Elective caesarean sections at maternal request

Obstetricians find themselves somewhere between a rock and a fairly indurated place.

If you were to deliver a baby by caesarean section for no reason other than a firm request from a woman, you would be in good company. Almost 70 per cent of British obstetricians responding to an anonymous survey said they would do the same thing. In fact, similar surveys suggest that almost a third of obstetricians indicate a preference for elective caesarean delivery for themselves. Now that one in four Australian babies are delivered abdominally, finding even more reasons to perform caesarean sections sounds like a disaster for champions of the WHO-mandated caesarean section rate of 10 per cent. But we live and work in the era of the televised 'extreme makeover', begging the question of who should really decide how and when a baby is delivered. In the last 12 months, this question has received prominent space in flagship journals in Europe, the United Kingdom, North America and Australia.

John Queenan, deputy editor of the American journal *Obstetrics and Gynecology*, concedes there is confusion among obstetricians:

> ***Given a clear delineation of risks (we will never know the absolutes), who is in the best position to decide on cesarean delivery? The mother undergoing the surgery? The advocate for the baby to be delivered? The father? The physicians performing the delivery? The pediatrician? The hospital administrator? The third-party payer? They all have definite interests and different points of view.***

Queenan, however, does not see agonising over such maternal requests as a debate over ethics:

> ***The mother, father and baby live with the consequences of these decisions, so the information on which the decision is based must be accurate. The question is not the ethics of patient choice, but lack of scientific proof of risks and benefits.***

Every year, more than 60,000 caesarean sections are performed in Australia alone. It seems astonishing that an accurate picture of the risks and benefits of such a common procedure continues to elude us. 'Physicians do not even have a standardized presentation of the risks and benefits of elective cesarean delivery compared with vaginal delivery,' Queenan says. 'What should be straight-forward can be elusive and malleable.'

Even strident critics of elective caesarean delivery at maternal request, and there are many such voices in the literature, concede that using ethical grounds to decline such a request has shaky foundations. Olubusola Amu and colleagues opine that:

> ***Ultimately, competent women are free to decline medical advice and treatment for rational or irrational reasons, or for no reason, even if, as a consequence, they or their fetus suffer death or injury. The law is clear that the unborn child has no independent status and that a mentally competent expectant mother's wishes must take precedence. Unfortunately, the law does not distinguish between the rights of a mentally competent but foolish (unwise) pregnant woman and other adults. Therefore, if caesarean section is the preferred mode of delivery by the mother, her choice, however foolish or irrational, must be respected.***

The suggestion that a woman who requests an elective caesarean delivery is either foolish or irrational makes some obstetricians bristle. 'The strongest argument against caesarean delivery relates to maternal complications. However, evidence supporting this for elective operations under regional blockade with antibiotic cover and thromboprophylaxis is poor,' argues Sara Paterson-Brown, a consultant at Queen Charlotte's and Chelsea Hospital in London. 'Data on mortality from caesarean section relate to procedures performed for medical or obstetric reasons, often emergencies and often under general anaesthesia. These are not comparable to the elective procedure.'

We live and work in the era of the televised "extreme makeover" – who should decide how and where a baby is delivered?

Leonie Penna, writing in June this year in the British journal *Current Obstetrics and Gynaecology*, points out some important considerations for obstetricians when confronted with a maternal request for elective caesarean delivery. 'It remains to be tested as to whether a clinician agreeing to a non-medically-indicated caesarean section that resulted

in a serious complication would be considered negligent.' On the other side of the coin, though, she concedes that elective caesarean delivery might assist an obstetrician in 'avoiding criticism if things go wrong in labour, including medico-legal issues'. If a woman or her baby experience a serious adverse outcome of labour, and she had strenuously requested an elective caesarean delivery and this had been denied, how many obstetricians would feel secure in their management?

'Some clinicians feel that their own autonomy and rights as a specialist are eroded when a patient persists in a request for a caesarean section against their advice,' says Dr Penna. 'Certainly for a woman to refuse to listen to the opinion of a clinician on the basis that they believe the doctor is trying to sway their decision could be argued as doing this; however, in reality, most women are prepared to consider a specialist's views as long as these are given in a balanced and non-confrontational way.'

