MATERNAL CHOICE AND ELECTIVE CAESAREAN

What are the issues?

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Emma is interested in this topic because of its high profile in the media, with celebrities deeming themselves 'too posh to push', and because when attending antenatal clinics many women seem to want a caesarean often regardless of whether they have a clinical indication and many seem to have the perception that it is the 'easy option' as opposed to a natural birth.

In recent years there has been growing concern about the ever increasing number of babies being delivered in the United Kingdom (UK) by caesarean section. The most recent caesarean section audit carried out by the Royal College of Obstetricians and Gynaecologists (RCOG) was conducted in 2001.[1] It was found at that time that the national Caesarean Section Rate (CSR) stood at 21.3% compared with a spontaneous vaginal delivery rate of 67%. These rates are comparable with the United States of America (USA), although greatly exceed those of other European countries. (See table 1)

The same audit reported the most common primary indications for performing caesarean sections to be fetal compromise, failure to progress (dystocia), previous caesarean section and breech presentation.

Interestingly, it seems that more and more women are having caesarean sections without any clinical indication and this appears to be becoming more socially acceptable. The RCOG audit report suggests that maternal request is in fact contributing to the rising CSR. The results of a questionnaire-based study relating to preferred mode of delivery, as part of the audit, showed a total of 5.3% of mothers who preferred to deliver by caesarean section.[1] Women who had had a previous caesarean section were more likely to express this preference. (See table 2)

So why is the caesarean section becoming so popular? It has been suggested that women are often ill informed of the risks and benefits of a caesarean section versus a normal vaginal delivery. This is apparent in the associated literature. A study in 2001 found that those preferring a caesarean section, 6.4% of the study population, were generally more anxious, poorly informed of the risks of the procedure and overestimated its safety.[2] Further to this, a more recent study, in 2006, showed that even when given a comprehensive written statement of potential risks and benefits of caesarean section and vaginal delivery, still 13% of nulliparous women would request a section given the option.[3]

A debate on the subject of elective caesarean section on request, featured in the British Medical Journal (BMJ),[4] suggests various reasons for women preferring this procedure. For example, women who have had a previous difficult instrumental delivery or an emergency section after a prolonged labour may not contemplate another attempt at vaginal delivery. There are also increasing numbers of requests for caesarean section in order to protect the pelvic floor from obstetric trauma. Indeed, a survey of female obstetricians showed that 31% would like to deliver by elective caesarean section with 80% citing fear of perineal damage as their main reason.[5] A similar survey provides support for these findings.[6] Half of the obstetricians questioned would prefer a caesarean section, with more male obstetricians desiring a caesarean delivery for their partners.

Country	Year	CSR (%)
England	2000	21.3
Wales	2000	24.2
Northern Ireland	2000/01	23.9
Scotland	1999	19.3
USA	1999	22.0
Denmark	1999	13.7
Norway	1999	12.6
Sweden	1999	12.2
Finland	1999	15.1
France	1999	17.5
Italy	1999	22.5

Table 1 International caesarean section rates[1]

It is clear that there is little evidence upon which women can base their decision to have an elective caesarean section in an uncomplicated pregnancy. The ethics of randomising women with uncomplicated pregnancies to elective caesarean section or vaginal delivery are certainly questionable. A systematic review of studies relating to the maternal and neonatal outcomes of caesarean sections at maternal request and planned vaginal deliveries has found, after assessment across many outcomes, that there were no major differences, although they were unable to make any definitive conclusions on such a weak evidence base.[7]

Of course, women can request caesarean sections all they want but it falls on the obstetrician to perform them. Therefore, what are their views on this matter? A large scale international survey of obstetricians' attitudes towards caesarean sections at maternal request was conducted in 2006.[8] It was found that 79% of UK obstetricians would perform caesarean sections at maternal request and this was the highest figure throughout Europe. A similar study, focusing on the UK alone, found similar results.[9] Sixty-nine percent of obstetricians were willing to perform caesarean sections in the absence of any obstetric indications and 60%

of study participants also claimed that their practice had changed recently.

Therefore, if women are requesting caesarean sections and on the whole obstetricians are willing to perform them, is this ethically and morally just?

