

CAROLINE DE COSTA

HAIL CAESAR

WHY ONE IN THREE AUSTRALIAN BABIES IS
BORN BY CAESAREAN SECTION

First published in 2008 by Boolarong Press

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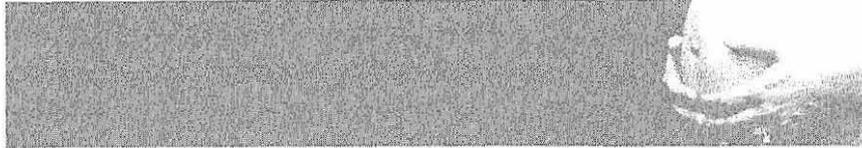


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For my mother

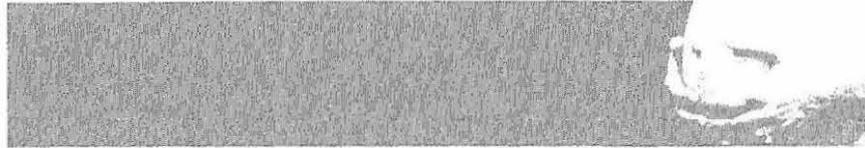


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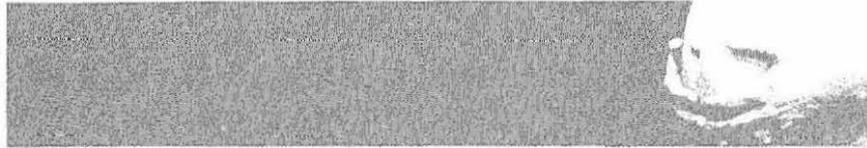
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*GLOSSARY OF MEDICAL TERMS
USED IN THIS BOOK*

Antacids- drugs which lower the acidity of the stomach contents

Anti-emetics – drugs which help prevent vomiting

Antepartum haemorrhage- vaginal bleeding before the birth of the baby

Breech presentation – way in which a baby may lie in the womb with bottom and legs, rather than head, in the lower part

Cephalic presentation – the most common way in which a baby lies in the womb, that is, head down so that the head is the first part to be born in a vaginal birth

Cervix – the 'neck' or lower part of the uterus; dilates to open the uterus during normal labour, allowing the baby to be pushed out into the world

Colostomy- an opening, temporary or permanent, into the bowel to which a bag is attached to collect bowel contents – this procedure is used for some bowel cancers and other damage or disease of the bowel

Diabetes – a common condition in which inadequate amounts of insulin are produced by the pancreas, a large gland close to the stomach. Insulin

controls the level of sugar in the blood; a normal level is required for optimal bodily functioning in both pregnant and non-pregnant women

Fetus – the developing child while in the uterus

Forceps- instruments shaped rather like salad tongs used to deliver a baby vaginally

Gestation – length of pregnancy, in weeks

Gynaecology – the branch of medicine dealing with the reproductive organs of non-pregnant women, and the diagnosis and treatment of disorders and diseases of those organs

Haemorrhage – heavy bleeding

Hypertension – raised blood pressure

Midwifery – the branch of nursing concerned with the care of women in pregnancy and during birth, and of the mother and baby following birth

Obstetrics – the branch of medicine concerned with the care of women during pregnancy and birth, includes both normal and abnormal pregnancies and births

Oestrogen – hormone produced by the ovary and responsible for feminine characteristics

Ovary – organ in the female pelvis which produces both eggs (ova) and female hormones

Oxytocic – drug which contracts the uterus

Oxytocin – hormone produced by the pituitary gland which brings about the contractions of labour

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Partogram - a record of progress in labour using a graph that is designed to show clearly when the cervix is not dilating and labour is slowing down

Perineum - the area of skin and muscle between the vagina and the anus

Placenta – the plate-shaped organ that directs oxygen and other nutrients from the mother's blood into the bloodstream of the fetus via the umbilical cord; the placenta also transfers all waste products from the baby back into the mother

