Royal College of Obstetricians & Gynaecologists

Planned Caesarean Birth

Consent Advice No. 14

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Planned Caesarean Birth

When to use this guidance

This is the first edition of this guidance.

This guidance is for healthcare professionals to aid the provision of appropriate and balanced information about the potential benefits, risks and alternative modes of childbirth to those considering a planned (elective) caesarean birth. Planned caesarean birth is an alternative to planned vaginal birth for women with a number of conditions diagnosed before or during pregnancy, or on request for women with no specific medical indication.

This guidance is relevant for women who are aged 16 years and over with mental capacity, and people under 16 years of age who are Gillick competent*, to help make the decisions that are appropriate for them.

This guidance uses the term 'woman' (pronouns 'she' or 'her') to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include pregnant people who do not identify themselves as women and are considering a planned caesarean birth. Obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

How to use this guidance

This guidance should be used by healthcare professionals to support meaningful discussions tailored to the individual's needs as part of the informed decision-making and consent process for those considering a planned caesarean birth, by reference to the General Medical Council's guidance on decision making and consent[1] and the following information resources on caesarean birth:

- National Institute for Health and Care Excellence (NICE) Information for the public: *Intrapartum care: the care you should expect* (www.nice.org.uk/guidance/ng235/informationforpublic).
- RCOG patient information leaflets[2] on *Considering a caesarean birth*, *Placenta praevia, placenta accreta and vasa praevia*, and *Breech baby at the end of pregnancy*.
- NHS website (www.nhs.uk/conditions/caesarean-section/).
- Obstetric Anaesthetists' Association information for mothers (www.labourpains.org).
- Baby Centre *Who will be with me during a caesarean birth?* (Video) (www.babycentre.co.uk/v25008653/who-will-be-with-me-during-a-caesarean-birth-video).

How to provide information

For planned caesarean birth, the information should be provided during the antenatal period and ideally well in advance of admission to hospital. Information should be made available in commonly used languages, and large print/Braille versions should be made available for those with impaired vision. Translators must be made available for those unable to read and/or understand the information. For non-English speaking users, consent should be obtained with the use of an interpreter. Healthcare professionals should not rely on family members or friends as interpreters.

* Gillick competence outlines whether a child (under 16) can consent to their own medical treatment without the need for parental knowledge or expressed permission. If the child has sufficient maturity and understanding to make informed decisions about their treatment, they would be considered Gillick competent.

Healthcare professionals are encouraged to consider using visual or other explanatory aids to support women in understanding their personalised risk, taking account of their clinical and personal circumstances, compared with population level risk. **Discussions should take into consideration the risks that a reasonable woman in this woman's position would regard as relevant when making a decision about available options of birth.**

Recording informed consent

Using the information in the attached consent form, healthcare professionals should explain to women that the potential risks for planned casesarean birth or planned vaginal birth, as stated,[3–5] are summary estimates only, mainly based on available evidence as reviewed by NICE.[3] It is acknowledged there were some limitations with the quality of evidence and not all the evidence was from a comparison of planned mode of birth. Women should be informed by healthcare professionals that the risks include both relative effects (risks of an outcome in one group compared with another) and absolute effects (risks of a specific outcome happening in a group). For example, in uncommon outcomes such as maternal death or neonatal mortality, large relative effects can represent a small absolute increase in risk, because of the low baseline rate of this risk.

Women planning a vaginal birth should also be informed that in the UK, approximately 1 in 8 women planning a vaginal birth have an assisted vaginal birth (using ventouse or forceps) and aproximately 1 in 5 women have an emergency or unplanned caesarean birth.[6] These figures are higher in primiparous women (between 1 in 2 and 1 in 3 for assisted vaginal birth and up to 1 in 3 for an emergency caesarean birth).[6]

After provision and discussion of all available information, women should be offered the time and opportunity to clarify any concerns they may have, before seeking their written consent.

