Cesarean section on request

To the Editor

It is always a real pleasure to receive your Journal. As an obstetrician and gynecologist (Obst & Gyn), I first read those dealing with my specialty. In the December 2004 issue, "Cesarean Section on request"[1], 2 colleagues from Qatar display the present-day situation, mainly in the developed world, and how pregnant ladies request cesarean section (CS) in fully normal pregnancies just because they do not want to go into labor. The authors do their best to embellish the CS without any medical indication and proudly report that CSs, in some parts of the superlative world, are as safe as normal deliveries! For instance, they mention that CS protects the pelvic floor from prolapse, that an elective CS has a lower maternal mortality rate than emergency ones and hint to figures from the United Kingdom (UK) and Israel. For the sake of objectivity, they also, mention that CS is still a cause of maternal death, worldwide, and that it is many times more risky than vaginal delivery. They, shyly, mention some, but not all, of the late risks of CS and stress its relative safety in UK, for instance, and wonder, "Where the state of art is in different parts of the world?" What distresses a doctor reading this article is the fact that an Obst & Gyn is thus, regressed and degraded to an inert performer or executor of patients' will, not forgetting that a majority of them, namely, the patients, do not really know and realize what is better for them. Being and becoming a mother means a lot of noble and humane meanings: the most important is altruism and is offering more than receiving. Being a doctor, too, is and should embrace and adopt similar if not the same principles. A doctor is supposed and is expected to offer every patient a true, objective and scientific counseling as to what is better for mother and baby, as well as for the whole society at large. Let me give one example: a young lady came to see me 3 months after having undergone a CS for a breech in her very first cyesis. She complained that her doctor did not wait long enough and hurriedly did a section. On pelvic examination, there was marked vaginismus and moderate pelvic contraction. I assured her that her doctor did the right thing as there was a reasonable indication for the abdominal delivery. She was extremely worried lest she might need CS in her future pregnancy, which reflects the marked love to have a rather large number of kids in our oriental societies, and which we, doctors, are supposed to respect and to do our best to make it real and with the least risk to mother, baby and society. In conclusion, I would like to say that a doctor has a great role in his/her society, which is much higher and nobler than doing a CS just because an unwary patient was imbibed with a wrong idea: that CS would obviate any bad consequences of a vaginal delivery and any protracted pain and pushing down "like a cow". The dilemma, in our present-day turmoiled human existence is that, human beings forget those eternal principles of good and evil and lose that sharpness of inner sight as of what is white and what is black and all the nuances between these 2 ends of the color spectrum. I hope that our 2 young colleagues would tolerate a differing second opinion with tolerance and good will for ever searching for what is better or even best.

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Reply from the Author

We are proud to report that our maternal and perinatal mortality and morbidity figures are comparable to those in the developed world. This includes results from CS. Sadly this has also led to the population acting very similarly to that in Europe and the States in the form of a sharp increase in requests for non medically indicated cesarean section (NMICS). Approximately 10% of our primips and a smaller number of our multips request NMICS. After lengthy counseling by one or more consultants, we still do perform a small number of NMICS. It has become such a recognized entity that the legal adviser has been involved, as it may lead to situations where the hospital may be liable if a vaginal delivery led to any complications. We fully support your view that women in the Middle East expect to have a much larger family than in the west. We strongly believe that a vaginal delivery is the best thing for a woman intending to have 2 or more children as do most of our patients. In an attempt to throw light on the subject and open a debate, we had a number of prominent speakers and open discussion groups on the subject. We remain, however, in a time where counseling is

mandatory. This process is an equal relationship, whereby, we pass information to the patient in a manner she best understands and attempt to understand and alleviate her anxieties. When she adamantly refuses to go into labor, there is not much an obstetrician can do. We thank you for sharing your views and look forward to hearing more about similar experiences in the area.

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References

1. Abushama MA, Badreldeen A. Cesarean section on request. ***Saudi Med J*** 2004; 25: 1820-1823.