Postpartum haemorrhage – excessive vaginal bleeding following the birth of the baby

Pre-eclampsia – condition of raised blood pressure, swelling of hands and feet and sometimes face, and presence of protein in the urine, that occurs in pregnancy, with potential risks to the woman and her baby and possibly requiring delivery by caesarean section

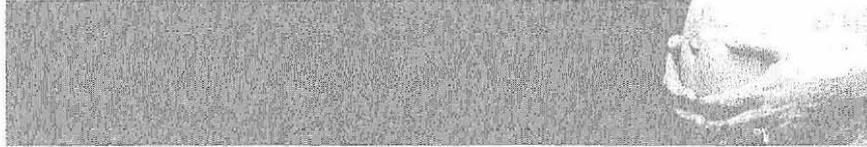
Pre-term – before 37 completed weeks of pregnancy –has replaced the term 'premature' in medical practice though 'premature' is still widely used in non-medical literature

Progesterone – hormone produced during pregnancy that is essential for normal development of the fetus and placenta

Prostaglandins – substances produced naturally around the time of labour that help establish uterine contractions; synthetic prostaglandins are used to induce labour.

Uterus – the womb, the organ in which the fetus (baby) grows

Vacuum extractor – instrument used to assist a vaginal birth; the vacuum 'cup' is applied by suction to the top of the baby's head and pulled down during the mother's contractions



*LIST OF ABBREVIATIONS
USED IN THIS BOOK*

ACOG – American College of Obstetricians and Gynaecologists

ANZJOG – Australian and New Zealand Journal of Obstetrics and Gynaecology

APH – antepartum haemorrhage

BJOG – British Journal of Obstetrics and Gynaecology

BMJ – British Medical Journal

BPD – biparietal diameter

CTG - cardiotocograph

EFM – electronic fetal monitoring

ECV – external cephalic version

FNT – fetal nuchal translucency

GA – general anaesthesia

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GDM – gestational diabetes mellitus

IUFD – intra-uterine fetal death

IV – intravenous

IVF – in vitro fertilisation

JAMA – Journal of the American Medical Association

LSCS – lower segment caesarean section

MJA – Medical Journal of Australia

MRI – magnetic resonance imaging

NEJM – New England Journal of Medicine

PPH – postpartum haemorrhage

RANZCOG – Royal Australian and New Zealand College of Obstetricians and Gynaecologists

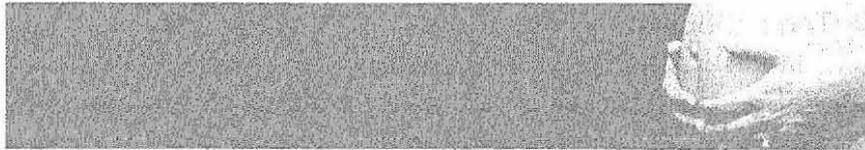
RCOG – Royal College of Obstetricians and Gynaecologists

SMH – Sydney Morning Herald

TOS – trial of scar

US,USS – ultrasound, ultrasound scan

VBAC – vaginal birth after caesarean section



ONE

INTRODUCTION - SOME PRECONCEPTIONS

On a cold November morning in the year 1817, the Princess Charlotte, prostrate in her four-poster bed at the royal residence of Claremont House, in the countryside south of London, took one final breath, and slipped away to meet her Maker. She had just endured a labour of fifty hours, ending in a prolonged and difficult birth. Charlotte, twenty one years old, was the daughter of the Prince of Wales, which made her third in line to the English throne. Her grandfather, the aging and mad King George III, had twelve living children, but no other legitimate grandchildren who might provide a strong royal line. The Prince of Wales was grossly obese, elderly, and lazy, unlikely himself to father more children. The whole nation had been depending on Charlotte, who was as popular throughout England as Princess Diana would become nearly 200 years later. News of her two previous miscarriages had caused great public concern, and the outcome of this third pregnancy was anxiously awaited. Her premature dying caused an outpouring of public grief not matched again until the death of Diana, and plunged England into deep dynastic difficulty.