References

1. General Medical Council. *Decision making and consent*. London: GMC; 2020 [www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent]. Accessed 21 Nov 2024.
2. Royal College of Obstetricians and Gynaecologists. Patient information [www.rcog.org.uk/for-the-public/browse-our-patient-information/]. Accessed 21 Nov 2024.
3. National Institute for Health and Care Excellence. *Caesarean birth*. *Tools and resources. Appendix A – Benefits and risks of vaginal and caesarean birth*. NICE guideline [NG192]. London: NICE; March 2021, Updated August 2024 [www.nice.org.uk/guidance/ng192/resources]. Accessed 21 Nov 2024.
4. Royal College of Obstetricians and Gynaecologists. *Assisted Vaginal Birth*. Green-top Guideline No. 26. London: RCOG; 2020.
5. Kawakita T, Landy HJ. Surgical site infections after cesarean delivery: epidemiology, prevention and treatment. *Matern Health Neonatol Perinatol* 2017;3:12.
6. NHS Digital. NHS Maternity Statistics, 2020-21: HES NHS Maternity Statistics Tables [digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2020-21]. Accessed 21 Nov 2024.

Consent form for planned caesarean birth

Patient identifier:

Name of proposed procedure: Planned caesarean birth

Birth of baby/babies through a cut in your abdomen (tummy) and uterus (womb).

Anaesthetic: This procedure will require an anaesthetic (to ensure that you do not feel any pain). This will be discussed with you by an anaesthetist before the procedure.

Statement of healthcare professional (to be filled in by healthcare professional with appropriate knowledge of caesarean birth):

I have explained the procedure to the woman, specifically, I have explained:

- This procedure involves birth of baby/babies through a cut in your abdomen and uterus.
- Numbers quoted below are estimates only based on the data currently available.

Summary estimates of risks of planned caesarean birth compared to planned vaginal birth to inform discussions. Precise numerical estimates of risks cannot be given and will vary for individual women.

		Planned caesarean birth	Planned vaginal birth
Risks for the woman	**Perineal tears (third- or fourth-degree)**	0 per 100 000	560 per 100 000 vaginal births (about 1 in 179) – risk is higher for assisted vaginal birth than for unassisted vaginal birth
	Urinary incontinence occurring more than 1 year after birth	7300–19 600 per 100 000 (about 1 in 5–14)	19 800 per 100 000 (about 1 in 5) for assisted vaginal birth 48 700 per 100 000 (about 1 in 2) for unassisted vaginal birth
	Faecal incontinence occurring more than 1 year after birth	7800 per 100 000 (about 1 in 13)	15 100 per 100 000 for assisted vaginal birth (about 1 in 7) No difference for unassisted vaginal birth
	Urinary tract injury	About 1 per 1000*	No data available
	Wound infection, which may require readmission to hospital for treatment	2–7 per 100 (about 1 in 14–50)	Infection rates of perineal tears or episiotomy is variable ranging from less than 1 per 100 to 13 per 100, but there is less likelihood of readmission being required
	Hospital stay	About 4 days on average	About 2 and a half days on average
	Uterine rupture in future pregnancy or birth	200 per 100 000 (1 in 500)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	7 per 100 000 (about 1 in 14 000) Risk is higher for planned vaginal birth in women who have had multiple previous caesarean births
	Emergency hysterectomy: removal of your uterus	200 per 100 000 (about 1 in 500)	100 per 100 000 (1 in 1000)
	Placenta accreta spectrum (abnormally adherent or invasive afterbirth) in future pregnancy	100 per 100 000 (1 in 1000)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	34 per 100 000 (about 1 in 2900)
	Maternal death (death within 6 weeks of childbirth)	25 per 100 000 (1 in 4000)	4 per 100 000 (1 in 25 000)
	Perineal/abdominal pain	Typical pain scores† of 1 (during birth) and 4.5 (3 days after birth)	Typical pain scores† of 7.3 (during birth) and 5.2 (3 days after birth)
	Risks associated with anaesthesia	As discussed with the anaesthetist	

Risks to the baby	**Skin lacerations/cuts**	1–2 per 100	Up to 10 per 100 with assisted vaginal birth Unlikely with unassisted vaginal birth
	Childhood obesity	Evidence to compare this outcome is limited/conflicting	
	Asthma	1809 per 100 000 (about 1 in 55)	1500 per 100 000 (about 1 in 67)
	Higher neonatal mortality (death of babies within 28 days of birth)	58 per 100 000 (about 1 in 1700)	30 per 100 000 (about 1 in 3300)