	Vaginal delivery	Caesarean section	No preference dictated by medical reasons	Preference	Don't know
All women	76.2	5.3	6.5	8.7	2.5
Primigravida	75.8	3.3	10.1	6.7	3.6
Multiparous	76.6	7.0	3.5	10.3	1.6
Multip, previous SVD only	86.1	3.2	2.9	5.3	1.3
Multip, previous section	45.0	19.9	3.1	27.1	3.1
Multip, previous operative birth	76.1	7.0	5.6	9.9	1.1
Multip, previous stillbirth	65.6	9.4	3.1	10.8	3.1
More than 2 years to conceive /infertility treatment	72.3	5.9	6.4	10.1	2.7
No problems to report on current pregnancy	79.8	4.7	6.7	5.7	2.4
Problems reported:					
Placenta praevia	79.3	5.5	6.4	11.0	2.8
Breech	59.7	8.2	6.6	20.9	4.1
Maternal health problem	58.2	10.6	3.5	24.7	1.8
Health problem with baby	69.2	1.9	7.7	17.3	1.9

Table 2 Maternal preferences for childbirth[1]

THE ETHICAL PRINCIPLE OF AUTONOMY

The ethical principle of autonomy can be defined as *'the capacity to think, decide, and act on the basis of such thought and decision, freely and independently.'*[10] In relation to the healthcare setting, respect for a patient's autonomy requires health professionals to help patients come to their own decisions about their care, for example, by providing the necessary information to aid them in making that decision. It is also important that they respect and follow the patient's decision, even if they believe it to be wrong.

Patient autonomy can certainly be used as an argument for allowing caesarean sections to be performed at maternal request. Indeed the Changing Childbirth report, published in 1993, suggested that women should have a pivotal role in their obstetric care, ie have their autonomy respected.[11] This standing is supported by many professionals in the field. For example, in a debate on this subject published in the BMJ,[4] Paterson-Brown was of the following opinion:

> '*We should respect a woman's view and choice if it is fully informed, if she expresses a logical reason for wanting a caesarean section, and if she can demonstrate an understanding of the implications of the procedure. We should not be dictating to women what they should think, nor should we be judgmental of their values if they happen to differ from our own.*'

Interestingly, in a comment in a later journal the same author states that, if counselled correctly, most women will agree to labour anyway.[12]

Paterson-Brown seems to assume that an autonomous patient has an unconditional right to have her wishes fulfilled. However, as she states that we should not be dictating to women what they should think we should also not be acting solely on patient demands. In the same discussion, Amu *et al* mention the difference between positive and negative rights.[4] Patients do not appear to be able to demand a treatment (positive right) in the same way they are able to decline a recommended treatment (negative right). The authors therefore conclude that this results in an *'ethical conflict between patients' rights to autonomous decision and carers' rights to autonomy in operating in accord with accepted medical practice.'*

The opinion has been offered that maternal autonomy is *'the most compelling ethical canon'* and it is important that obstetricians have autonomy-based obligations to the mother.[13] The General Medical Council's advice on good medical practice certainly agrees with this.[14] It states how healthcare professionals cannot maintain their professional integrity, self-respect or credibility if they are surrendering to the often 'foolish' or 'irrational' demands of patients, particularly if this constitutes bad medical practice or disagrees with their deeply held values.

THE ETHICAL PRINCIPLE OF BENEFICENCE

It has been emphasised that the obstetrician has ***beneficence-based obligations*** to the mother and that both the mother and the obstetrician have beneficence-based obligations to the fetus.[13] The ethical principle of beneficence emphasises the moral importance of doing good to others, and in a medical context this relates to acting in the patient's best interests.[10]

In the situation of maternal request for caesarean section with no clinical indication, the obstetrician may refuse to perform the procedure believing this to be acting with beneficence or in the patient's best interests. On the other hand, the patients themselves, however well informed, may believe that by having a caesarean section they would be acting with beneficence towards their unborn child. The obstetrician may also want to question if refusing a caesarean section to a woman who is adamant she does not want to labour or who may even have an intense fear of vaginal delivery is the best course of action.

