Review Article

Indian Journal of Maternal-Fetal and Neonatal Medicine
Volume 3 Number 1, January - June 2016
DOI: http://dx.doi.org/10.21088/ijmfnm.2347.999X.3116.7

Ceasarean Section on Maternal Request

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Abstract

Ceasarean section on maternal request is defined as a ceasarean delivery for a singleton pregnancy on maternal request in absence of medical or obstetrical indication. Obstetrics is a speciality dealing with two lives, closely linked whose interest may not always coincide. Ceaesarean section is a major surgical procedure with potential risk to mother and neonate. Intense psychological fear of childbirth is termed as tocophobia. This fear is expressed as fear of pelvic floor injury, of requiring emergency caesarean section, of loosing the baby. Such factors lead to ceasrean section on demand. In India, the family sometimes demand that baby is born on auspicious date and time. Physician must decide according to principles of autonomy, beneficence, non-malificence and distributive justice. Physician's perspective is from legal, financial, ethical aspects. Caesarean section on maternal request has social, cultural, psychological facets. Obstetritian should explain risk-benefits of the procedure to the patient and take the decision on ethical guidelines.

Keywords: Caesarean Section; Maternal Request; Ethics; Vaginal Delivery; Autonomy; Justice.

Introduction

Cesarean section on maternal request (CSMR), patient choice cesarean, or cesarean on demand all refer to elective caesarean section (CS) for singleton term pregnancy carried out on maternal request in the absence of maternal or fetal indications [1] Cesarean section on maternal request is not associated with judicious use of technology or health care. Normal physiological process is involved in pregnancy and birth. Eighty percent of pregnancies are considered normal and uncomplicated. Based on this evidence, the World Health Organization (WHO) and the International Federation of Gynecologists and bstetricians (FIGO) have set 10-15% as the standard cesarean rate. Obstetrics is a branch involving two patients,whose lives are interlinked , with difficult decision-making. Obstetrical ethics must acknowledge the perspectives of maternal patient, fetal patient, and obstetrician in this decision making [3].

Rising Trends in Ceasarean Section

In modern obstetrics, there is increase in the CS rate. This escalating CS rate is a major public health problem because caesarean section increases the health risk for mothers and babies as well as the cost of health care compared with normal deliveries [4]. Exact cause for the rising rates of Caesarean sections cannot be assigned. Medical, Institutional, legal, psychological and sociodemographic factors contribute to the rising rate of CS [5]. The rates for CS on maternal request in absence of any specific indication are increasing [6].

Complications of Ceasarean Section

Like all surgical procedures,cesarean section have potential harm [7]. Safety data on elective caesarean sections on request is not available and it is not entirely risk-free. Febrile morbidity and sepsis, wound infection, blood loss, operative injury to bladder and ureter, anesthesia-related complications are uncommon, but always remain a potential threat for mother and baby. Pulmonary embolism remains a leading cause of maternal mortality which is likely to occur following a caesarean section. Blood loss for a healthy woman after a vaginal delivery is estimated

to be 500 ml in comparison to 1,000 ml for a cesarean delivery, thus increasing the possible need for a blood transfusion during the postpartum period [8].

Late Consequences of CS

Recurrent CS, scar rupture, hysterectomy, and maternal and fetal deaths are some of the future important risks. Previous CS increases the risk of multiple placental abnormalities like placental abruption, placenta previa, and adherent placentation in future pregnancies [6].

Reduction of Future Fertility

Women delivered by CS were less likely to have a subsequent pregnancy (66.9%) compared with those having spontaneous vaginal delivery (73.9%) and instrumental vaginal delivery (71.6%). Women delivered by CS were also found more likely to have an ectopic pregnancy in their next pregnancy. Wang et al 32 reported 14 cases of pregnancy on the cicatrix of previous CS at the uterine isthmus in the 1st trimester. Six cases of abdominal wall scar endometrioma after CS have been recorded by Wasfie et al [6].

Neonatal Consideration

Cesarean delivery without labor is associated with an increased risk of neonatal respiratory complications including transient tachypnoea of the newborn which in turn increases admission, oxygen therapy and ventilatory support. The incidence of respiratory distress is much higher than in vaginal delivery [9].

Complications of Vaginal Delivery

Negative effects of vaginal childbirth has been studied extensively. Neurophysiological investigations, imaging studies, uretharal pressure measurements and clinical data, all indicate that vaginal delivery, in particular vaginal operative delivery, is associated with, impairment of pelvic oragan support and levetor ani function and spincter damage, as well as pudendal nerve trauma [10].

Why Woman wants Elective Section

How caesarean sections are perceived include changes in patients' preferences and the part doctors play, in decision making. How women view the care they want to receive in labour and delivery may have changed, moving from the notion of demedicalisation that was common in the early 1980s to the increased demand for the use of medical technology found in today's world [11].

