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The professional responsibility model of obstetric ethics and caesarean delivery

Frank A. Chervenak, MD, Given Foundation Professor and Chairman [a,b,*], Laurence B. McCullough, PhD, Dalton Tomlin Chair in Medical Ethics and Health Policy [c]

[a] Department of Obstetrics and Gynecology, Weill Medical College of Cornell University, New York, USA
[b] New York Presbyterian Hospital, 525 East 68th Street, M-724, Box 122, New York, NY 10065, USA
[c] Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, TX, USA

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In this chapter, we provide an account of the professional responsibility model of obstetric ethics, and identify its implications for two major topics: patient-choice caesarean delivery and trial of labour after caesarean delivery. The professional responsibility model of obstetric ethics is based on the ethical concept of medicine as a profession and the ethical principles of beneficence and respect for autonomy. The obstetrician has beneficence-based and autonomy-based obligations to the pregnant woman and beneficence-based obligations to the fetus when it is a patient. Because the viable fetus is a patient, the ethics of caesarean delivery requires balancing of obligations to the pregnant and fetal patient. The implication of the professional responsibility model for patient-choice caesarean delivery is that the obstetrician should respond to such requests with a recommendation against non-indicated caesarean delivery and for vaginal delivery. These recommendations should be explained and discussed in the informed consent process. It is ethically permissible to implement an informed, reflective decision for non-indicated caesarean delivery. The implication for trial of labour after caesarean delivery is that, in settings properly equipped and staffed, the obstetrician should offer both trial of labour after caesarean delivery and planned caesarean delivery to women who have had one previous low transverse incision. The obstetrician should recommend against trial of labour after caesarean delivery for women with a previous classical incision.

* Corresponding author. New York Presbyterian Hospital, 525 East 68th Street, M-724, Box 122, New York, NY 10065, USA. Tel.: +212 746 3012; Fax: +212 746 8727.
E-mail address: fac2001@med.cornell.edu (F.A. Chervenak).

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Introduction

Ethics is an essential aspect of offering, recommending, recommending against, and carrying out caesarean delivery. On the basis of our previous work,[1] we present the professional responsibility model of obstetric ethics. We then apply this model to clinical decision making about caesarean delivery and address two especially ethically challenging clinical topics: patient-choice caesarean delivery[2,3] and trial of labour after caesarean delivery (TOLAC).[4]

We emphasise a preventive ethics approach.[5] Preventive ethics aims to prevent ethical conflict in clinical practice by using the informed consent process to offer caesarean delivery as a medically reasonable alternative to vaginal delivery, recommending caesarean delivery, and recommending against caesarean delivery. The professional responsibility model of obstetric ethics grounds and guides this preventive ethics approach.

Professional responsibility model of obstetric ethics

Before describing the professional responsibility model, we provide a summary of the tools of ethical reasoning. We begin by defining ethics, medical ethics, and the fundamental ethical principles of beneficence and respect for autonomy. We then show how these two principles should interact in obstetric judgment and practice, with emphasis on the core concept of the fetus as a patient. We then describe the professional responsibility of obstetric ethics.

Ethics and professional medical ethics

Ethics is the disciplined study of morality. Morality concerns right and wrong behaviour and good and bad character. Professional medical ethics is the disciplined study of morality in medicine and identifies the obligations of clinicians to patients.[5] Medical ethics should not be confused with the many sources of morality in a pluralistic society. These include, but are not limited to, law, the world's religions, ethnic and cultural traditions, families, and personal experience. Professional medical ethics seeks to bridge these differences and identify the obligations of clinicians to their patients in all global cultures and national settings.

The first step in doing so is to recognise that professional medical ethics is secular. This recognition was achieved in the 18th-century European and American Enlightenments.[6] Secular professional medical ethics makes no reference to deity or deities or to revealed tradition, but to what reasoned, evidence-based discourse requires and produces. At the same time, secular professional medical ethics is not intrinsically hostile to religious beliefs. Therefore, ethical principles and virtues should be understood to apply to all clinicians, regardless of their personal religious and spiritual beliefs and regardless of their nationality or place of practice.[5]

The traditions and practices of medicine constitute an obvious source of morality for physicians. These traditions provide an important reference point for professional medical ethics because they are based on the obligation to protect and promote the health-related interests of the patient. This obligation tells physicians what morality in medicine ought to be, but only in very general, abstract terms. The provision of a clinically applicable account of that obligation is, in clinical practice, the central task of professional medical ethics, using ethical principles.[5] Two ethical principles play a central role in professional medical ethics.