In a similar ethical discussion in an earlier journal it was concluded that beneficence-based clinical judgement still favours vaginal delivery, although with a thorough informed consent process implementing a woman's request for caesarean section is ethically permissible.[15] A comment in another article, however, challenges this.[16] It proposes that a woman cannot be properly informed given that there is almost a total lack of reliable information relating to the short and longterm risks of a caesarean section versus vaginal delivery in a normal woman at term. Given this, it would be therefore difficult to determine, in an uncomplicated pregnancy, which mode of delivery would be in the best interests of the mother and fetus anyway.

THE ETHICAL PRINCIPLE OF NON-MALEFICENCE

A further relevant ethical principle is that of ***non-maleficence***, which is acting to avoid harm. This principle is the other side of the coin to the principle of beneficence and states that we should not harm patients. This does not really add anything to the principle of beneficence but can be related to this ethical discussion. It should be simply highlighted that maternal autonomy is only one element in ethical clinical practice and another is avoiding harm. A doctor may act with non-maleficence in refusing a caesarean section to a woman where in their opinion it would not be in the interests of the mother or the baby.

THE ETHICAL PRINCIPLE OF JUSTICE

The principle of justice comprises of two main elements. Firstly, that patients in similar situations should normally have access to the same healthcare, and secondly, that in determining what level of healthcare should be available for one set of patients we should take into account the effect of such a use of resources on others.[10] In other words, we should try and distribute our limited resources fairly.

It was found difficult to determine the NHS cost of caesarean section; however, in an article in the BMJ it was estimated that in one UK hospital it would total £668.[17] This greatly exceeds the cost of a vaginal delivery and that of induction of labour, estimated in the same article at £644 in a nulliparous woman and £494 in a multiparous woman. It is therefore questionable, both in an economical and an ethical sense, whether paying for procedures that do not necessarily need to be done constitutes the best use of resources.

Regardless of cost, not all hospitals may necessarily have the resources to be performing caesarean sections at maternal request. Often, especially in the small district general hospitals, theatre time for caesarean sections is split with other operative lists. The principle of justice comes into play in this instance. It could be seen that those listed for necessary operations are not being treated fairly in that they would be inevitably be made to wait longer.

With regards to the element of cost of elective caesarean sections, it could however be argued that if the woman does not labour well, a caesarean section may be inevitable anyway. It may be the case that both the emotional and financial cost of a failed vaginal delivery followed by an emergency caesarean section is far higher than simply performing a caesarean section in the first instance.

CONCLUSION

Having discussed the ethical arguments for and against performing caesarean sections at maternal request, incorporating the relevant literature, I will conclude by also offering my own opinions.

To summarise, it is evident that the number of babies being born by caesarean section is ever rising and I am in no doubt that elective caesarean sections in uncomplicated pregnancies are contributing to this. I agree with many of the authors that before making any decision about the mode of delivery a woman should be fully informed of the risks. The extent to which the obstetrician doctor can confidently do this, however, is questionable, given the lack of the evidence. How can any doctor predict or even offer an opinion on what they think might happen at the time of the actual event? The obstetrician and the patient should work as a partnership in deciding what is best for both the mother and the unborn child.

This does not necessarily mean that women should be given the option to have a caesarean section without any clinical indication. There are instances when there may be a slight clinical reason why a caesarean section may be the best line of action, but equally a vaginal delivery could still be safely attempted. In these cases it is reasonable to let the woman decide which mode of delivery she would prefer.

It is a waste of resources to employ two surgeons, an anaesthetist, an anaesthetic nurse, a whole theatre team and a midwife for an elective caesarean section when a vaginal delivery uses far fewer staff. In smaller units, such as the Royal Lancaster Infirmary, there is a conflict between using the theatres for caesareans or gynaecology. Caesarean sections are performed in the same theatre as the gynaecological surgery list. It is arguably unfair to those patients to be 'pushed out' for a procedure that does not necessarily need to be done.

The statement 'too posh to push', instigated by the media, points at the often rich and famous women who pay to have caesarean sections done privately and often at their convenience. Maybe this should continue to be the case, that if a woman requests an elective caesarean section in an uncomplicated pregnancy she should have to pay for it. Or maybe the NHS could instil a charge for such elective procedures? It could be argued that in a world with family planning, prenatal and antenatal screening, IVF and the emerging concept of 'the designer baby' can we do all this and deny the woman a safe mode of delivery?

The debate will continue . . .

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