decision-making about their labor and the steps that might lead to a cesarean, and if staff and hospitals can be more emotionally supportive. Unlike most other surgery, however, a cesarean section is performed as part of a major life event for women, and often also for their partners and families.

Considering current cesarean section rates, any improvement in cesarean practice stands to benefit a large proportion of the population, providing it does not popularize cesareans themselves. Currently in the United States and Australia, on average every third woman has her baby by cesarean section, although in some private Australian hospitals this rate is as high as every second woman. Rates around the world vary from 40 percent in Italy and Mexico to 14 percent in the Netherlands (5).

Smith and colleagues mention several practices that they have questioned and changed in relation to cesarean surgery in order to "mimic" the woman-centered aspects of "natural" vaginal birth. Beyond this, however, the authors say that they attempt to increase the chances of early postnatal skin-to-skin contact for well babies (rather than taking a well baby away from the mother to a separate location for weighing, identification, and swaddling before being given to the mother or father), and early breastfeeding. Interestingly, despite the title and focus of their paper, the authors do not identify "woman-centered" care as a key word.

First, we express concern with the term "natural" being applied to major abdominal surgery. There can be nothing natural about surgery—it is by definition an intervention. Furthermore, in terms of the surgical process of cesarean section, we would argue that it is impossible to mimic the natural physiological process of unaffected labor and birth, with the woman giving birth when the baby is ready.

Second, if it is truly impossible to mimic nature, we believe that it is unfair to imply to the childbearing public that it is possible to have a cesarean that is "natural." To us, the term "natural" also implies a process associated with less adverse outcomes than the usual process (presumably a "medicalized cesarean"?). The practice changes suggested by Smith et al do not seriously reduce any of the major adverse effects associated with cesarean surgery. Sound research shows that, regardless, the procedure carries a wealth of adverse outcomes for both mother and baby (6–8).

We therefore question whether it is even ethical to suggest the notion of a "natural" cesarean section. Some believe that the fact that the surgery carries serious risks for both mother and baby is one of modern civilization's best kept secrets (9), since many women are led to believe that cesarean section is the safest option for them (10). By alluding to the possibility that a cesarean could be experienced in a "natural" way, the authors encourage the public to build on their current (mis)perception of the safety of this surgery. This belief, in turn, could make it even more difficult to reduce high and rising national cesarean section rates. Indeed, we find the term "natural caesarean" about as euphemistic and misleading as "friendly fire" and "collateral damage"—terms used in relation to modern warfare.

Third, we are concerned that some hospitals (particularly in the private sector) might see a practice termed "natural caesarean" as a useful marketing gimmick to attract more customers and raise profits, in the same way that hotel-based postnatal care has been used in some parts of Australia (11,12). Believing they can offer a "natural caesarean" might also take away the focus for some staff from the urgent need to improve maternity care overall, which would lead to better clinical and satisfaction outcomes for all women. The greater danger can be in legitimizing cesarean section through its "naturalization," suggesting that the cesarean epidemic is no longer a problem. This sanctioning of surgical procedures threatens the health and well-being of mothers and babies everywhere, since it does not address the problem of the high rate of cesarean sections but, rather, tries to make the process "nicer," more "natural," and therefore not a problem. The intention of this approach may be laudable, but it is not sufficient and not evidence-based for safety.

Although we critique use of the term "natural caesarean," we nevertheless welcome the concept of improving the psychological and social aspects of cesarean section. We also believe a concomitant approach should focus on improving maternity care for all women, which would lead to a reduction in the overall cesarean section rate. We therefore suggest that the model of practice suggested by the authors be called "improving caesarean section," and that such practice should be introduced with a substantive body of evidence

to justify its development. At the same time a wider body of institutional improvement and customized quality improvement strategies should be implemented to promote normal birth and reduce unnecessary medical and surgical interventions, in alignment with the Ten Steps of the Mother-Friendly Childbirth Initiative (13), the Ten Steps for Successful Breastfeeding (part of the Baby Friendly Hospital Initiative) (14), and the UK's *Making Normal Birth a Reality* consensus statement (15).

In addition, it is essential to provide the type of emotional support and continuity of caregiver that has been shown to promote normal birth and reduce the frequency of cesarean section (16,17,18), and to support vaginal birth after a previous cesarean section for the 80 percent of women who could successfully achieve it (19). Against this wider change, most women would then avoid an unnecessary cesarean section, and those women who really need the procedure would have an "improved" cesarean experience.

What Can We Conclude?

Concerted efforts are required to reduce cesarean section rates overall by offering models of care and support techniques that are alternative to traditional highly medicalized care and that have been shown to minimize the prevalence of cesarean section without compromising maternal and newborn outcomes. We encourage any effort to change practice that might improve women's experiences for having a cesarean section. Nevertheless, we believe it should be done through developing "improved" cesarean experiences as part of a broader overall philosophy that promotes and supports the normal physiology of birth and, accordingly, the health, safety, and well-being of mothers and babies.

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