London obstetricians Devendra and Arulkumaran conclude their paper by saying, 'In dealing with requests for caesarean sections, obstetricians should establish the reasons for the request and provide clear, unbiased information based on the best available evidence.' Obtaining that clear, unbiased information to provide to women is the major stumbling block that we, as obstetricians, face. To date, there is no study of a suitable size and quality that directly compares the outcomes, both short- and long-term, for women randomised to either undergo an elective caesarean section, or to try labour (knowing that caesarean section will be the outcome in a proportion of attempts). There may never be such a 'term cephalic trial'. Yet this is precisely the information that is required to inform our negotiations with women and their families.

'We would expect that physicians always act in the best interest of their patients,' says John Queenan. 'Providing accurate information on the risks and benefits of cesarean delivery is a complex problem that cannot be answered easily. Could you imagine proposing a randomized controlled trial to your institutional review board?' Indeed.

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Caesarean section: The end point in reproductive emancipation for women?

Caesarean section rates are always controversial. Interest in pregnancy and the birthing process is an inherent part of human nature. Strangers pat pregnant women on the stomach in supermarket queues and stop to admire their newborn babies in strollers.

Caesarean section rates are therefore an emotive issue. There are groups who fervently believe that natural childbirth by vaginal delivery is almost the only acceptable method of delivery and represents the ultimate bonding experience between mother and baby.

However caesarean section rates are rising. They now represent about 23 per cent of all deliveries in Australia and the rate is going up every year.

There are four main drivers for this – patient request, litigation, increasing maternal age and second generation caesarean section for women who inherited a difficult pelvis from their mother and were delivered by caesarean section themselves.

The most important is patient choice. Women are requesting caesarean section as their preferred mode of delivery. There is good data to show that elective caesarean section performed under a spinal block with antibiotic cover has the same risks for mother and baby as when the delivery is performed vaginally. Caesarean section, effectively a vagi-

nal bypass procedure, will reduce (but not negate) the risk of subsequent vaginal prolapse and the need for pelvic floor surgery in later years.

Modern, emancipated women are increasingly exercising their right to choose by deciding that a planned caesarean section is their preferred mode of delivery. This is not a decision lightly made. Most patients carefully research the subject using a wide range of references including their birthing classes. What seems to have great influence on their decision making process is talking to their friends and mothers who have had vaginal deliveries and face up to a year of pelvic floor exercises with occasional urinary and flatal incontinence as constant irritants.

It can be argued that women exercising their rights to choose a mode of delivery is a logical end point in female reproductive emancipation. For centuries women have been limited in their lifestyle and career choices by their reproductive systems. All of that began to change with the introduction of safe contraception, especially the pill, in the 1960s. Reproductive emancipation is now enhanced by many contraceptive choices, the provision of safe termination of pregnancy services, in vitro fertilisation and other infertility treatment, which includes oocyte (egg) freezing as a method of insurance against reproductive ageing, and good childbirth education classes.

When childbirth education classes were introduced it was assumed that informed women would reject technology and medical interference and opt for the most natural childbirth choices available. It is a great irony that this has turned out not to be the case. Informed women are increasingly choosing pain relief and surgical delivery, which fits the pattern of their otherwise busy, productive and technology based lifestyles. Elective caesarean section provides them with definition and control over their birthing process including knowing the exact time their babies are delivered up to a month or two in advance.

The fact that many women are making these choices is of great concern to the natural birth lobby. A majority of women will continue to choose natural childbirth as their preferred option and so they should. However lobby groups should not seek to take away the full spectrum of birthing choices for women or attempt to coerce women into their way of doing things.

Women can now choose when they want to become pregnant, get assistance if they are having trouble falling pregnant and finally choose when and how they will have their babies.

There are now lots of safe ways to have a baby and women's choices need to be respected and protected.

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Primary elective caesarean section: Patient's choice or obstetrician's dilemma?

Every obstetrician has or will be asked by a fit healthy young woman in her first pregnancy with no medical or obstetric factors to deliver her baby by elective caesarean section. This begs the questions:

- Is it reasonable to acquiesce without question?
- Is there evidence to support such an action?
- Should her request be refused?
- Is there evidence to support such a refusal?