Although the preference to elective cesarean section is experienced in both the developing and the developed world, the reasons may vary from society to society. The willingness of a planned delivery and psychological fear of labor pain seems to be the main reason for women choosing caesarean section. Protection of the pelvic floor is also proposed reason for requesting a caesarean. They believe that childbirth inevitably damages the pelvic floor, and that caesarean sections can effectively prevent subsequent incontinence, prolapse and sexual dysfunction. Some women mistakenly believe that a C-section will better preserve their pre-baby figure [9].

This intense psychological fear of childbirth is termed as tocophobia. This fear expressed as fear of pelvic floor injury, of requiring emergency caesarean section, of losing the baby and of being left alone in labour. It is estimated that 6-10% of women suffer from tocophobia . Secondary tocophobia is another condition that may occur due to previous traumatic delivery. Most of the women who had previous unsuccessful vaginal delivery resulting in emergency caesarean section usually do not prefer vaginal delivery for the next time. Many women who have had instrumental delivery would prefer to have caesarean section if they needed a second instrumental delivery . Many women request to have caesarean section because they want bilateral tubectomy at the same time [9].

CSMR based on Personal Preferences

Woman may believe that elective C-section will interfere less with her schedule than the uncertain onset of labor. A patient who wants her own doctor to be involved in her delivery, requests a C-section be done according to her obstetricians convenience and availability. CSMR could be scheduled to suit the patient and the physician [12]. In India, the family sometimes demands that the baby be born on a auspicious date and time, obviously by CS, as decided by horoscopic/astrological calculations [6].

Why Surgeons Prefer Ceasarean Section

Defensive obstetrics is another common reason for high rates of CS. It has been observed that 82% of physicians performed CS to avoid medical negligence claims. Defensive obstetrics violates the fundamental principle of medical practice. Though defensive obstetrics has increased, litigations are not decreased. This is closely related to daylight obstetrics for the

obstetrician's convenience. Elective CS is set in favor of weekdays and daylight. It takes usually 30 minutes to perform a CS while conducting a vaginal birth may need 12 hours or more heavily taxing on the obstetrician's time and patience. Doctors and hospitals earn more money from a CS than from a vaginal delivery. High CS rates financially benefit doctors, hospitals, and industries [6].

Advantages of Elective Section

For the health workers, increased reimbursement, reduced time taken in caring for the patient, and reduced risk of litigations could encourage obstetricians to prefer elective cesarean section over vaginal deliveries [13]. Avoidance of pain during labour has also been cited as a potential maternal benefit , but could be addressed by due attention to pain relief in labour. An elective CS allows better planning and avoids the uncertainty of the onset of labour [1].

Feminist View

The control of reproduction has been a central theme of feminist writings. We must interpret our own experience in the cultural context in which we live. We must judge the value of technologies in the context of the social, political and economic setting. With vaginal birth, mothers experience an increase in self-esteem. basis for their decision making. Women value emotional connections between people. Such differences highlight the disadvantage women experience in the world of obstetric decision making that affect birth, babies and their future generations [14].

Women Enpowerment

A fully empowered woman, will make her choice, understanding the benefits of vaginal delivery, not facing economic pressure, and not worried about possible cosmetic effects. A fully empowered woman will consider her life-long reproductive career, along with other aspects of her physical, spiritual, social, and cultural well being. Obstetrical care involves creating and supporting the structures needed to ensure empowerment, from good antenatal care, to reasonable maternity benefits for women [12]. Sheila Kitzinger argues that, the power and strength that women exercise in giving birth is rendered invisible by increasing reliance on technological delivery [15].

Ethical Aspects of Ceasarean Section On Maternal Request

Informed Consent and Patient Autonomy

For informed consent ,it is necessary that the person making the decision has the knowledge and understanding about the procedure, be mentally and legally competent, alternatives choices should be provided, and the decision should be made voluntary [16].

Autonomy and informed choice is the other central ethical issue in this debate. It is includes negative rights (rights to remain free from interference by others) and positive rights (rights to be given something.) Patient's autonomy includes the negative right of a competent person to refuse a treatment or procedure. This is related to the duty of a physician to do no harm. There is also a positive right of the patient to access treatment. There is definitely an asymmetry to these rights, with the negative right to refuse treatment being stronger than the positive right to access treatment. If a woman did not request a C-section, or refused one if offered by her physician, is she morally responsible if a fetal problem occurs ? Does that same situation hold for the practitioner who refuses to honor a request for a C-section? [12]

Paternalism

Medical Paternalism is also at stake in this debate. Paternalism means treating a patient as if she is incapable of exercising responsible choice [15].

