



# Royal College of Obstetricians and Gynaecologists

## Consent Advice No. 7

October 2009

### CAESAREAN SECTION

This is the second edition of this guidance, which was previously published in 2006 under the same title.

This paper provides advice for clinicians in obtaining consent of a woman undergoing caesarean section.

This paper is intended to be appropriate for a number of procedures and combinations and the consent form should be carefully edited under the heading 'Name of proposed procedure or course of treatment' to accurately describe the exact procedure to be performed, after discussion with the woman. The paper follows the structure of Consent Form 1 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland. It should be used in conjunction with RCOG Clinical Governance Advice, *Obtaining Valid Consent*.<sup>1</sup>

The aim of this advice is to ensure that all women are given consistent and adequate information for consent; it is intended to be used together with dedicated patient information. After discharge, women should have clear direction to obtaining help if there are unforeseen problems.

Clinicians should be prepared to discuss with the woman any of the points listed on the following pages.

#### Presenting information on risk

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

The above descriptors are based on the RCOG Clinical Governance Advice, *Presenting Information on Risk*.<sup>2</sup> They are used throughout this document.

To assist clinicians at a local level, we have included at the end of this document a fully printable page 2 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland, Consent Form 1. This page can be incorporated into local trust documents, subject to local trust governance approval.

## CONSENT FORM

### 1. Name of proposed procedure or course of treatment

Caesarean section.

### 2. The proposed procedure

Describe the nature of caesarean section. Explain the procedure as described in the patient information.

**Note:** If any other procedures are anticipated, these must be discussed and a separate consent obtained. A decision for sterilisation should not be made while the woman is in labour or immediately prior to the procedure. An additional specific consent form should be used for sterilisation at caesarean section.

### 3. Intended benefits

To secure the safest and/or quickest route of delivery in the circumstances present at the time the decision is made, where the anticipated risks to mother and/or baby of an alternative mode of delivery outweigh those of caesarean section.

### 4. Serious and frequently occurring risks<sup>3-5</sup>

It is recommended that clinicians make every effort to separate serious from frequently occurring risks. Women who are obese, who have significant pathology, who have had previous surgery or who have pre-existing medical conditions must understand that the quoted risks for serious or frequent complications will be increased.

Complication rates for all caesarean sections are very common. Complication rates from caesarean section performed during labour have overall complication rates greater than during a planned procedure (24 women in every 100 compared with 16 women in every 100). Complication rates are higher at 9-10 cm dilatation when compared with 0-1 cm (33 women in every 100 compared with 17 women in every 100).

#### 4.1 Serious risks

Serious risks include:

##### **Maternal:**

- emergency hysterectomy, seven to eight women in every 1000 (uncommon)
- need for further surgery at a later date, including curettage, five women in every 1000 (uncommon)
- admission to intensive care unit (highly dependent on reason for caesarean section), nine women in every 1000 (uncommon)
- thromboembolic disease, 4-16 women in every 10 000 (rare)
- bladder injury, one woman in every 1000 (rare)
- ureteric injury, three women in every 10 000 (rare)
- death, approximately one woman in every 12 000 (very rare).

##### **Future pregnancies:**

- increased risk of uterine rupture during subsequent pregnancies/deliveries, two to seven women in every 1000 (uncommon)
- increased risk of antepartum stillbirth, one to four woman in every 1000 (uncommon)
- increased risk in subsequent pregnancies of placenta praevia and placenta accreta, four to eight women in every 1000 (uncommon).

#### 4.2 Frequent risks

Frequent risks include:

##### **Maternal:**

- persistent wound and abdominal discomfort in the first few months after surgery, nine women in every 100 (common)
- increased risk of repeat caesarean section when vaginal delivery attempted in subsequent pregnancies, one woman in every four (very common)
- readmission to hospital, five women in every 100 (common)
- haemorrhage, five woman in every 1000 (uncommon)
- infection, six women in every 100 (common).

#### **Fetal:**

- lacerations, one to two babies in every 100 (common).

#### **5. Any extra procedures which may become necessary during the procedure**

- Hysterectomy
- Blood transfusion
- Repair of damage to bowel, bladder or blood vessels.

#### **6. What the procedure is likely to involve, the benefits and risks of any available alternative treatments, including no treatment**

Delivery of the baby or babies and placenta or placentas through an open approach through an abdominal incision and an incision into the uterus. Both incisions are usually transverse. If either a midline abdominal incision or a classical uterine incision is being considered, the woman must be informed of the reasons and the added risks. Sometimes forceps are used to deliver the head, especially with breech presentations. The reason for the caesarean section must be clearly discussed, as must the risks to mother and/or baby of not performing the caesarean section. An informed, competent pregnant woman may choose the no-treatment option; that is, she may refuse caesarean section, even when this would be detrimental to her own health or the wellbeing of her fetus.