The first is the ethical principle of beneficence. In ethical reasoning generally, the principle of beneficence requires one to act in a way that is reliably expected to produce a greater balance of benefits over harms in the lives of others.[5,7] In professional medical ethics, this principle requires the physician to seek a greater balance of clinical over clinical harms in the lives of patients.[5] The task of beneficence-based clinical judgment is to reach reasoned judgments about the appropriate balance of clinical goods and harms when not all of them can be achieved in a particular clinical situation, such as a request for an elective caesarean delivery.

Beneficence-based clinical judgment has an ancient pedigree. Its first expression in the history of Western medical ethics occurs in the Hippocratic Oath and accompanying texts.[8] These texts make an important claim: to interpret reliably the health-related interests of the patient from medicine's

perspective. This perspective is provided by accumulated scientific research, clinical experience, and reasoned responses to uncertainty. As rigorously evidence-based, beneficence-based clinical judgment is not based on the idiosyncratic judgment of the physician (i.e. merely on clinical impression or intuition). On the basis of this rigorous clinical perspective, focused on the best available evidence, beneficence-based clinical judgment identifies the clinical benefits that can be achieved for the patient based on the competencies of medicine. The clinical benefits that medicine is competent to seek for patients are the prevention and management of disease, injury, disability, lost functional status, and unnecessary pain and suffering, and the prevention of premature or unnecessary death. Pain and suffering become unnecessary when they do not result in achieving the other goods of clinical care (e.g. allowing a woman to labour without effective analgesia).[5]

The ethical principle of non-maleficence requires the clinician not to cause harm and is best understood as expressing the limits of beneficence-based clinical judgment. This ethical principle is also known as *Primum non nocere* or 'first do no harm.' This commonly invoked dogma is really a Latinised misinterpretation of the Hippocratic texts, which emphasised beneficence while avoiding harm when approaching the limits of medicine to maintain or improve the patient's condition or to alter the course of disease or injury.[5,7] Non-maleficence should be incorporated into beneficence-based clinical judgment: when the physician approaches the limits of beneficence-based clinical judgment (i.e. when the evidence for expected clinical benefit diminishes and the risks of clinical harm increases), then the clinician should proceed with great caution. The clinician should be especially concerned in such clinical circumstances to prevent serious, far-reaching, and irreversible clinical harm to the patient.

We acknowledge that there is an inherent risk of paternalism in beneficence-based clinical judgment. By this, we mean that beneficence-based clinical judgment, if it is, mistakenly, considered to be the sole source of professional responsibility and therefore moral authority in obstetrical care, invites the unwary obstetrician to conclude that beneficence-based judgments can simply be imposed on the pregnant woman in violation of her autonomy. Paternalism can be dehumanising treatment of the pregnant woman and, therefore, should be avoided in obstetric practice.

The antidote to paternalism is respect for the pregnant woman's autonomy.[5,7] This ethical principle requires the clinician to empower the pregnant woman to make informed decisions about the management of her pregnancy. The most important way that clinicians fulfill this obligation is to identify medically reasonable alternatives to the pregnant woman and to identify alternatives that, while technically possible, are reliably judged to be medically reasonable. 'Medically reasonable' means that there is a beneficence-based clinical judgment that a form of clinical management or intervention has a reliable evidence base for expected net clinical benefit. There is no ethical obligation to offer a technically possible alternative that does not meet this test for being medically reasonable. When this is met, the alternative should be offered, along with all other medically reasonable alternatives. Sometimes, the evidence clearly supports one alternative as clinically superior to others or as the only medically reasonable alternative. In such clinical circumstances, the clinician should recommend this alternative to the pregnant woman. Sometimes, the evidence clearly supports an alternative as not medically reasonable. In such clinical circumstances, the clinician should not offer this alternative to the pregnant woman. Sometimes, the evidence clearly supports an alternative as not only not medically reasonable but, on balance, clinically harmful. In such clinical circumstances, the clinician should recommend against this clinical alternative and not carry it out.

Patients exercise their capacity for autonomous decision making in response to alternatives that are offered or recommended by the clinician in the informed consent process. The capacity for autonomous decision making has three components: (1) absorbing and retaining information about her condition and the medically reasonable diagnostic and therapeutic responses to it; (2) understanding that information (i.e. evaluating and rank-ordering those responses and appreciating that she could experience the risks of treatment; and (3) expressing a value-based preference. The clinician has a role to play in each of these. They are, respectively, as follows: (1) to recognise the capacity of each patient to deal with medical information and not to underestimate that capacity, provide information (i.e. disclose and explain all medically reasonable alternatives) and recognise the validity of the values and beliefs of the patient; (2) not to interfere with but, when necessary, to assist the patient in her evaluation and ranking of the medically reasonable diagnostic and therapeutic alternatives for managing her condition; and (3) to elicit and implement the patient's value-based preference.[5]

