Caesarean Section on Maternal Request: How Clear Medical Evidence Fails to Produce Ethical Consensus

Daniel Robert Reilly, BSc, MD, MHSc (Bioethics), FRCSC

Department of Obstetrics and Gynecology, McMaster University, Hamilton ON

Abstract

National and international bodies have used evidence-based medicine to apply the principles of beneficence and nonmaleficence to guide a physician's response to a request for Caesarean section without medical indication. Although they are nearly unanimous in their condemnation of saying "yes," a physician who weighs risks unequally, who weighs risks in a patient-centred manner, or who values autonomy may find saying "no" to be an unacceptable choice.

Résumé

Des organismes nationaux et internationaux ont fait appel à la médecine factuelle en vue de mettre en œuvre les principes de bienfaisance et de non-malfaisance pour guider la réaction d'un médecin à une demande de césarienne sans indication médicale. Bien que les médecins soient pratiquement unanimes à décrier le fait d'acquiescer à une telle demande, un médecin qui évalue les risques de façon inégale ou à partir du point de vue de la patiente, ou qui accorde préséance à l'autonomie de celle-ci, peut en venir à considérer le refus de cette demande comme étant un choix inacceptable.

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THE CLINICAL SETTING

The patient is a 39-year-old primigravid physician with low obstetrical risk whose due date is confirmed by first trimester ultrasound. She wishes to have a Caesarean section on maternal request. A thick binder of literature has informed her request. From a medical perspective she acknowledges CSMR may increase her risk of the following: wound complications,[1,2] infection,[1–3] anaesthetic complications,[2,3] cardiac arrest,[2] venous thromboembolism,[2] hysterectomy,[2] longer hospital stay,[1–3] difficulty breastfeeding,[3] death,[4–6] future placenta previa and accreta,[7–9] stillbirth in future pregnancy,[10] and surgical complications during future Caesarean sections.[9] She feels these risks are outweighed by the benefits of averting a possible emergency CS, operative delivery, and perineal tears and by the medical benefit of reducing the risk of the following: stillbirth in this pregnancy,[3,11] blood transfusion,[2,3] fetal injury,[11] neonatal encephalopathy,[11] brachial plexus injury in the newborn,[3,11] premenopausal stress incontinence,[12–17] and fecal incontinence.[18] Requesting that the CSMR be booked in her 39th week, the patient feels the only risk for her child is transient respiratory morbidity[3,19,20] with no long-term consequence. It is clear she also has personal reasons for her request that she will not discuss, except to say she is not being coerced. As an informed patient, she expects her doctor to respect her autonomy and to provide the CSMR.

Key Words: Elective Caesarean section, patient autonomy, ethics, evidence-based medicine

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PROFESSIONAL GUIDELINES

The International Federation of Gynecology and Obstetrics has declared that Caesarean section for non-medical reasons is "ethically not justified."[21] The Society of Obstetricians and Gynaecologists of Canada and organizations representing other Canadian maternity health care providers have published a joint policy statement on normal childbirth that states "Caesarean section should be reserved for pregnancies in which there is a threat to the health of the mother and/or baby."[22] The American College of Obstetricians and Gynecologists states that CSMR should not be performed before the 39th week of pregnancy and that it is not recommended for women "desiring several children."[23] These bodies have applied the ethical principles of beneficence, nonmaleficence, and justice to arrive at their conclusions. But when these principles are applied to this patient's request, three difficulties arise. The fiduciary duty of care to patients makes bedside application of justice problematic once coercion is ruled out. The analysis of beneficence and nonmaleficence used by these bodies assumes all harms are

equal. Only the ACOG guidelines directly address patient autonomy.

When justice is set aside, patient autonomy is considered, and a weighing of risks is permitted, three options emerge. The physician can agree with the patient's analysis of beneficence and nonmaleficence and provide the CSMR. The physician may disagree with, or remain undecided about, the patient's analysis of beneficence and nonmaleficence and provide the CS on the basis of respect for patient autonomy. Or, to be consistent with the guidelines, the physician may disagree with the patient's analysis of beneficence and nonmaleficence, override patient autonomy, and refuse to provide the CSMR.

JUSTICE AT THE BEDSIDE

The principle of justice deals with matters such as fair allocation of, and access to, health care resources.[24] When serving on hospital committees and other administrative bodies, physicians consider resource allocation and the social implications of health care policy. These bodies may consider concerns about increased costs; they may also consider arguments that advocating CSMR as a safe procedure will increase its use, and that by advocating CSMR physicians are seen as not understanding or supporting "natural birth." An administrative body may decide that consideration of justice requires that CSMR not be permitted in the area under their jurisdiction. Physicians within that jurisdiction must then decide whether they will respect the policy, challenge it, defy it and face possible sanction, or leave the jurisdiction.

One aspect of justice that is very important at the bedside is fair opportunity. Fair opportunity prompts physicians to ask if coercion may be occurring. Coercion may be direct if the patient's choices are limited by threat of physical, emotional, or financial harm, but physicians must also be sensitive to indirect coercion, also known as structural violence.[25] A patient is experiencing structural violence if her choices are constrained or motivated by extrinsic factors such as poverty or discrimination based on gender, race, or sexual orientation. Both direct and indirect coercion make informed consent or refusal impossible.