#### **7. Statement of patient: procedures which should not be carried out without further discussion**

Other procedures, which may be appropriate but not essential at the time, such as ovarian cystectomy/oophorectomy, should be discussed and the woman's wishes recorded.

#### **8. Preoperative information**

A record should be made of any sources of information (e.g. RCOG or locally produced information leaflets/tapes) given to the woman prior to surgery.

#### **9. Anaesthesia**

Where possible, the woman must be aware of the form of anaesthesia planned and should be given an opportunity to discuss this in detail with the anaesthetist before surgery. It should be noted that, with obesity, there are increased risks, both surgical and anaesthetic.

#### **References**

1. Royal College of Obstetricians and Gynaecologists. *Obtaining Valid Consent*. Clinical Governance Advice No 6. London: RCOG; 2008 [[www.rcog.org.uk/womens-health/clinical-guidance/obtaining-valid-consent](http://www.rcog.org.uk/womens-health/clinical-guidance/obtaining-valid-consent)].
2. Royal College of Obstetricians and Gynaecologists. *Presenting Information on Risk*. Clinical Governance Advice No. 7. London: RCOG; 2008 [[www.rcog.org.uk/womens-health/clinical-guidance/presenting-information-risk](http://www.rcog.org.uk/womens-health/clinical-guidance/presenting-information-risk)].
3. Hager RM, Daltveit AK, Hofoss D, Nilsen ST, Kolaas T, Oian P, *et al*. Complications of caesarean deliveries: rates and risk factors. *Am J Obstet Gynecol* 2004;**190**:428-34.
4. National Collaborating Centre for Women's and Children's Health. *Caesarean Section*. Clinical Guideline. London: RCOG Press; 2004. [[www.nice.org.uk/Guidance/CG13](http://www.nice.org.uk/Guidance/CG13)].
5. Royal College of Obstetricians and Gynaecologists. *Birth After Previous Caesarean Section*. Green-top Guideline No. 45. London: RCOG; February 2007 [[www.rcog.org.uk/womens-health/clinical-guidance/birth-after-previous-caesarean-birth-green-top-45](http://www.rcog.org.uk/womens-health/clinical-guidance/birth-after-previous-caesarean-birth-green-top-45)].

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The final version is the responsibility of the Consent Group of the RCOG.

Consent Advice review process will commence in  
2013 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 attendant after the valid consent of the patient in the light of clinical data and the diagnostic and treatment options available. The responsibility for clinical management rests with the practitioner and their employing authority and should satisfy local clinical governance probity.

**Patient identifier/label**

## **Name of proposed procedure or course of treatment**

(include brief explanation if medical term not clear) *Caesarean section*

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient, in particular, I have explained:

The intended benefits: *Delivery of baby/babies through a cut in the abdomen (tummy) and uterus (womb) in a situation where the risks of vaginal delivery are more than those of a caesarean section operation*

Serious risks:

- *Emergency hysterectomy, 7–8 women in every 1000 (uncommon)*
- *Need for further surgery at a later date, 5 women in every 1000 (uncommon)*
- *Admission to intensive care unit, 9 women in every 1000 (uncommon)*
- *Increased risk of a tear in the womb in future pregnancies, 2–7 women in every 1000 (uncommon)*
- *Developing a blood clot, 4–16 women in every 10 000 (rare)*
- *Stillbirth in future pregnancies, 1–4 women in every 1000 (uncommon)*
- *In a future pregnancy, the placenta covers the entrance to the womb (placenta praevia), 4–8 women in every 1000 (uncommon)*
- *Injury to the urinary system, 1 woman in every 1000 (rare)*
- *Death, approximately 1 woman in every 12 000 (very rare)*

Frequent risks:

*Common: persistent wound and abdominal discomfort, repeat caesarean section in subsequent pregnancies, readmission to hospital, minor cuts to the baby's skin*

*Uncommon: haemorrhage, infection*

Any extra procedures which may become necessary during the procedure

- blood transfusion
- other procedure (please specify) *hysterectomy, repair to damaged organs*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided

This procedure will involve:

- general and/or regional anaesthesia       local anaesthesia       sedation

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

Name (PRINT) ..... Job title .....

**Contact details** (if patient wishes to discuss options later) .....

**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 .....

Name (PRINT).....

**Top copy accepted by patient: yes/no** (please ring)