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Throughout the Princess's labour, Royal Physicians, courtiers and ladies-in-waiting had been in constant attendance. The Archbishop of Canterbury and the Home Secretary waited in a downstairs room, while her husband, Prince Leopold, was often at her side. The first stage of her labour, lasting 26 hours, was characterised by inefficient contractions of the uterus – there was very slow progress towards the full dilatation, or opening up, of the cervix that is an essential step in natural birth. The second stage of labour, that part involving the actual pushing of the baby out into the world, which at the beginning of the 21st century we believe should be accomplished in two or three hours, dragged on for twenty-four. The attending doctors were concerned by the appearance of meconium, the dark green bowel contents of the newborn - meconium detected in the course of labour suggests that the infant is becoming distressed. And indeed the child, a boy, was stillborn. Following the birth there was a brisk haemorrhage which undoubtedly contributed to the Princess's demise. Despite the best efforts of the galaxy of medical talent gathered at Charlotte's bedside, the royal line could not be secured. So depressed by the tragic event was the Royal Physician Sir Richard Croft that he later committed suicide.

Looking back, it is clear that a caesarean section, performed, perhaps, after several hours of lack of progress in the second stage of labour, might have resulted in a healthy mother and a live-born infant. The need for subsequent events – the rapid marriage of the Duke of Kent, brother of the Prince of Wales, and the production of another heir to the throne in the person of Queen Victoria - might have been averted. England might never have known the splendour and prudery of the Victorian era. Sadly for Charlotte, the operation was still in its infancy, and no doctor would have dared attempt it upon a princess.

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One hundred years later, things were better, but only somewhat. The work of Ernest Hemingway is noted for its tough, particularly masculine qualities, and its realistic portrayal of the brutality and futility of war. It is remarkable then that in *A Farewell to Arms*, which is based on Hemingway's experiences as a volunteer ambulance driver during World War I, the most significant and poignant death is not on the battlefield from wounds but in the labour ward from the complications of caesarean section. Catherine is the English nurse central to the story and, as in Charlotte's case, her labour does not progress normally. Hemingway does not flinch from describing the exhaustion and remorseless pain of her contractions:

"They've got to give me something," Catherine said. "They've got to give me something. Oh, please, doctor, give me enough to do some good!"

Henry, Catherine's lover, speaks with her doctor:

"What do you think?"

"I would advise a caesarean operation. If it were my wife I would do a caesarean."

"What about infection?"

"The danger is not so great as in a high forceps delivery."

"Operate as soon as you can," I said.

The operation proceeds; for part of the time Henry watches from a gallery with several nurses.

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Down below, under the light, the doctor was sewing up the great long forcep-spread, thick-edged wound. Another doctor in a mask gave an anaesthetic. Two nurses in masks handed things. It looked like a drawing of the Inquisition.

The baby is delivered, "a fine boy", but like Charlotte's son, stillborn. Catherine too starts to bleed, and dies within hours. By 1917, caesarean section was an established part of the obstetric repertoire, but still it had a high mortality, up to 25% of women dying when the surgery was performed after a long labour like Catherine's.

It seems she had one haemorrhage after another. They couldn't stop it. I went into the room and stayed with Catherine until she died. She was unconscious all the time, and it did not take her very long to die.