The common law in the USA played an important role in clarifying the clinician's obligation to provide information to the patient to empower her to make informed decisions. Two major contributions were made in the 20th century: the concepts of simple and informed consent. The concept of simple consent was established in a landmark gynaecologic case, *Schloendorff v. the society of the New York hospital*. Simple consent concerns whether the patient says 'yes' or 'no' to medical intervention.[9,10] To this day, in the medical and bioethics literature, this decision is quoted: 'Every human being of adult years and sound mind has the right to determine what shall be done with his body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.'[9]

The concept of informed consent further evolved to include disclosure of information sufficient to enable patients to make informed decisions about whether to say 'yes' or 'no' to medical intervention.[10] Two accepted legal standards emerged. The professional community standard defines adequate disclosure in the context of what relevantly trained and experienced clinicians actually tell patients. The reasonable person standard, which is used by most states in the USA (where the states regulate the practice of medicine, not the federal government), goes further and requires the clinician to disclose 'material' information. This means information that any patient in a particular patient's condition needs to know and that the lay person of average sophistication should not be expected to know. Patients need to know what the physician thinks is clinically salient (i.e. the physician's beneficence-based clinical judgment about medically reasonable alternatives: what they involve and their clinical benefits and risks). The reasonable person standard has emerged as the accepted ethical standard.[5,10] We, therefore, use it in this chapter. On this standard, the clinician should disclose to the pregnant woman her or the fetus's diagnosis (including differential diagnosis when that is all that is known), the medically reasonable alternatives to diagnose and manage the patient's condition, the short-term and long-term clinical benefits and risks of each alternative, and the evidence-based, deliberative judgment of the clinician that the clinical benefits outweigh the clinical harms.

Respect for autonomy does not require the clinician to implement a patient's preference simply on the basis that the patient has freely expressed it. Put another way, the exercise of rights by the patient should not be regarded as an absolute determinant of the clinician's clinical practice.[5,7]

The ethical principles of beneficence and respect for autonomy should guide professional obstetric clinical judgment and practice. There are beneficence-based and autonomy-based obligations to the pregnant woman: the clinician's perspective on the pregnant woman's health-related interests provides the basis for the clinician's beneficence-based obligations to her, whereas her own perspective on those interests provides the basis for the clinician's autonomy-based obligations to her, as described above. Because of an insufficiently developed central nervous system, the fetus cannot meaningfully be said to possess values and beliefs. Thus, there is no basis for saying that a fetus has a perspective on its interests. There can, therefore, be no autonomy-based obligations to any fetus. Obviously, the clinician has a perspective on the fetus's health-related interests, and the clinician can have beneficence-based obligations to the fetus, but only when the fetus is a patient. Because of its importance for obstetric clinical judgment and practice, the ethical concept of the fetus as a patient requires detailed consideration.[5]

Developments in fetal diagnosis and management strategies to optimise fetal outcome have become widely accepted, encouraging the development of the ethical concept of the fetus as a patient. This concept has considerable clinical significance because, when the fetus is a patient, directive counselling (i.e. recommending a form of management for fetal benefit), is appropriate, and when the fetus is not a patient, non-directive counselling (i.e. not recommending a form of management for fetal benefit) is appropriate.[5]

One prominent approach for establishing whether or not the fetus is a patient attempts to show whether or not the fetus has independent moral status. 'Independent moral status' for the fetus means that one or more characteristics that the fetus possesses in and of itself and, therefore, independently of the pregnant woman or any other factor, generate and therefore ground obligations to the fetus on the part of the pregnant woman and her clinician. Many fetal characteristics have been nominated for this role, including moment of conception, implantation, central nervous system development, quickening, and the moment of birth. It should come as no surprise that there is considerable variation among ethical arguments about when the fetus acquires independent moral status. One view is that the fetus has independent

moral status from the moment of conception or implantation. Another view is that independent moral status is acquired in degrees, thus resulting in 'graded' moral status. Still another view holds, at least by implication, that the fetus never has independent moral status so long as it is *in utero*.[11,12]

Despite a centuries-old, global, and an ever-expanding theological and philosophical literature on this subject, there has been no closure on a single authoritative account of the independent moral status of the fetus. Given the absence of a single method that would be authoritative for all of the markedly diverse theological and philosophical schools of thought involved in this endless debate, closure is impossible. All attempts to explain the ethical concept on the basis of the purported independent moral status of the fetus are irresolvably controversial, and thus provide no reliable clinical basis for the application of the concept.