*** Figures based on planned and unplanned caesarean births.**

† **Using a scale where 1 is no pain through to 10 which is most severe pain.**

***Note*: Studies including pregnant women with breech presentations, multiple pregnancies, preterm births, babies who are small-for-gestational-age, placenta praevia, and maternal infections were excluded.**

I have discussed the risks that this woman considers are relevant to her, taking into account her individual circumstances, risk factors and plans for future pregnancies (specify details):

I have discussed the risks of alternative modes of childbirth (including planned vaginal birth: unassisted or assisted, emergency caesarean birth). ☐

I have discussed the procedures that may become necessary during the caesarean birth (tick as appropriate from following list if agreed by the woman):

- Blood transfusion ☐
- Repair of any damage to bowel, bladder or blood vessels ☐
- Emergency hysterectomy (when necessary, as a life-saving procedure) ☐

The following resources have been provided (specify details):

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I confirm ..... **has been offered time and opportunity to seek clarification on the information provided.**

Healthcare professional:

Signed ..... Date .....

Name (PRINT) .....

GMC/NMC number .....

Job title .....

Contact details (if patient wishes to discuss options or ask further questions later):

.....

Woman or service-user:

I do / do not agree* to the procedure, examination or treatment described, including the procedures, treatments or examinations which may become necessary (*please delete as appropriate).

I do / do not agree* that students may be present during the procedure (*please delete as appropriate).

I do / do not agree* that students may examine me during the procedure (*please delete as appropriate).

Signed ..... Date .....

Name (PRINT) .....

Statement of interpreter (where appropriate):

I have interpreted the information above to the woman to the best of my ability and in a way in which I believe they can understand.

Signed ..... Date .....

Name (PRINT) .....

Contact details .....

Confirmation of consent on the day of the procedure/treatment (to be completed by a healthcare professional and the woman or service-user).

Healthcare professional:

Signed ..... Date .....

Name (PRINT) .....

GMC/NMC number .....

Job title .....

Woman or service-user:

I confirm that I still want the procedure/treatment to go ahead.

Signed ..... Date .....

Name (PRINT) .....

Or

I confirm I have withdrawn my consent for the procedure/treatment.

Signed ..... Date .....

Name (PRINT) .....

This Consent Advice was produced on behalf of the Royal College of Obstetricians and Gynaecologists by the RCOG Consent Task and Finish Group, whose membership included:

Mrs G Kumar FRCOG, Wrexham, Chair, Consent Task and Finish Group; L Berg, RCOG Trainees Representative; Mr A Pickersgill MRCOG, Stockport; Dr F Plaat FRCA, Royal College of Anaesthetists Representative; Dr M Ross-Davie, Royal College of Midwives Representative; L Brigante, Royal College of Midwives Quality and Standards Advisor; Professor T Draycott FRCOG, Vice-President, RCOG Clinical Quality; Dr J Plumb MBE, RCOG Women's Network Representative; Dr A Gorry MRCOG, Chair, RCOG Patient Information Committee; L Thomas, Head of Quality Improvement, RCOG; S Miles, Guidance Editorial Manager, RCOG; S Cooper, Business Coordinator, RCOG; M Sadler, Guidance Editorial Manager, RCOG; and L Burke, Committee Administrator, RCOG.

The following individuals and organisations submitted comments at peer review:

Association for Improvement in the Maternity Services (AIMS); Birthrights; Birth Trauma Association; British Maternal & Fetal Medicine Society; Miss A Diyaf MRCOG, Bridgend; T Francis and E Thomas, Partners at Hempsons, London; P Hull, Founder of caesareanbirth.org; RCOG Patient Safety Committee; Sujatha Thamban FRCOG, London; and the UK National Screening Committee.

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Dr P Owen FRCOG, Glasgow; and Miss A Ali, Guidance Editorial Assistant, RCOG.

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The Chair of the Patient Safety Committee was: Dr S Cunningham MRCOG, Stoke-on-Trent; and the Vice Chair was: Mrs G Kumar FRCOG, Wrexham.

The review process will commence in 2025, unless otherwise indicated.

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces Consent Advice as an aid to good clinical practice. The ultimate implementation of a particular clinical procedure or treatment plan must be made by the doctor or other healthcare professional after obtaining a valid consent from the patient in light of the clinical data and the diagnostic and treatment options available. The responsibility for clinical care rests with the practitioner and their employing authority and should satisfy local clinical governance probity.