Patient choice cesarean delivery: ethical issues

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Current Opinion in Obstetrics and Gynecology
2008, 20:116–119

Purpose of review
We have recently identified three salient questions within the patient choice cesarean delivery controversy. First, is performing cesarean delivery on maternal request consistent with good professional medial practice? Second, how should physicians respond to or counsel patients who request patient choice cesarean delivery? Third, should patient choice cesarean delivery be routinely offered to all pregnant women?

Recent findings
In a well informed patient, performing a cesarean delivery on maternal request is medically and ethically acceptable. Physicians, as patient advocates and promoters of overall health and welfare of their patients, however, should, in the absence of an accepted medical indication, recommend against medically unindicated cesarean delivery. While we believe that current evidence supports a physician's decision to accede to an informed patient's request for such a delivery, it does not follow that obstetricians should routinely offer elective cesareans to all patients.

Summary
When a patient makes a request for an elective cesarean delivery, obstetricians, in their capacity as patient advocate, must help guide their patient through the labyrinth of detailed medical information toward a decision that respects both the patient's autonomy and the physician's obligation to optimize the health of both the mother and the newborn.

Keywords
autonomy, cesarean delivery on maternal request, patient choice cesarean

Curr Opin Obstet Gynecol 20:116–119
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1040-872X

Introduction

The clinical controversy of cesarean delivery on maternal request has become a hot topic in the field of obstetrics over the past few years. Cesarean delivery on maternal request is defined as a primary cesarean delivery done on the request of the mother in the absence of any medical or obstetric indication [1,2•]. The American College of Obstetrics and Gynecology estimates that 2.5% of all births in the United States are cesarean delivery on maternal request, although that number may be overestimating the actual incidence [3]. Despite the increase in demand for cesarean delivery, there are few scientific data that directly compare the mode of delivery in regards to maternal and neonatal outcomes. At the National Institutes of Health State-of-the-Science Conference on cesarean delivery on maternal request in 2006, a panel concluded that the magnitude and impact of cesarean delivery on maternal request is 'difficult to quantify. There is insufficient evidence to evaluate fully the benefits and risks of cesarean delivery on maternal request as compared to planned vaginal delivery and more research is needed. Until quality evidence becomes available, any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical principles' [1,2•].

Important clinical and ethical issues

We have recently identified three salient questions within the patient choice cesarean delivery controversy, which we will review in this article [4•]. How should physicians respond to or counsel patients who request patient choice cesarean delivery? Is performing cesarean delivery on maternal request consistent with good professional medial practice? Should patient choice cesarean delivery be routinely offered to all pregnant women? While it may be relatively simple to arrive at reasonable answers to these questions, it is important to consider the fact that medicine is an evolving science and as evidence accumulates regarding the short and long-term implications of medically unindicated cesarean delivery, the answers to these questions may change. For example, research has indicated that mode of delivery (i.e., cesarean versus vaginal delivery) in certain situations, such as breech fetuses, can improve neonatal outcome [5]. In low-risk patients, without a specific medical indication for cesarean delivery, however, the impact of the mode of

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delivery on neonatal outcomes has not been as clear. In fact, data from Latin America have shown that cesarean delivery may actually worsen neonatal outcomes [6].

Systematic reviews acknowledge the significant limitations of evidence [6]. There are no randomized controlled trials and few prospective long-term studies evaluating the outcomes of elective cesarean delivery compared with vaginal birth. In addition, much of the current data are flawed by problems such as inconsistent terminology, retrospective data that assume a cesarean was on maternal request if no medical reason was indicated on the birth certificate, and few data on planned deliveries as opposed to actual delivery mode. In lieu of such data, proxy studies, such as the Term Breech Trial, have been cited as evidence of the safety of patient choice cesarean delivery [5].

