

Maternal request caesarean section: maternal vs medical autonomy

Maternal request caesarean section often pitches patient autonomy against medical autonomy. Where possible patient autonomy should form the cornerstone of treatment, without abdicating the physician's duty of care to the patient by agreeing to procedures which may cause more harm than good to the patient even if the patient so wishes.

Maternal requests for caesarean delivery in the absence of a medical indication, also called patient choice caesarean section or caesarean section on demand, present obstetricians with a moral and ethical dilemma (Devendra and Arulkumaran, 2003; Chigbu et al, 2007). There is some confusion as to how to proceed in such situations, especially in the face of conflicting advice. International Federation of Obstetrics and Gynaecology guidance (Schenker and Cain, 1999) states that performing a maternal request caesarean section is unethical. However, there is concern that refusal of such requests amounts to paternalism, erosion of the patient's autonomy and preventing the patient from deciding on the type of delivery she wants (Minkoff and Chervenak, 2003). The American College of Obstetricians and Gynaecologists (2003) and others (Hannah, 2004) advise that following a full discussion of the risks and benefits the overall health of the woman is promoted by an elective caesarean section if she still wishes to be so delivered.

Others believe obstetricians are right to refuse caesarean delivery requests if they believe the risk ratio is unfavourable to the patient even if the patient accepts this risk (Klien, 2004). Most physicians agree that, as natural phenomena, pregnancy and labour should be allowed to occur without intervention unless this is required. Another view is that vaginal delivery produces a poorer outcome than caesarean delivery so all deliveries should be by caesarean section. Clearly this is not the situation.

Caesarean section is relatively safer than it was 50 years ago, but it still carries higher morbidity and mortality than vaginal delivery (Hall and Bewley, 1999), in the index pregnancy as well as in subsequent pregnancies (Mozurkewich and Hutton, 2000). Maternal request for caesarean delivery in the authors' experience is often a front for other concerns or aspirations about the pregnancy and/or delivery. It is important that such requests are investigated. More often than not medical and non-medical underlying issues will come to the fore.

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The number of maternal requests for caesarean delivery is increasing. Where these requests have been made, not uncommonly there is a lack of appreciation of what to expect during the pregnancy and labour. Increasingly prenatal classes are not being held because of the shortage of midwives. Time constraints mean that the antenatal clinic is not an appropriate place to impart this information. Another reason for rising rates of maternal request caesarean section is the belief that caesarean delivery protects the pelvic floor despite the lack of evidence for this (Dietz and Wilson, 2005). There is evidence that maternal request caesarean section is increasingly a phenomenon of the affluent woman (Alves and Shiekh, 2005). Women are seeking to emulate celebrities in having their babies delivered by caesarean section (Asthana, 2005).

Patient autonomy

Patient autonomy, an integral part of good medical practice, confers on the patient a right to accept or decline a treatment proposed by the doctor. Such autonomy is not without limit and does not give the patient the right to demand a particular treatment. Increasingly, many patients seek to compel doctors to deliver them by caesarean section in the name of patient autonomy. However, a doctor's role, as pointed out by Lord Donaldson in *Re J (A Minor) (Medical Treatment)* [1992], 'is not a limited technical one of repairing or servicing a body.'

The patient's overall health should be considered and a doctor is abdicating his/her duty of care to the patient rather than respecting patient autonomy in agreeing to a caesarean delivery which he or she believes is medically unnecessary or which may be harmful to the patient (Stirrat and Gill, 2005; Steer, 2006). This is no different from any other situation where the treatment sought by the patient differs from that advised by the doctor.

The patient's right to self-determination needs to be recognized in allowing the patient to participate in and contribute to his/her treatment plan, and to make a choice from one or none of the treatment options advised by his/her doctor. The patient may bring to the discussion treatments not offered by the doctor, but cannot compel the doctor to provide them. The issues should be fully discussed, and where agreement or compromise cannot be made, then a second opinion should be sought (National Institute for Health and Clinical Excellence, 2004).

Cost

In poor parts of the world maternal request caesarean sections use a significant part of maternity budgets. The ethical issue of using scarce resources to treat a minority of patients arises, aside from whether the requested caesarean is ethically and clinically justified in the first case.

In the UK, maternal request caesarean sections divert funds from other areas, leading to the unavailability of services that could otherwise have benefited others. This poses an ethical issue as the resources of the NHS are not infinite. Would it be acceptable to perform a maternal request caesarean section, either privately or within the NHS, if patients had to pay for such operations? Paying for the operation would remove difficulties over resource allocation but the ethical issue of performing an operation one believes is unnecessary, which may expose the patient to more risk, remains whether the patient pays for it or not.

Medical autonomy

The doctor owes the patient a duty of care to provide the best possible care for the patient within the capabilities of his or her clinical competence and experience. It is the patient's right to refuse the advised treatment even if this will lead to morbidity or mortality, and this should be respected provided the patient is competent to make such a decision. The converse is not applicable, however; the patient cannot require the doctor to provide treatment the doctor believes is clinically or ethically inappropriate. Lord Donaldson stated this eloquently in the case of *Re R (A Minor)* [1992]:

'No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision to treat is dependent upon an exercise of his own professional judgement...'

And also in *Re J (A minor)* [1991]

'The Doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contraindicated, or for some other reason is a treatment which they could conscientiously administer. The court or parents, for their part, can refuse to consent to treatment A or B or both, but cannot insist upon treatment C.'

The doctor hence has professional autonomy in deciding the treatment he or she will or will not administer to the patient. Such treatment or non-treatment needs to be endorsable by responsible medical opinion [*Bolam v Friern Hospital Management Committee* 1957] as well as being amenable to logical analysis [*Bolitho v City and Hackney Health Authority* 1997].

Conclusions

Maternal request caesarean section can put the patient-doctor relationship under strain, as it brings into conflict patient and medical autonomy. Guidance is available and education of the parties involved is needed.

Patient autonomy cannot compel the doctor to provide treatment to which he or she has clinical, ethical or moral objections. Medical autonomy allows the doctor to advise and treat the patient within the limits of his or her experience, clinical skills and competence, but cannot compel the patient to undergo the treatment if he/she is competent and chooses not to have the operation.

These autonomies are equal, and patients and doctors need to recognize this. Each request should be carefully considered on its own merit as often the request is a front for other concerns. A multidisciplinary approach may be necessary. Referral for a second opinion is often useful when issues cannot be resolved. **BJHM**

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KEY POINTS

- Maternal request caesarean section is a growing phenomenon in contemporary obstetric practice and brings into conflict medical and maternal autonomy.
- Opinion is divided as to the best way to proceed in such situations, but there is legal guidance.
- Pregnant women and obstetricians need to be aware of the limits of their respective autonomies, and recognize that neither supersedes the other.
- Respect for patient autonomy does not include an abdication of the duty of care owed to the patient.
- A second opinion can be useful in resolving cases where differences of opinion persist.