The patient under consideration states that she is making her decision freely and is not being coerced. At the bedside, her physician's primary obligation is to ensure that her care is the best possible within the constraints of the health care system. One requirement of fiduciary duty to the patient is to favour her interests over the interests of others.[26] If CSMR is prohibited, or if the physician feels that the justice implications of the procedure are so grave that fiduciary duty must be set aside, the patient should be informed of this so that she may seek alternative care. Otherwise, the principle of justice does not apply to the physician's decision whether or not to provide CSMR. Therefore autonomy, beneficence, and nonmaleficence are left to guide the decision.

ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
CS	Caesarean section
CSMR	Caesarean section on maternal request
ECS	emergency Caesarean section
FIGO	International Federation of Gynecology and Obstetrics

OPTION ONE

The principle of beneficence dictates that physicians contribute positively to their patients' welfare (that they "do good" for patients).[24] Nonmaleficence requires that physicians do no harm.[24] When a course of action must be chosen, beneficence leads to pursuit of the option with the greatest chance of benefit, while nonmaleficence leads to pursuit of the option with the least risk of harm. Numerical estimates of chance for benefit and risk of harm rely on epidemiological studies.

Applying epidemiological studies to a specific patient presents two difficulties. First, when all adverse outcomes are aggregated as morbidity, all medical complications take on equal significance. For example, CSMR increases the risk of hysterectomy,[2] while labour increases the risk of pelvic floor trauma.[12–18] Studies that consider total adverse events find that planned labour is associated with fewer adverse events and thus less risk.[1,2,6] The patient under consideration has judged that the possibility of pelvic floor trauma, blood transfusion, and newborn complications are far more significant to her than other events, and thus she is willing to risk the adverse events associated with CSMR to avoid them. A physician who agrees with this weighing of risks would provide any comparable woman with CSMR. A patient-centred doctor may assign significance to risks on the basis of the patient's perspective and decide that balancing beneficence and nonmaleficence favours CSMR for this patient, but that it may not for other patients.

The second difficulty in applying the results of studies to particular patients arises from the fact that each patient faces a different risk of emergency CS. This is the mode of delivery with the highest maternal and newborn risk.[3,5,6,27] The risk of morbidity associated with CSMR is fairly clear. The risk of planned labour is a composite risk, consisting of the risk associated with vaginal birth multiplied by the probability of vaginal birth plus the risk associated with ECS multiplied by the probability of ECS. For a woman at average risk of ECS, planned labour appears to be safer than

CSMR, but when the risk of ECS is higher than average, CSMR becomes the safer choice at a certain point. A particular woman's risk of ECS is unknown. Despite this uncertainty, clinical judgement may dictate that the risk of ECS is high enough to make CSMR the safer choice for a particular woman.

On the basis of the physician's and the patient's assignment of differing weights to each risk and benefit associated with CSMR and planned labour, or on the basis of either's assessment of risk of ECS, an obstetrician may decide that the balance of beneficence and nonmaleficence favours CSMR. If the patient wishes to make the safer choice, and the physician is not morally compromised by providing it, then it must be provided if the system permits.

OPTION TWO

If a physician cannot determine which mode of delivery is safer, then beneficence and nonmaleficence do not apply and only autonomy remains. The patient's wishes are honoured if the system and the physician's morality permit. The situation is more difficult if a physician believes that CSMR is the choice carrying greater risk of harm. Is the risk of harm sufficient to deny autonomy? The physician will either commit an act that exposes a patient to harm or harm a patient by denying her the right to self-determination and control of her person. Which is the lesser wrong is a judgement that each physician must make, and the conclusion may vary depending on patient circumstances.

OPTION THREE

A physician may decide that the imperative to do no harm requires that CSMR not be performed. This decision is consistent with the FIGO and SOGC statements and thus may be standard of care. The physician may inform the patient that performing CSMR is below professional standards and is therefore not an option.

It could also be argued that the decision to rank the balance of beneficence and nonmaleficence above patient autonomy is a moral judgement and not a standard of care issue. If a physician is refusing to provide a treatment because of moral objections, that must be clearly and promptly communicated.[28] The physician must still provide information about all options for the patient and cannot withhold information because of a moral objection to a particular option.

It is unclear if a physician refusing to perform CSMR is obligated to refer the patient elsewhere for CSMR. The professional bodies (FIGO, SOGC, and ACOG) and provincial licensing bodies are silent on this issue. The Canadian Medical Association has stated that referral of a patient for termination of pregnancy is not required if a physician finds the procedure morally unacceptable but that access to termination must not be obstructed.[29] The requirement not to obstruct access is grounded in respect for patient autonomy (which applies to CSMR) and ensuring patients' safe access to standard of care (which does not apply to CSMR, because it is not the standard of care).

CONCLUSION

In the clinical scenario described, a patient who happens to be a physician requests that her obstetrician provide a CSMR. Since coercion is not an issue, the principle of justice does not provide guidance for this bedside decision. National and international professional bodies have applied the principles of beneficence and nonmaleficence to this consideration, and they are nearly unanimous in their condemnation of CSMR. However, a physician who weighs risks unequally, who weighs risks in a patient-centred manner, or who values autonomy may disagree with this condemnation.

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