The absence of a reliable evidence base for clinical benefit or harm should not be interpreted to support an assumption of clinical benefit from patient choice cesarean delivery. Making this assumption represents a step backwards and not forwards for evidence-based medicine. As such, it is important to consider how physicians should counsel patients who make a request for elective cesarean delivery. While the risk–benefit paradigm for cesarean delivery has evolved, with advances such as safer surgical and anesthetic techniques, more effective antibiotics, and better availability of blood products, vaginal delivery, overall, is still considered the safer mode of delivery in the uncomplicated low-risk patient. Physicians, as patient advocates and promoters of overall health and welfare of their patients, should, in the absence of an accepted medical indication, recommend against cesarean delivery in response to requests for it.

It is important to emphasize, however, that in a well informed patient, who has been appropriately counseled about known risks, benefits and alternatives, performing a cesarean delivery on maternal request is medically and ethically acceptable. In fact, a major emphasis in medical ethics over the past four decades is that physicians should make every effort to ensure that the rights of all patients are respected. Notably, obstetrical authorities [7] have increasingly begun to support a physician's decision to implement an informed pregnant patient's request for cesarean delivery in the absence of an accepted medical indication. In its *Fundamental Elements of the Patient–Physician Relationship*, the American Medical Association (AMA) [8] reflects this consensus view in its enumeration of patients' rights. This is ethically straightforward: whereas in the past this was considered controversial [9], there is now a consensus [7,10–12] that in a well informed patient, who received appropriate informed consent, performing a patient choice cesarean delivery is consistent with good professional practice.

The AMA's 'Fundamental Elements' concisely states [8], 'The patient has the right to make decisions regarding the healthcare that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.' The physician's role in this process is to identify medically reasonable alternatives. The physician exercises beneficence-based, expert clinical judgment as the first step of the informed consent process, to identify from among technically possible alternatives those alternatives that are reliably expected to result in a greater balance of clinical goods over clinical harms for the patient. In the subsequent steps of the informed consent process, the patient reaches a judgment about whether to accept one of these medically reasonable alternatives or to reject them [13–15].

In the technical language of ethics, the patient's role in the informed consent process involves the exercise of a negative right: the right not to be interfered with in one's decision making and in one's own behavior [13–15]. Since the exercise of negative rights rarely adversely affects anyone other than the individual exercising negative rights, there are very few ethically justified limits on negative rights. This is why adult, competent patients have the right to refuse medical care, including life-saving intervention, except in emergencies in which there is no time for the informed consent process [14].

Positive rights are different: they are claims by individuals of access to the resources of others made in order to advance the interests of the individual exercising positive rights [15]. By the very nature of positive rights, their exercise always has implications for the interests and rights of others, especially those whose resources of judgment, skill, time, energy, or money are required. Positive rights thus always come with ethically justified limitations; the task is to identify reliably what those limitations should be.

In forming beneficence-based clinical judgment about medical reasonableness, obstetricians should not think binomially [16••]. Instead, clinical judgment should recognize a continuum of reasonableness. At one end of this continuum is a clearly indicated cesarean delivery, which should not just be presented but recommended. At the other end of the continuum, there is a clearly non-indicated cesarean, which should not be presented and when requested should be recommended against.

In response to a request by a patient for elective cesarean delivery in the absence of an accepted clinical indication, physicians should not abandon their professional role and its core responsibilities. In particular, practice standards should not change in the absence of a reliable evidence base for change. The patient's positive rights can be justifiably limited by clinical judgment. Physicians

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should directively, not nondirectively, counsel the patient using available data. In addition, it is critical to assure that the patient is not subject to undue influence by her obstetrician or other factors [17]. In fact, even in countries such as Brazil where cesarean rates in private hospitals approach 80–90%, it has been shown [18] that this is not necessarily a reflection of maternal choice, and that a woman's role in the rise in cesarean rates is overemphasized, possibly with physician preference a more realistic explanation.

