Royal College of Obstetricians & Gynaecologists

Planned Caesarean Birth

Consent Advice No. XX
Month 2021

Consent advice for planned caesarean birth

When to use this guidance

The purpose of this guidance is to ensure appropriate information about the benefits, risks and alternatives are provided to those considering planned caesarean birth.

This guidance is relevant for women and other service users 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.

The guidance uses the term 'woman'; however, it is important to acknowledge that 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.

How to use this guidance

This guidance should be used 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 and in conjunction with the GMC guidance on decision-making and consent.[1]

It should be used in conjunction with reliable information resources on caesarean birth, including:

- The RCOG's Patient Information leaflets on Choosing to have a caesarean section, Placenta praevia, placenta accreta and vasa praevia, Breech baby at the end of pregnancy, (www.rcog.org.uk/en/patients/patient-leaflets/);
- The NHS website (www.nhs.uk/conditions/caesarean-section/);
- The Obstetric Anaesthetists' Association information for mothers website (www.labourpains.com);
- and Baby Centre (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 in advance of admission to the hospital. Information should be made available in commonly used languages and large print/Braille versions should be available for those with impaired vision. Translators must be 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. Health care professionals should not rely on family members or friends as interpreters.

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. **The discussion should centre on what this particular woman regards as relevant when making a decision about available options of birth.**

Taking written consent

At the end of the explanation and discussion about the procedure, women should be given 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.

2. National Institute for Health and Care Excellence. NICE Guideline [NG192]. Caesarean Birth. London: NICE; 2021.

Consent Form for Planned Caesarean Birth

Patient identifier:

Name of proposed procedure: Planned caesarean birth (PCB)
Birth of baby/babies through a cut in your abdomen (tummy) and uterus (womb).

Anaesthetic: This procedure will involve:
General anaesthesia Regional anaesthesia

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

I have explained the procedure to the woman; in particular, I have explained:

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

Intended benefits

For women

- Less perineal and abdominal pain during and up to 3 days after birth compared with vaginal birth
- Fewer vaginal tears (0 per 100 000 compared to 560 per 100 000 with vaginal birth)
- Lesser risk of urinary incontinence occurring more than 1 year after birth (27 520 per 100 000 compared to 48 700 per 100 000 with vaginal birth)
- Lesser risk of faecal incontinence occurring more than 1 year after birth (7410 per 100 000 compared to 15 100 per 100 000 after assisted vaginal birth, no difference when compared to unassisted vaginal birth)

For babies

Safer way for your baby to be born when caesarean birth is medically indicated compared with vaginal birth.

Risks, including any risks of significance to this particular woman

For women

- Wound infection (2–7 per 100), may require readmission to hospital for treatment
- Longer hospital stay (1–2 days longer stay compared to vaginal birth)
- Higher risk of uterine rupture in future pregnancy or birth (1020 per 100 000 compared to 40 per 100 000); risk is higher after multiple caesarean births and after emergency caesarean compared to planned caesarean births
- Higher risk of emergency hysterectomy: removal of your uterus (150 per 100 000 compared to 80 per 100 000 with vaginal birth)
- Higher risk of placenta accreta (adherent afterbirth) in future pregnancy (100 per 100 000 compared to 40 per 100 000 with vaginal birth); risk is higher after multiple caesarean births and after emergency caesarean compared to planned caesarean births
- Higher risk of death (24 per 100 000 compared to 4 per 100 000 with vaginal birth)
- Risks of anaesthesia (as discussed with anaesthetist)

For babies

- Risk of skin lacerations/cuts during caesarean birth (1–2 per 100).
- Higher risk of childhood obesity (4560 per 100 000 compared to 4050 per 100 000)
- Higher risk of asthma (1810 per 100 000 compared to 1500 per 100 000 with vaginal birth)
- Higher neonatal mortality: death of babies within 28 days of birth (50 per 100 000 compared to 30 per 100 000 with vaginal birth)

I have also discussed the benefits and risks of alternative options (including vaginal birth: unassisted or assisted, emergency caesarean birth). ☐

I have discussed any concerns of this particular woman taking into account their individual circumstances, risk factors and plans for future pregnancies (specify details below):

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I have discussed any procedures that may become necessary during the caesarean (tick as appropriate from following list):

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

The following leaflet/tape/electronic information/link has been provided: (specify details)

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I confirm the woman has been given time and opportunity to seek clarification on the information provided on planned caesarean birth.

Healthcare professional

Signed ..... Date .....
Name (PRINT) .....
GMC/NMC number .....
Job title .....
Contact details (if patient wishes to discuss options later)

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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 patient to the best of my ability and in a way in which I believe s/he can understand
Signed ..... Date .....

Confirmation of consent (to be completed by a health professional and the woman or service user on the day of the procedure, treatment or examination)

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 or examination

Signed ..... Date .....
Name (PRINT) .....

This Consent Advice was produced on behalf of the Royal College of Obstetricians and Gynaecologists by:

The following individuals and organisations submitted comments at peer review: XX

The Chair of the Patient Safety Committee was: Dr S Cummingham MRCOG, Stoke-on-Trent.

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All RCOG guidance developers are asked to declare any conflicts of interest. A statement summarising any conflicts of interest for this Consent Advice is available from: https://www.rcog.org.uk/en/guidelinesresearch-services/guidelines/caXX

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

The guideline will be considered for update 3 years after publication, with an intermediate assessment of the need to update 2 years after publication.