Justice

The principle of justice deals with matters such as fair allocation of, and access to, health care resources. When serving on hospital committees and other administrative bodies, physicians consider resource allocation and the social implications of health care policy [17].

Even in private health facilities where occupying the operating team may not directly lead to denying others life saving care, the use of medical insurance for the "non-medically indicated" cesarean section could eventually lead to higher health insurance premiums and denying other people lifesaving care if they may then not be able to afford the premiums. Situation may arise that what happened as a respect for a woman's autonomy, has ended up causing harm to society [18].

By applying resources to do C-sections that are not medically indicated, we deviate from the greater challenges of obstetrical care. Unnecessary surgery in the developed world seems unjustified when necessary surgery of the same kind in the developing world is commonly unavailable [12].

Physicians Perspective

Physician's autonomy and medical training require him/ her to inform the patient and recommend the most appropriate course of action. Traditional medical teaching is that a surgical intervention such as CS requires justification. Thus, in case of disagreement, physician's autonomy and professional integrity allows him/her to reject the patient's request, provided that the patient is not put at risk and that timely provisions could be made for the transfer of care to another physician [1].

Carefully supervised vaginal delivery after CS needs to be enthusiastically encouraged by promoting trial of scar or trial of labor. The question of seeking a second opinion from a senior and experienced obstetrician before performing a CS for a controversial indication, may be seriously considered or debated in the best interest of the profession and of the women as well [6].

The first step for the obstetrician is to listen to the patient and interrogate why and what source of information made her to request for the caesarean section [19]. The physician must not use power and influence to force the patient's choice. The physician's obligation is to ensure that the patient has the support needed to make her own choice. Patient autonomy also includes the positive right to be informed about the risks and benefits of a procedure and to voluntarily consent to the procedure in the light of the relevant information. There Should be open dialogue between patient and physician, based on trust and mutual respect. It is essential that there is good, nonbiased and reliable information available to be shared with the patient in question [12]. Patients have the right to decline care but not to demand treatment that the physician believes to be unnecessarily risky [19].

Counselling

Health professionals need to ensure that the information given to women is accurate and imparted at a level that is appropriate to the women concerned and interventions should be evidence-based, and the intervention should strictly be applied to women with complications [5].

Documentation of Clinical Decisions

It is, important that decisions pertaining to the mode of delivery are well recorded, especially where the woman or her family prefer an elective cesarean section. This becomes important when an adverse maternal and/or neonatal outcome (eg, death) occurs and could be attributed to the procedure. The health practitioners need to demonstrate how the decision was reached and that informed consent was obtained [7].

Fetus

It could be argued on ethical grounds, that the requirements of justice should provide the unborn with a fair opportunity at the start of life. This may not be applicable in cases of CSMR because of the absence of fetal indication for the intervention [7].

Remove Fear of Vaginal Delivery

Ideally, possible modes of delivery ought to be discussed much earlier in the pregnancy. Every pregnant woman wants to have a vaginal delivery with a very short labour, no or little requirement for pain relief and an intact perineum. If antenatal education is not complete then women can have unrealistic expectations and birth plans. It is very important that antenatal education emphasises the lack of control over events and that although vaginal delivery is most likely to happen, interventions can be necessary for medical reasons. Information about labour analgesia and its benefits should be discussed with the antenatal mothers [9].

Beyond information, ideal care would include emotional and social support. Social structures that accentuate the positive and empowering nature of childbirth need to be strengthened. Positive rights to information, education and empowerment are embodied within the sexual and reproductive rights framework, and should be actively pursued as part of our responsibility as advocates for women. Empowerment and adequate support might reduce the attractions of CSMR [12].

Greater attention should be given to the social, medical cultural and political -economic aspects of maternity care. Women in labour should be offered moral and psychological support. Proper counseling should be done to relieve her pain , fear, stress, anxiety regarding vaginal birth [20]. Participation at a vaginal birth which provides continuous support throughout labor may alleviate fears of powerlessness and isolation [14].

Legal Aspects

Complications may happen in instances where CSMR is denied, and legal consequences might harm the obstetrician. In the US, a positive association between obstetricians' insurance premiums and primary caesarean delivery rates has been reported,

and it was suggested that obstetricians may carry out non medically indicated CS to fend off liability problems . On the other hand, CSMR is not risk free, and despite the woman's request, litigation might arise in case of adverse outcome [1] Litigations have occurred in the case of adverse neonatal outcomes when elective cesarean section could have possibility prevented occurrences of such events. The debate of the ethics of elective cesarean section therefore has legal marks [7].

Financial Aspect

Chilean study explored association between private health insurance coverage and high caesarean section rates. Financial incentives to book more patients and doctors expectations to attend the birth personally resulted in scheduling elective caesarean deliveries [21].