The number of women requesting primary elective caesarean section is small and at present probably has only a small impact on the overall caesarean section rate. However the notion that caesarean section is an operation for which the benefits outweigh the risk in this situation must necessarily impact on the readiness of women to accept caesarean section when there is a perceived or real obstetric or medical factor present. This acceptance of caesarean section is probably an important influence on overall caesarean section rates and explains some of the requests for elective caesarean section following adverse experiences in previous pregnancies.

As medical practitioners, we have an ethical responsibility to act in the best interests of our patients to ensure the best maternal and fetal outcome and we have an obligation not to cause harm.

At the present time, there is limited data on the short and long term effect of caesarean section on maternal and perinatal morbidity and mortality compared with vaginal delivery. Single issues are often cited as a defence of caesarean section such as the risk of pelvic floor injury or as a defence of vaginal

delivery such as placenta praevia in subsequent pregnancies. This oversimplification does little to help the practising obstetrician feel confident that he or she is able to truthfully counsel the mother or that by performing a caesarean section the desired outcome will be achieved, that is, there will be both a short and long term benefit to the mother and the baby of the procedure.

The current evidence suggests that elective caesarean section is not associated with an increased maternal mortality; however, the data with regard to maternal morbidity is less reassuring. The present data indicates that elective prelabour caesarean section has a small increase in both absolute and relative maternal risks as compared with spontaneous vaginal delivery. The difference is less if caesarean section is compared with operative vaginal delivery.

One of the major limitations of current data comparing morbidity is due to the limited information with regard to the implications for future deliveries. A recent meta-analysis of controlled trials of elective repeat caesarean section versus trial of labour demonstrated that the former is associated with an increased risk of febrile morbidity transfusion and hysterectomy but does not completely protect from uterine rupture or perinatal death.[1] There is clear data indicating that women delivered by caesarean section are at significantly increased risk of placental abruption placenta praevia and placenta accreta in subsequent pregnancies and the recent case controlled study in Scotland which showed a significantly increased risk of stillbirth after 34 weeks in women who had a previous caesarean section is of great concern.[2] Primary caesarean section may appear to be a safe intervention but may have significant pathophysiological consequences.

Avoidance of pelvic floor damage has in recent years been a major factor leading to requests for elective caesarean section. There is no dispute that pelvic floor injury is associated with vaginal birth. The question that must be asked is: 'How protective is caesarean section and does the degree of protection justify caesarean section?' With further research and application of data it would seem likely that antenatal and postpartum strategies will be developed to reduce pelvic floor morbidity and that a small subgroup of women may be identified which would benefit from caesarean section but there can be no justification at present for nulliparous women being offered a caesarean section for pelvic floor protection given the overall data on primary elective caesarean section.

The data on fetal morbidity does not appear to support primary elective caesarean section. There is no convincing evidence that caesarean section is neuroprotective for the fetus and despite increasing caesarean section rates there has been no decline in nerve palsies or fracture risks. More importantly prelabour caesarean section is associated with an increase in central nervous system depression, feeding difficulty, and the need for mechanical ventilation. The increased risk of respiratory problems in babies born by caesarean section reduces in frequency with gestation such that by 40 weeks it equates with those babies born vaginally.

On balance the current evidence does not support primary caesarean section as a safer option for mother and fetus in either the short or long term. The Committee for the Ethical Aspects of Human Reproduction of the International Federation of Obstetrics and Gynaecology (FIGO) addressed this issue in a report in 1999 and concluded 'performing caesarean section for non-medical reasons is not justified'.[3] However, the question remains as to whether or not a mother has a right to request a caesarean section. It is clearly the responsibility of the medical practitioner to inquire as to the reason for the request and as part of the process of obtaining adequately informed consent must discuss the consequences of the intervention. The notion of autonomy recognises that a patient can decline treatment but it does not carry an obligation that the practitioner undertakes a procedure that is medically unproven or potentially harmful nor does it support a patient dictating medical choices for non-medical reasons.[4]

It is essential that all obstetricians consider this issue and adopt a position with which they individually believe is both ethical and in the best interest of the mother and her fetus. Given the current evidence it would be prudent for those practitioners who undertake primary elective caesarean sections to record their discussion with the mother. A notation – 'patient request' - with no elaboration may be insufficient defence if an adverse outcome were to occur, either in the short or longer term and the practitioner were to be challenged in regard to her/his reason for undertaking the procedure given the current evidence.

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