Things were getting better, though. It was dawning upon doctors that hesitation was the main cause of death in women who had caesarean births – waiting for hours during long slow labours, and performing multiple internal examinations to assess progress (or the lack of it) greatly increased women's chances of developing fatal infections or massive blood loss. Once it seemed that a caesarean might be indicated, it was better to proceed immediately. By 1926 the operation was sufficiently reputable for it to be performed to deliver the future Queen Elizabeth II, "feet first." Refinements to the techniques of surgery and better anaesthetics had reduced deaths from caesareans amongst mothers having the operation to less than 1% when the surgery was performed early in labour. This figure was not all that different from the death rate for women having vaginal births - childbirth was still a hazardous business for women. "Childbirth is four times more dangerous than coalmining, and

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coalmining is men's most dangerous occupation," wrote one social commentator at the time. However the total number of women having caesareans was still very low: fewer than one in a hundred of the women giving birth in the 1920s underwent caesarean, in the United Kingdom, the United States, and Australia.

Gradually through the 1930s and 40s these numbers rose. This steady upward trend was accompanied by a move away from the home and into the hospital as the place of birth – at least in developed countries, including Australia. However despite more births taking place in hospital, the rate at which women died in childbirth did not change much between the end of the nineteenth century and the late 1930s. Then in 1936 antibiotics were introduced– these drugs, extraordinarily effective in treating 'childbed fever, brought about a dramatic fall in deaths amongst all women giving birth. They also made caesarean section a safer operation.

In 1959, a well-known Scottish obstetrician named Ian Donald published a textbook of obstetrics, a book that was to run to seven editions and educate thousands of medical students, including myself. Professor Donald had quite a lot to say about caesareans. "Caesarean section," he wrote, "is now performed with increasing impunity, thanks largely to antibiotics, improved anaesthesia and the availability of blood transfusion...but it would be a great mistake to regard it as a means of finding a happy outcome to all our obstetric afflictions." At the time the caesarean section rate in his hospital was 7%, a figure considered very high, and Donald feared that it might rise even higher, though he probably could not have imagined today's figures. (More about Ian Donald later. He pioneered the use of ultrasound to investigate the health of

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unborn babies during pregnancy, an idea that came to him when he was in the Navy during the Second World War and saw sonar being used to detect submarines in the sea below him. Fetuses swimming in their own internal sea can now have their well-being routinely assessed as a direct result of Donald's canny thinking.)

Less than forty years after Donald wrote his prophetic words, in June of 1996, the respected medical journal *The Lancet* of London reported the results of a survey of a group of obstetricians, both female and male. These doctors were questioned about their birthing preferences, for themselves or their partners, in various hypothetical situations. How would you like to give birth, they were asked, if you had a normal, full-term baby with no complications expected in labour? Amongst women obstetricians 31%, and amongst men 8%, said that they would *request* an elective caesarean section in preference to a vaginal birth. The preference for caesareans was greatly increased when relatively minor complications of pregnancy were postulated, such as a big baby or being 'overdue'. Clearly these obstetricians viewed caesarean section as a safe and desirable method of birth that should be available on request to women. Possible damage to the bowel, incontinence of urine and compromised sexual function following vaginal birth were amongst the reasons given by the obstetricians for their personal choice of a planned caesarean. In 1996, rates of caesarean section in the United Kingdom were close to 20% of all births; in the United States and other developed countries the figure hovered around 25%, and in certain populations – women who were private patients in Brazil, for example – the rate was said to exceed 90% of all births.

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So caesarean section, from being a dangerous operation with the strong possibility of death or disablement, has become in a short time the recommended birth method for a large number of women, and the method of *choice* for a significant group of these. In 2003, 28% of more than 250,000 Australian women giving birth did so by caesarean section. In 2008, in many parts of Australia, more than 30% of babies, nearly one in three, arrive in the world via the operating theatre. Many people find this information disturbing or bizarre. These operations must be unnecessary, they say. Babies have been born the way Nature intended for thousands of years. There is a belief, widespread in the general community, that far too many caesars are being done. There is talk of a caesarean epidemic. A strong and vocal movement has grown up, initially amongst midwives and consumers, questioning the current rates of caesarean section in most developed countries, claiming these are far too high, and calling for an increased proportion of women who have previously had caesarean deliveries to attempt 'VBAC' (pronounced 'vee-bac') -vaginal birth in future pregnancies. In the *Sydney Morning Herald (SMH)* in January 2008, journalist Ruth Pollard wrote several articles warning of the potential dangers of increasing Australian caesarean rates. "The number of caesarean births in Australia," she said, "is reaching unmanageable levels, placing lives at risk and tying up thousands of hospital beds, operating theatres and health workers with a costly elective procedure. If the caesarean rate rises to 39% - which many experts fear will happen soon – it will mean thousands more surgical births each year. In a public system that is hundreds of beds and thousands of staff short, and in the midst of a mini-baby boom, that extra strain would be unbearable."