A clinically reliable explanation of the ethical concept of the fetus as a patient starts with the recognition that being a patient does not require that one possess independent moral status. The ethical concept of being a patient is clinically straightforward: a human being (1) is presented to a clinician (or other healthcare professional); and (2) there exist clinical interventions that are reliably expected to be efficacious, in that they are reliably expected to result in a greater balance of clinical benefits over harms for the human being in question.[5] In the technical language of normative ethics, this is known as the dependent moral status of the fetus.

The authors have argued elsewhere that beneficence-based obligations to the fetus exist when the fetus is reliably expected later to achieve independent moral status as a child and person.[5] That is, the fetus is a patient when the fetus is presented for medical interventions, whether diagnostic or therapeutic, that reasonably can be expected to result in a greater balance of goods over harms for the fetus and therefore the child and person the fetus can later become during early childhood. The ethical significance of the concept of the fetus as a patient, therefore, depends on links that can be established between the fetus and its later achieving independent moral status.

One such link is viability. Viability, however, must be understood in terms of both biological and technological factors. It is only by virtue of both factors that a viable fetus can exist *ex utero*, and thus achieve independent moral status. When a fetus is viable, that is, when it is of sufficient maturity so that it can survive into the neonatal period and achieve independent moral status given the availability of the requisite technological support, and when it is presented to the clinician, the fetus is a patient.

Viability exists as a function of biomedical and technological capacities, which are different in different parts of the world. As a consequence, there is, at the present time, no worldwide, uniform gestational age to define viability. In the USA, we believe, viability presently occurs at about 24 weeks of gestational age.[13,14]

Before viability, the only link between the fetus and its later becoming a child is the pregnant woman's decision to continue her pregnancy to viability. The pre-viable fetus is therefore a patient solely as a function of the pregnant woman's autonomous decision to confer this moral status on her fetus(es).[5]

When the fetus is a patient, directive counselling for fetal benefit is ethically justified. In clinical practice, directive counselling for fetal benefit involves one or more of the following: recommending against termination of pregnancy; recommending against non-aggressive management; or recommending aggressive management. Aggressive obstetric management includes interventions such as fetal surveillance, tocolysis, caesarean delivery, or delivery in a tertiary care centre when indicated.

Non-aggressive obstetric management excludes such interventions. Directive counselling for fetal benefit, however, must take account of the presence and severity of fetal anomalies, extreme prematurity, and obligations to the pregnant woman.

Directive counselling for fetal benefit must occur in the context of balancing beneficence-based obligations to the fetus against beneficence-based and autonomy- based obligations to the pregnant woman. Such balancing must recognise that a pregnant woman is obligated only to take reasonable risks of medical interventions that are reliably expected to benefit the viable fetus or child later.

Obviously, any strategy for directive counselling for fetal benefit that takes account of obligations to the pregnant woman must be open to the possibility of conflict between the clinician's recommendation and a pregnant woman's autonomous decision to the contrary. Such conflict is best managed preventively through the informed consent process as an ongoing dialogue throughout a woman's pregnancy, augmented as necessary by negotiation and respectful persuasion.[5]

This approach to obstetric ethics is known as the professional responsibility model of obstetric ethics.[1] This model provides an antidote to the rights-based reductionism that characterises much of the literature on obstetric ethics. This oversimplification of obstetric ethics occurs when the only or overriding ethical consideration is rights of either the pregnant woman or the fetus.

Right-based reductionism is best illustrated by the abortion controversy. One extreme asserts that fetal rights always override the rights of the pregnant woman. This is fetal-rights reductionism. Termination of pregnancy at any gestational age or for any reason is impermissible, regardless of whether the pregnancy is voluntary or not or viable or not. The other extreme asserts that the pregnant woman's rights always override fetal rights. This is woman's-rights reductionism. Termination of pregnancy is therefore permissible at any gestational age and for any or many reasons.[15]

Such rights-talk is initially appealing because of the simple dichotomy at its heart: one either has rights or one does not and, if one does, others must respect one's rights. This simple dichotomy is simplistic and does not withstand close clinical ethical scrutiny. Unavoidable controversy surrounds the nature and limits of fetal and women's rights. Such rights are based on many factors, including cultural, political, and religious beliefs that do not lend themselves to compromise and are outside of the physician–patient relationship.

Consider the simplistic claim that a pregnant woman has unconditional right to control what happens to her body. The claim ignores a fundamental question: should this right be understood to come with limits or with no exceptions throughout the entire pregnancy? Professional integrity sets justified limits on the preferences of pregnant women.[5] For example, a distraught woman who is 34 weeks pregnant reports that her husband has deserted her and insists on termination of pregnancy immediately. The professional responsibility model requires her obstetrician not to implement her request because feticide is ruled out by the obstetrician's beneficence-based obligation to protect the life of this fetal patient. The obstetrician should therefore recommend against feticide and explain that no conscientious obstetrician should implement her request. There are many such circumstances in which a pregnant woman's request for a termination of pregnancy should not be implemented unquestioningly.