The health practitioner can be guided, by his or her own concept of ethics. While it may probably be easier in public, non-paying health facilities to discourage cesarean section on demand, it may be different in private for profit-health facilities where the financial interests for losing out patients to competing health facilities may be considerable [3].

Institutional Aspect

Institutions may consider concerns about increased costs; they may also argue 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 [17].

At the public health level the increasing CS rates, a trend common to most countries, is a source of worry. While a variety of counter measures such as educational programs and guidelines have been proposed, CSMR has the potential to aggravate the trend, particularly as a first CS appears to be strongly predictive of subsequent cesareans. It has been argued that this could result in loss of obstetric and midwifery skills in the management of vaginal birth [1].

Committee Opinion

The International Federation of Gynaecology and Obstetrics has declared that Caesarean section for non-medical reasons is "ethically not justified." The Society of Obstetricians and Gynaecologists of Canada and organizations srepresenting 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." 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." These bodies have applied the ethical principles of beneficence, nonmaleficence, and justice to arrive at their conclusions [17].

Medical practitioners have considered cultural values, reinforced technology, and medicalised women's fear of labour to justify their preference for surgical births [22].

Discussion

Globally, more women are choosing to deliver by elective cesarean section than ever before.[7] Risks and benefits must be assessed in the light of reproductive rights, and decisions must be made with the aim of maximizing the empowerment of women. Information presently given to women about risks vs. benefits must be the best available if given in a strictly medical context without the needed social and cultural supports . Interest of practitioners in surgical procedures, for reasons such as medico-legal risk, convenience and insurance coverage must be addressed, and remedied, as there will continue to be the possibility that conflicts of interest will occur [12].

While the preference to elective cesarean section is experienced in both the developing and the developed world, and opposition and support are exhibited in almost all societies, the ethical and social analysis taking into account issues like distributive justice and national health resources, the local safety issues surrounding elective cesarean section and reasons why women choose operative delivery may differ from society to society [7].

Women should make informed decisions about the mode of delivery that will preserve their own health and that of their babies and the larger community. Health practitioners need to appreciate that a request for an elective cesarean section may mask a cry for help in several areas of a woman's life.

The safety of elective cesarean section has not been studied rigorously. Most of the literature on the maternal and neonatal outcomes following cesarean

section addresses the emergency cesarean section, and this may not be comparable to elective cesarean section. However, some of the hazards in individual health facilities would be the same for both elective and emergency procedures. In the ideal world, randomized controlled trials would enlighten in determining which was safer, and by how much was the difference between the safety between elective and emergency cesarean section [7].

When women request a caesarean section without medical indication, their requests are related to factors such as quality of care, culture and delivery of care and fears of substandard care and lack of support. These women have frequently experienced psychologically or physically traumatic birth in a previous pregnancy. Women's perceived lack of control in labour may underlie a desire for caesarean section 23. Taking into account such personal circumstances and agreeing to caesarean delivery is more beneficial than subjecting the woman to the process of vaginal birth against her will [1].

Physicians, as promoter of health and welfare of the patients, should, in the absence of an accepted medical indicaton, recommend against cesarean delivery on request. However, in a well informed patient, who has been counseled about known risks, benefits and alternatives, performing a caesarean on maternal request is medically and ethically acceptable [24].

Service providers should consider the training and professional developments of Obstreticians and whether they have sufficient experience of physiologic or uncomplicated childbirth [20]. Greater attention should be given to the social, medical cultural and political-economic aspects of maternity care [25].

Conclusion

Every obstetrician has faced ethical dilemma, as there is increase in number of women requesting caesarean section for non-medical reason. Rising trends in ceasarean section, especially those performed for 'non-medical reasons' will cause negative consequences for mother, child and society in general.

Ceasarean section on maternal request has social, cultural, psychological aspects from patients perspective. Physician's perspective is from legal, financial, ethical aspects. In dealing with ceasarean section on maternal request, obstetrician should discuss risk-benefits of the procedure with patient, remove her fear for vaginal delivery. With informed consent, caesarean section on maternal request is ethical.

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STATEMENT ABOUT OWNERSHIP AND OTHER PARTICULARS
"Indian Journal of Maternal-Fetal and Neonatal Medicine" (See Rule 8)

1. Place of Publication	:	Delhi
2. Periodicity of Publication	:	Quarterly
3. Printer's Name	:	**Asharfi Lal**
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
4. Publisher's Name	:	**Asharfi Lal**
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
5. Editor's Name	:	**Asharfi Lal** (Editor-in-Chief)
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
6. Name & Address of Individuals	:	**Asharfi Lal**
who own the newspaper and particulars of shareholders holding more than one per cent of the total capital	:	3/258-259, Trilok Puri, Delhi-91

I Asharfi Lal, hereby declare that the particulars given above are true to the best of my knowledge and belief.

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(Asharfi Lal)