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Amongst women who have recently given birth by caesarean there is, however, a wide range of opinions. Writing in the *Good Weekend* supplement of the *SMH* in 2003, journalist Kate Hamilton described the retrospective views of several women who had undergone caesarean section. Jo Bainbridge was the convenor of a South Australian based group, Caesarean Awareness Recovery and Support (CARES) which she formed after experiencing an emergency caesarean in her first pregnancy. She had been in labour for 17 hours when progress slowed, and she was told she required a caesarean for fetal distress and failure to progress. "At that point," Bainbridge is quoted as saying to Hamilton, "I was really needing somebody to tell me that everything was okay. I didn't want saving from it. What I wanted was somebody to get in my inner circle and tell me I was doing good. But nobody seemed to do that. I asked if I could have an epidural to try and calm down and get refocused, but they said it was too late. I was whisked off to surgery.

"I felt really incapacitated, which was against my character," continued Bainbridge. "Needing to rely on other people was wearing down my self esteem...I felt completely out of control."

Another woman, West Australian Diana Hubble, also had negative recollections of the events leading up to her first birth, a caesarean, which she recounted to Hamilton. Hubble's diabetes increased her chances of having a larger than average baby and she felt that her private obstetrician pushed her into having a caesarean rather than supporting her desire for a vaginal birth. "He kept saying it would be safer for me to have a caesar but I stood by my decision until he told me this horror story about another diabetic whose baby was so big

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they had to dislocate its shoulder to get it out. I burst into tears and agreed to the caesarean.” A similar article in the *Weekend Australian* in 2005, by Susan Horsburgh, quotes Sonya Porter, who gave birth to her first child in 2002. “They said (the labour) was going on too long and I had to have a caesarean.”

On the other hand, when in a recent issue of *The Australian Women’s Weekly* writer Hannah Dahlen deplored the fact that “one in three” Australian women don’t get to experience “the greatest triumph and high a woman will ever get” – vaginal birth – reader and caesarean mother Rebecca Smith responded sharply. “Hannah Dahlen suggests ...that a mother who has a caesarean doesn’t give birth!” she wrote in the following issue. “I gave birth by caesarean not by choice but because my baby was breech and a caesarean was the safest option for him. I can assure you that, although my son was not born ‘naturally’, *I gave birth*. I just experienced it in a different way. Let us celebrate all women, whatever their choice or circumstances, for having the amazing ability to procreate.” And Brisbane PR consultant Lisa Tarabay told Susan Horsburgh in the *Weekend Australian* of her first delivery, of twins, an emergency caesarean done for premature rupture of membranes. She was positive about the experience: “I had done the classes and read the books and had no desire to huff and puff.” Tarabay’s second birth was an elective caesarean: “I felt far more in control because there’s no unpredictability. You’re not bugged. You’re in a good state of mind to discuss things with the doctor. It’s just as fabulous and the father can have just as much participation.” Of her third planned pregnancy and caesarean she said: “I hate being pregnant. I would bond just as readily if I went to the hospital and was handed a baby.” Another woman, Melbourne accountant Nadia Carlin, told Horsburgh how she had opted for a caesarean on request. “It was all calm, I could choose the

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time, it was the best 20 minutes of my life. I would have loved an easy natural birth but you don't know what you're going to get – one hour or fifteen with the cord wrapped around the baby's neck." So it does appear that a substantial number of Australian women regard caesarean section as a procedure they can choose themselves, albeit after discussion with their doctors.