Consider the simplistic claim that the fetus has an unconditional right to life or to complete gestation. The presence of a fetal anomaly incompatible with life belies such claims as lacking scientific and clinical foundation, because medicine has no capacity to correct such anomalies. Such claims lack an authoritative foundation in either religion or philosophy.[5] There is no single authoritative perspective from which the incompatible differences of these diverse views on fetal rights can be resolved.[5] To insist on an unconditional right to life or to complete gestation, therefore, has no place in professional obstetric ethics.

The woman's-rights reductionism approach can apply to intrapartum management. This approach asserts an unconditional right of the pregnant woman to control her body in all aspects of the management of pregnancy, including the performance of caesarean delivery: ' … the moral and legal primacy of the competent, informed pregnant woman in decision making is overwhelming.'[12] Another expression of this approach at first seems to be non-reductionist. Its authors acknowledge patient safety as a 'first-order issue'[16] and support what they call 'restrictive guidelines' based on protecting the life and health of pregnant women.[16] This more nuanced approach, however, is abandoned in favour of the woman's-rights reductionism model when it is asserted: 'Crucially, even when restrictive guidelines are warranted the rights of pregnant women to bodily integrity must be maintained.'[17] Some express this approach explicitly (e.g. that 'women have fully endowed rights that do not diminish with conception, nor progressively degrade as pregnancy advances to viability and birth.'[17] The woman's-rights reductionism approach has been used to claim the right of pregnant women to have a clinically non-indicated caesarean delivery.[18,19] Another example is the assertion of the pregnant woman's autonomy as an 'unrestricted negative right' (i.e. an unconditional right to non-interference with refusal of caesarean delivery): 'autonomy is an inter-relational right — ultimately there is no circumstance in which someone should be brought to an operating room against their will.'[20]

Rights-based reductionism in obstetric ethics is a fallacy, because it unacceptably distorts the professional nature of the relationship of an obstetrician to his or her patients. The professional obligations of the obstetrician originate in the ethical concept of medicine as a profession. This concept was introduced into the history of medicine by Drs. John Gregory (1724–1773) of Scotland and Thomas

Percival (1740–1804) of England. This concept requires the clinician to make three commitments: (1) becoming and remaining scientifically and clinically competent; (2) protecting and promoting the health-related and other interests of the patient as the physician's primary concern and motivation; and (3) preserving and strengthening medicine as what Percival called a 'public trust,' a social institution that exists primarily for the benefit of society not its members (in contrast to the concept of medicine as a merchant guild).[21] In the professional responsibility model obstetricians have beneficence-based an autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient.[5,22] The evidence-based clinical judgment about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms. The pregnant woman's autonomy is empowered by offering or recommending medically reasonable alternatives, as explained above.

The contrast with rights-based reductionism is stark. Fetal-rights reductionism, despite its simplicity and powerful initial appeal, is fallacious because it leads obstetric ethics into conceptual and such clinical failure. This model, therefore, should be abandoned. Woman's-rights reductionism is a failure as well and requires the obstetrician to implement birth plans that unconditionally exclude caesarean delivery or the unconditional right to planned home birth. This model eliminates the obstetrician's beneficence-based obligations to both the pregnant and fetal patients, and therefore reduces the obstetrician to a mere automaton. This model also has absurd implications (e.g. ruling out, as potential paternalism, strongly and repeatedly recommending that pregnant women who abuse tobacco and alcohol seek help and be supported in doing so). Respect for the pregnant woman's rights allows simply accepting such clinically choices by patients because they have made clinically unwise, but autonomous, choices. This is abandonment from the perspective of professional responsibility for patients. The woman's-rights reductionism model, despite its simplicity and powerful appeal for many, is fallacious because it leads obstetric ethics to conceptual and clinical failure. This model, therefore, also should be abandoned.