While we believe that current evidence supports a physician's decision to accede to an informed patient's request for such a delivery, it does not follow that obstetricians should routinely offer elective cesareans to all patients [18]. Others, however, disagree [11,19,20]. Hankins *et al.* [20] analyzed previously published data to assess the theoretical impact of elective cesarean delivery at 39 weeks on the risk of shoulder dystocia, fetal trauma, neonatal encephalopathy, and intrauterine fetal demise. They concluded, 'cesarean delivery performed on women at 39 weeks would substantially reduce the occurrence of [all these factors and] it is reasonable to inform pregnant women of the risk' [20]. This analysis was theoretical and did not assess neonatal and maternal risks associated with cesarean delivery, however, such as neonatal respiratory difficulty and the reproductive burden during subsequent pregnancies. In view of this, it would be inappropriate to view such speculation as determinative. Thus, physicians are under no obligation to initiate discussions about elective cesarean delivery, especially as the impact, both to the individual as well as globally to the general public health, has not been studied adequately, with potentially vast and clinically significant consequences. It is premature and therefore inappropriate to consider seriously any change in this current professional standard.

We believe that the challenge for the medical profession is to define specific high-risk groups who may benefit from planned cesarean. Perhaps these subgroups of women may benefit from cesarean and should be offered elective cesarean delivery. Recently, we have shown that categorical black-and-white thinking of the obstetrical profession is clinically and ethically flawed and a more nuanced, individualized approach is the most appropriate way to manage patients regarding cesarean delivery on maternal request [16••].

Additionally, physicians need to rigorously adhere to the requirements of professional integrity including the potential bias in the obstetrician's discussion with the patient introduced by economic or other forms of self-interest. We caution against a misinterpretation of patients' autonomy. Doctors' medical expertise and authority should not be marshaled to convince a woman to choose cesarean delivery. Respect for patients' autonomy should not be used as an excuse to persuade more women to undergo cesarean delivery for reasons such as a doctor's convenience or potentially lowering professional liability.

Conclusion

When a patient makes a request for an elective cesarean delivery, obstetricians, in their capacity as patient advocate, must help guide their patient through the labyrinth of detailed medical information toward a decision that respects both the patient's autonomy and the physician's obligation to optimize the health of both the mother and the newborn.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:
- • of special interest
- •• of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 193).

1 National Institutes of Health. NIH State-of-the-Science Conference statement on cesarean delivery on maternal request. NIH Consensus and State-of-the-Science Statements. Bethesda (MD): NIH; 2006. http://consensus.nih.gov/2006/CesareanStatement_Final053106.pdf. [Accessed 3 November 2007]

2 • National Institutes of Health. National Institutes of Health state-of-the-science conference statement: Cesarean delivery on maternal request March 27–29, 2006. Obstet Gynecol 2006; 107: 1386–1397.

This article documents the NIH consensus statement regarding currently available data on cesarean delivery on maternal request. The panel concluded that there is insufficient evidence to evaluate fully the benefits and risks of cesarean delivery on maternal request compared with planned vaginal delivery and that any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with clinical principles.

3 ACOG Committee Opinion. Cesarean delivery on maternal request. Obstet Gynecol 2007; 386:1209–1212.

4 • Kalish RB, McCullough LB, Chervenak FA. Is nondirective counseling for patient choice cesarean delivery ethically justified? J Perinat Med 2007; 35:478–480.

This paper addresses how physicians should counsel women regarding patient choice cesarean delivery. The importance of directive counseling in response to maternal requests for cesarean delivery is emphasized.

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14 Faden RR, Beauchamp TL. A history and theory of informed consent. New York: Oxford University Press; 1986.

15 McCullough LB, Chervenak FA. Ethics in obstetrics and gynecology. New York: Oxford University Press; 1994.

16 Kalish RB, McCullough LB, Chervenak FA. Decision-making regarding
•• cesarean delivery. Lancet 2006; 367:883–885.
This article addresses the question of when there is clinical uncertainty about the benefits and risks of cesarean delivery, how should obstetricians and patients form their judgments. The authors propose a 'rethinking' regarding cesarean delivery that challenges the idea that all indications for cesarean delivery can be reliably categorized as medically indicated or not.

17 Kalish RB, McCullough L, Gupta M, *et al.* Intrapartum elective cesarean delivery: a previously unrecognized clinical entity. Obstet Gynecol 2004; 103:1137–1141.

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20 Hankins GDV, Clark SM, Munn MB. Cesarean section on request at 39 weeks: Impact on shoulder dystocia, fetal trauma, neonatal encephalopathy, and intrauterine fetal demise. Semin Perinatol 2006; 30:276–287.

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