Much of the blame for rising caesarean rates is laid at the feet of obstetricians: after all, we are the ones doing the operations, why don't we just stop? Writing in *The Australian* in May 2007, Dr Sarah Buckley, Brisbane general practitioner and mother of four, had this to say:

"Many in our culture including many doctors are convinced that surgical birth is at least as safe as normal vaginal birth. This gives us a low threshold for caesareans and few reasons for women and their carers to put in the effort required for normal birth. Add in the extra convenience for obstetricians, who don't need to wait around for caesarean mothers at difficult times of the day and night, and who are much less likely to be sued, and you have a recipe for full operating theatres and empty labour wards."

However obstetricians *are* concerned, both individually and in groups. They frequently express alarm at escalating caesarean rates, and devote whole conferences to efforts to decrease these rates. Ten years ago, in 1997, an editorial in *The Lancet* quoted "a leading UK obstetrician" who declared that the projected rise in the number of women having caesarean sections is "the most urgent crisis facing obstetrics." The Royal College of Obstetricians and Gynaecologists, based in London, has issued clear guidelines for the practice of caesarean section, strongly

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recommending that the operation be avoided if possible and that “when considering a caesarean section there should be discussion on the benefits and risks of (the operation) compared with vaginal birth specific to the woman and her pregnancy.” Australian obstetricians have continued to sound warnings about the situation in this country, most recently in the series of articles in the *Sydney Morning Herald* that appeared early in 2008, in which Ruth Pollard reported that “...many specialists have told the *Herald* that there is an increasing desire to reduce the number of elective surgical births and increase vaginal deliveries, not just to reduce dangerous complications but also to ease pressure on public hospitals and improve recovery time for women and babies.” Sydney obstetrician William Walters told Pollard that “...it is vital the number of elective caesareans is reduced. There is ongoing discussion looking at how normal birth can be encouraged with the view to reducing the rate of caesarean sections.” But there is no agreement amongst doctors, in Australia as overseas, as to what constitutes the ‘correct’ caesarean section rate, nor as to which operations might be the ‘unnecessary’ ones.

Meanwhile, in Addis Ababa, Ethiopia, Dr Catherine Hamlin, an Australian gynaecologist, has been continuing the work she and her late husband Reg, also a gynaecologist, began in the 1960s: the care of young women with obstetric fistulas. A fistula is a permanent hole between the bladder and the vagina, a devastating condition that can follow a difficult vaginal birth. The Hamlins devoted their professional lives to building and running the Fistula Hospital in the Ethiopian capital, an institution which carries out the surgical repair of hundreds of fistulas every year, and which also provides pre-operative and ongoing social support to the women in its care. Dr Hamlin candidly recognises that the fistulas are the direct result of poor

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or absent obstetric services, in particular the lack of facilities throughout Ethiopia for timely caesarean section, but for the moment such services are unlikely to materialise, and repair of fistulas after the event, in those young women who manage to survive a hideous and greatly prolonged obstructed labour, is the only practical solution.

So caesarean section is an operation currently judged from several widely differing viewpoints. In developed countries no other major surgical procedure arouses such passionate argument, while in less-developed areas of the world, thousands of women - and many more babies - die every year, in ghastly circumstances, because they do not have access to what is a very safe and relatively simple piece of surgery.

Though caesarean section is perhaps the most contentious operation in our current repertoire, as well as being one of the most common, accurate information is often conspicuously lacking from the debate. This book seeks to remedy that situation. While much of the information will interest women who are currently pregnant, or planning to be, and who will or may give birth by caesarean section, as well as those who have had children in this way, and for whom questions remain about their surgery, it is not intended to be a 'health' book. It is written for everybody because birth is a subject that interests almost everybody, female and male (as every mother will tell you, perfect strangers feel entitled to pat pregnant women's abdomens and peer into prams at newborn offspring) and when so many babies are born by caesarean good information about the surgery should be readily available.