Clinical decision making about caesarean delivery

Patient-choice caesarean delivery

Patient-choice caesarean delivery (also known as maternal-choice caesarean delivery) has become controversial worldwide. In the USA, for example, the American College of Obstetrics and Gynecologists stated in a committee opinion in 2003 that, although the right of patients to refuse unwanted surgery is well known, less clear is the right of patients to have a surgical procedure when scientific evidence supporting it is incomplete, of poor quality, or totally lacking.[23] The committee concluded that the evidence to support the benefit of caesarean delivery is still incomplete, and extensive morbidity and mortality data are still not available to compare caesarean delivery with planned vaginal delivery. In addition, the United States National Institutes of Health convened a 2006 conference on this issue that concluded that there is insufficient evidence to evaluate fully the benefits and risks of primary caesarean delivery compared with vaginal delivery, and that more research is needed.[24] The NIH conference concluded that: 'The magnitude of caesarean delivery on maternal request is difficult to quantify. There is insufficient evidence to evaluate fully the benefits and risks of caesarean delivery on maternal request compared with planned vaginal delivery. Any decision to perform a caesarean delivery on maternal request should be carefully individualised and consistent with ethical principles.'[24]

In the UK, the National Institute for Health and Clinical Excellence (NICE) 2011 report[25] notes the increasing rates of 'maternal request for caesarean delivery,' and that a common reason for such requests is the pregnant woman's concern for the safety of her baby. The report also notes that obstetricians implement as much as half of the requests that they receive. The report provides guidance for obstetricians in response to maternal request for caesarean delivery: 'When a woman requests a caesarean section the first response should be to determine the reason for the request and the factors that are contributing to the request. This can then be followed by the provision of information that compares the risks and benefits of planned caesarean section and vaginal birth.'[25] The report makes the following recommendation: 'For women requesting a caesarean section, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal

birth is still not an acceptable option, offer a planned caesarean section.' Obstetricians unwilling to carry out caesarean delivery on maternal request 'should refer the woman to an obstetrician who will perform caesarean section.'

These influential statements and reports emphasise clinical benefits and risks and the communication of these in the informed consent process. Put another way, ethics is an essential, though often implicit, component of patient-choice caesarean delivery.[26] Here, we provide an explicitly ethically justified, practical guidance for obstetricians in response to patient-choice caesarean delivery based on the professional responsibility model of obstetric ethics.

Beneficence-based considerations

Caesarean delivery has become safer over time with the advancement in surgical techniques, anesthetic options, antimicrobial availability and blood-banking techniques. There are several potential maternal and fetal benefits of undergoing caesarean delivery compared with planned vaginal delivery. Comprehensive beneficence-based clinical judgment requires that the potential benefits of caesarean delivery be balanced against the benefits of planned vaginal delivery and the risks of caesarean delivery.

Currently, beneficence-based clinical judgment favours vaginal delivery.[27] Hence, counselling should be directive, compared with non-directive counselling, clearly recommending vaginal delivery where appropriate.[9] We, therefore, disagree with the NICE report's purely non-directive approach.[25]

Autonomy-based considerations

Respect for autonomy remains the rationale for promoting caesarean delivery. Respect for autonomy surely is a core ethical obligation. Only in maternal-rights-based reductionism does it create an absolute obligation (i.e. an obligation that admits of no exceptions). The professional responsibility model rejects this account, as explained above. Instead, autonomy-based obligations must be balanced against beneficence-based obligations to the pregnant and fetal patients. A clinician should not conclude that every request for a caesarean delivery should be implemented routinely.

Respect for autonomy is implemented by adherence to the informed consent process, as described above. The obstetrician is expected to exercise professional, beneficence-based clinical judgment when making clinical recommendations and present the medically reasonable alternatives as well as the alternative of non-intervention. The woman can then exercise her rights to accept or refuse intervention. The right for autonomy does not warrant routine offering of caesarean delivery, because doing so is not supported in beneficence-based clinical judgment.

Beneficence and autonomy considered together

When considering beneficence-based and autonomy-based obligations together, there is no ethical obligation to offer non-indicated caesarean delivery in an appropriate informed consent process. The effect of offering caesarean delivery to all patients does not promote their health-related interests. Obstetricians must rigorously adhere to the requirements of professional integrity, to prevent potential bias from influencing the clinician's discussion with the patient introduced by economic gain or other forms of self-interest. The NICE report's[25] indications for offering planned caesarean delivery do not include routine offering of caesarean delivery and therefore reflect this ethical position.

As stated earlier, it is important not to misinterpret the ethical principle of respect for patient autonomy. The clinician's medical expertise and authority should not be marshalled to convince a patient to choose caesarean delivery. Respect for patients' autonomy should not be used as an excuse to persuade more women to undergo caesarean delivery for reasons such as the clinician's convenience or desire to reduce professional liability. When patients request caesarean delivery, obstetricians, in their capacity as patients' advocates, must guide patients through the labyrinth of medical information toward a decision that respects both the patient's autonomy and the clinician's obligation to optimise maternal–fetal health. Provision of evidence-based information about the clinical benefits and risks of

non-indicated caesarean delivery, as called for in the NICE report,[25] meets this important autonomy-enhancing goal.

Responding to requests for caesarean delivery

Although the risk–benefit paradigm for caesarean delivery has evolved, vaginal delivery as a rule is still considered the safest mode of delivery, as the short- and long-term safety issues of caesarean delivery need further study before the professional standard is changed. Clinicians, however, do need to respond to requests for counselling about caesarean delivery. In fact, current evidence supports a clinician's decision to accede to a patient's request for such a delivery, but only after a thorough and informed consent process and vigorous attempts to persuade her to accept vaginal delivery.[2,28]

When counselling the patient, a strategy of shared decision-making will help to prevent dehumanising paternalism. A particular plan of action should not be mandated unless it can be justified by its benefits or even potential benefits on the basis of the best available evidence. Obstetricians must engage in conversation with the patient, in order not to neglect an important implication of patient autonomy: when there is real uncertainty about clinical benefits and risks of reasonable alternatives, competent adults should be given the opportunity to make their own decisions about how to manage such uncertainty.

In cases with the highest levels of evidence, such as placenta previa, caesarean delivery can be recommended with confidence. When levels of uncertainty are high, however, as in using mid-forceps or allowing a prolonged second stage of labor, the pregnant woman's preferences should be given prominence in the decision-making process. The obstetrician is obligated to take the time to provide her with information and advice, elicit her values, explore her concerns and emotional and social needs, and work with her to make a thoughtful decision. Although the obstetrician is obligated to offer this guidance and outline available clinically reasonable choices, the decision should ultimately come from the patient who will live with the consequences of her choice. And, if the patient persists in her request for caesarean delivery after this counselling, it meets the test of being well supported in autonomy-based clinical judgment. Spontaneous and uninformed requests, however, do not meet this ethical standard. We emphasise that the NICE recommendation to offer planned caesarean delivery does not apply in such circumstances, but only when the women's request is well informed and carefully considered.

Obstetricians are not obligated to carry out caesarean deliveries if they morally disagree, as the NICE report emphasises.[25] In this case, the clinician should arrange for a second opinion or arrange for the woman's care to be transferred to a clinician willing to respect her request.

Patient-choice caesarean delivery is an ethically controversial topic in obstetrics. This controversy has renewed interest in the right of pregnant women to choose the mode of delivery regardless of an accepted medical indication. Respect for autonomy is a core ethical obligation of the clinician, but it is not an absolute obligation. It must be balanced against beneficence-based obligations to the pregnant woman and fetus. Autonomy-based, beneficence-based, and justice-based considerations do not support routinely recommending or offering caesarean delivery. Obstetricians should adhere to the professional responsibility model of obstetric ethics.[1]

The challenge for the medical profession is to study and define groups of women at high risk who may benefit from planned caesarean delivery. Once identified, such women can then be offered caesarean delivery consistent with beneficence-based clinical judgment about what is medically reasonable. Simplistic, 'all-or-none' thinking on the part of obstetrician is clinically and ethically not justified, and a more nuanced approach is more appropriate for managing patients with regard to caesarean delivery.[28] In addition, the role of patient-choice caesarean delivery during the intrapartum period needs further exploration. We have previously shown that one in eight intrapartum caesarean deliveries at our institution had an element of patient or physician choice.[28] Although the current evidence supports a clinician's decision to accede to an informed patient's request for such a delivery, it does not follow that clinicians should routinely offer caesarean delivery to all patients.

Trial of labor after caesarean delivery

In 2010, both a US National Institutes of Health Consensus Panel[29] and the American College of Obstetricians and Gynecologists [30] issued updated statements on vaginal birth after caesarean delivery.

In the UK, the NICE report[25] provides a thorough review of the clinical benefits and risks to both pregnant and fetal patients, and calls for an evidence-based approach to the informed consent process.[25] Both agree that there should be a thorough, evidence-based informed consent process in which pregnant women who have had a previous caesarean delivery be counselled concerning vaginal birth after caesarean delivery. Here, we provide an ethically justified, practical approach to the informed consent process for trial of labour after caesarean delivery (TOLAC).

Offering and recommending trial of labour after caesarean delivery in the informed consent process

When both repeat caesarean and TOLAC are supported in evidence-based, beneficence-based clinical judgment, both should be offered in clinical settings where TOLAC can be carried out safely. The NIH Consensus Panel[29] and American College of Obstetrics and Gynecology[30] statements are in consensus that TOLAC after a previous single low transverse uterine incision is medically reasonable and should be offered when there has been one previous low transverse incision. In the professional responsibility model of obstetric ethics, the evidence supports the beneficence-based clinical judgment that the clinical risks of TOLAC to both pregnant and fetal patients are acceptable when there has been one previous low transverse incision. Planned repeat caesarean delivery also has acceptable risks to both pregnant and fetal patients. Both, therefore, should be offered in the informed consent process to the pregnant woman with one previous low transverse incision, because both are medically reasonable in this clinical circumstance. Counselling about these alternatives should be non-directive.