I performed my first caesarean section in Papua-New Guinea in 1973, under the watchful eyes of a dour Englishman

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who did not believe women should practise obstetrics. I was a junior resident in Port Moresby General Hospital, and we were cautious about putting a scar on the uterus of a woman who might have her next baby out in the Papuan bush, far from an operating theatre and skilled medical help if she needed it. But this woman certainly needed her operation – while in labour she'd spent two days getting to the hospital by canoe, and had a large baby in a breech position. Despite my apprehension, and that of my consultant, I managed to make the incision, deliver the baby, a boy, and stitch up the wound without major complications. When she was well enough to leave hospital, seven days later, she was given the usual record book for her baby with a big drawing in red pen on the front, showing a baby emerging from a woman's belly, and she was told "Missus, taim yu karim narapela pikinini yumas go long haus sik!" (For non-pidgin speakers this is best read out loud.)

I was to perform many more – at least a thousand - during my training years in Papua-New Guinea, Ireland and the United Kingdom. Initial nervousness quickly disappeared as the numbers were chalked up but every now and then an unexpected problem or complication reminded me not to become too cocky. More than 25 years of full-time practice in Sydney and then in Cairns, averaging two caesareans per week, means another 3,000 done personally, plus the supervision of many more that were done by registrars and residents in training. Most of these resulted in the birth of a live and healthy baby to appreciative parents, but some did not. Some women were ecstatic about their surgery, some merely philosophical, and some extremely angry and frustrated at finding themselves giving birth in an operating theatre. With nearly all these women I was able to discuss their surgery, after the event if not

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before, and some of their stories, with their permission, are told in this book, for which I thank them.*

In the 35 years that I have been practising obstetrics, I have seen safe childbirth become even safer for both mothers and babies in developed countries (though not entirely risk-free.) In Australia, death rates for mothers have fallen from around 30 to around 8 per 100,000 births, and deaths of babies from 30 to 8 per 1000 births. Numerous factors have contributed to these quite dramatic falls in maternal and perinatal mortality: better antibiotics, better anaesthetics, better methods of resuscitation and treatment of very ill pregnant women and of very premature newborn babies, and early detection of fetal abnormality with the possibility of abortion for severely affected fetuses. However part of the whole package of improved obstetric care has been the ability to offer increasingly safe caesarean section to women with medical complications in their pregnancies. This contribution of the operation to lower mortality figures should not be overlooked in the discussion that swirls around the surgery.

In a shorter time frame, I have myself given birth to seven children. As a very young, single medical student in Ireland, I experienced with my first child a labour that dragged on from Wednesday to Saturday. This was in 1968, a time now seen by some as a kind of 'Golden Age' of childbirth. Certainly mine was a very 'natural' labour. Finally on the Saturday afternoon a kindly elderly male obstetrician administered a welcome dose of chloroform, then ran around to the other end of the bed to perform a difficult forceps delivery. Despite this drawn-out experience my wonderful first son and I bonded just fine. Today with such a labour I would have had a caesarean, probably on

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the Thursday morning. My later six children were all vaginal births.

So while I have never had a caesarean myself, as a practising obstetrician I can vouch for the accuracy of the clinical information, and at the end of the book I provide appropriate references. Inevitably, what I say will be coloured by my viewpoint as a doctor, but I hope this will be tempered by the fact that I am also a mother. The book is a look at what the operation is, an explanation of how it has come to be performed so often in so many countries, and an attempt to explain what the argument is all about.

*The names of the women used in the real-life stories (including those in Chapter 13) have been changed to protect privacy; all such changes are marked with an asterisk *.