Sometimes planned repeat caesarean delivery is substantively supported and TOLAC is not supported in beneficence-based clinical judgment. When the pregnant woman has had a previous classical incision on her uterus, caesarean delivery is clearly preferable to TOLAC. Caesarean delivery prevents the fetal and maternal risk of a ruptured classical incision in the uterus, and vaginal delivery would result in a substantial increase in morbidity and mortality for the pregnant and fetal patient, and would therefore violate non-maleficence. It follows that, in beneficence-based clinical judgment, only caesarean delivery should be offered and recommended to pregnant women with a previous classical incision. It also follows that the obstetrician has a beneficence-based obligation in the informed consent process to recommend against TOLAC in such cases. Counselling should be directive.

Trial of labour after caesarean delivery after two low transverse incisions is controversial. The American College of Obstetrics and Gynecology statement, on the basis of Level B evidence, states that: 'Women with two previous low transverse incisions may be considered candidates for TOLAC.'[30] The National Institutes of Health Consensus Panel was silent on this topic.[29] Level B evidence is inherently controversial in beneficence-based clinical judgment. As a result, obstetricians responsibly manage competing evidence-based, beneficence clinical judgment about the safety for pregnant and fetal patients of TOLAC when the pregnant woman has had two previous low transverse incisions. In the informed consent process, responsible management is achieved by offering TOLAC but only when the obstetrician explains the uncertainties of the current state of the evidence in this clinical circumstance.

The professional responsibility model of obstetric ethics provides the basis for an ethically justified, practical approach to offering and recommending TOLAC in the informed consent process with pregnant women with a previous caesarean delivery. For women with one previous low transverse incision, TOLAC and planned repeat caesarean delivery should be offered. It should be offered only in clinical settings properly equipped and staffed to do so. Obstetricians should recommend against TOLAC when the pregnant woman has had a previous classical incision. After two previous low transverse incisions, TOLAC may be offered provided that the informed consent process presents the uncertainties of the evidence.

Conclusion

The professional responsibility model of obstetric ethics is based on the pioneering medical ethics of two major figures in its history, Dr John Gregory and Dr Thomas Percival. The ethical concept of medicine as a profession introduced into the history of medical ethics in the 18th century by these two remarkable clinician-ethicists has proven to be both durable and clinically applicable today. The professional responsibility model of obstetric ethics protects clinical judgment and practice from the

simplistic, clinically inadequate alternatives of maternal rights-based reductionism and fetal rights-based reductionism. The professional responsibility model does so by requiring in all cases deliberative consideration of beneficence-based and autonomy-based obligations to the pregnant woman and beneficence-based obligations to the fetal patient. The informed consent process should be used as a preventive ethics tool to empower pregnant women to make informed and deliberative decisions. The informed consent process, as explained in this chapter, should guide obstetricians in their response to requests for caesarean delivery and in TOLAC.

Practice points

- The professional responsibility model of obstetric ethics requires the clinician to consider beneficence-based and autonomy-based obligations to the pregnant woman and beneficence-based obligation to the fetal patient in decision making about caesarean delivery.
- The obstetrician should use the informed consent process to empower the pregnant woman to make deliberative decisions about caesarean delivery.
- Directive counselling for the clinical benefit of the fetal or pregnant patient is ethically justified in the informed consent process about caesarean delivery.
- The obstetrician has no professional obligation to offer caesarean delivery routinely in the absence of accepted indications.
- The professional responsibility model of obstetric ethics requires the obstetrician to respond to a request for planned caesarean delivery by informing the pregnant woman that vaginal delivery is the safest mode of delivery, eliciting and addressing the patient's concerns, and recommending against caesarean delivery.
- The professional responsibility model of obstetric ethics supports offering both TOLAC and planned caesarean delivery for a woman with one previous low transverse incision, in settings properly equipped and staffed to provide TOLAC.
- The professional responsibility model of obstetric ethics requires the obstetrician to recommend against TOLAC to a woman who has had a previous classical incision.
- The professional responsibility model of obstetric ethics supports explaining the uncertainties of TOLAC to the woman who has had two previous low transverse incisions and offering both TOLAC and planned caesarean delivery.

Research agenda

- Outcome research comparing TOLAC with planned caesarean delivery for women with two previous low transverse incisions.

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