Cesarean Section on Demand: Is it Ethical?

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Conflict of Interest

- I do not get paid more for a cesarean section than a vaginal delivery
  - But my department does

Objectives

- Review the frameworks we use to make ethical decisions in medicine
- Discuss Elective Cesarean Section using these frameworks
Why this topic? Why now?

Comparative Cesarean Rates

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>'04</td>
<td>35%</td>
</tr>
<tr>
<td>Sweden</td>
<td>'03</td>
<td>29%</td>
</tr>
<tr>
<td>France</td>
<td>'01</td>
<td>22%</td>
</tr>
<tr>
<td>Denmark</td>
<td>'04</td>
<td>23%</td>
</tr>
<tr>
<td>Ireland</td>
<td>'02</td>
<td>25%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>'03</td>
<td>23%</td>
</tr>
<tr>
<td>UK</td>
<td>'04</td>
<td>26%</td>
</tr>
<tr>
<td>Germany</td>
<td>'04</td>
<td>26%</td>
</tr>
<tr>
<td>Australia</td>
<td>'04</td>
<td>29%</td>
</tr>
<tr>
<td>US</td>
<td>'04</td>
<td>25%</td>
</tr>
<tr>
<td>S. Korea</td>
<td>'04</td>
<td>15%</td>
</tr>
<tr>
<td>Italy</td>
<td>'03</td>
<td>10%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>'04</td>
<td>45%</td>
</tr>
</tbody>
</table>

Why now?

- European Journal of OB/GYN 1997
  - 31% of female obstetricians would choose an elective C/S

- Are Brazilian women really choosing to deliver by cesarean?
  - Population Council, Social Science and Medicine 2000

- Soaring C-Section Rate Troubles Doctors
  - Washington Post, 2007

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Why Now?

www.CesareanOnDemand.com

A leading Northwestern urogynecologist compares vaginal delivery to "rolling a bowling ball through the vagina," creating permanent muscle, fascia, and neurological damage.
Nomenclature

- C/S on Demand
- C/S on maternal request
- Elective C/S
- Medically elective cesarean
- Patient choice cesarean section
- Cesarean birth on demand
- Elective cesarean birth
- Patient choice elective cesarean section

What makes something Ethical?

Evidence-Based Ethics

- Descriptive Ethics
  - What is.
  - How are people behaving?

- Normative Ethics
  - What should be.
  - What is the right way to behave?
## What makes something Ethical?

- Principles of Bioethics
  - Autonomy
  - Beneficence
  - Non-Maleficence
  - Justice
- Veracity
- Confidentiality
- Respect for Persons
- Quality of Life
- Sanctity of Life

## What makes something Ethical?

- Communitarian Ethics
- Utilitarian Ethics
- Feminist Ethics
- Kantian Ethics

## Imagine a Patient

"Dr. Smith, I’m due to deliver next May. I’m a neuroscientist and I’ve reviewed all the relevant data in the literature; and I would like to request an elective cesarean section."
Imagine a Patient

“Dr. Smith, I’m due to deliver next May. I’m a perinatologist and I’ve reviewed all the relevant data in the literature; and I would like to request an elective cesarean section.”

Beneficence

• Doing Good
• Evidence-based Medicine
• Which is better: Elective C/S or Vaginal Delivery?
  • For the mother?
  • For the baby?

Which Outcomes Are Important?

• Maternal
  • Death
  • Infection
  • Transfusion
  • Hysterectomy
  • Incontinence
  • Respecting her wishes

• Fetal
  • NICU Admission
  • Death
  • Respiratory Compromise
  • Birth Trauma
  • Asphyxia
  • Cerebral Palsy
Show Me the Data

• Good ethics require good facts

Show Me the Data

• NEJM 2008
  • Randomized Trial
    • 100,000 women
    • 50,000 had an elective cesarean section
    • 50,000 had a planned vaginal delivery
  • The results?

Paucity of Good Data

• Biases
  • Risks of C/S
    • Influenced by comorbidities
    • Emergency surgeries
  • Risks of Vaginal Delivery
    • Operative vs. Nonoperative
    • Cesarean not an option (too late)
The Data

- Randomized
- Very little
- Term Breech Trial
  - 2088 with breech presentation
  - Randomized to planned C/S vs. planned vaginal delivery
    - Slightly better outcomes for babies
    - Slightly less short-term incontinence
    - No long-term differences (2yrs)
    - Too small to detect difference in major morbidities

The Data: NIH State of the Science
Outcomes Favoring C/S

- Hemorrhage
- Urinary incontinence
- Surgical complications
  - Compared to unplanned cesarean
  - Includes obstetrical trauma from operative vaginal delivery
- Fetal Mortality
- IVH
- Asphyxia
- Encephalopathy
- Birth injury
- Infection

Outcomes Favoring Vaginal Delivery

- Infection
- Anesthetic complications
- Subsequent previa
- Breast feeding
- Iatrogenic prematurity
- Length of Stay
Outcomes Favoring Neither

- Maternal Death
- Anorectal Function
- Sexual Function
- Pelvic Organ Prolapse
- Subsequent Stillbirth
- Postpartum Depression
- Pelvic Pain
- Fistula

Most of the Data was Weak

- Only 3 had "moderate-quality evidence"
  - Maternal hemorrhage
    - Favored C/S
  - Maternal Length of Stay
    - Favored vaginal delivery
  - Respiratory Morbidity to the Newborn
    - ?data from C/S before 39 weeks

Balancing the Risks/Benefits

- Fetal Mortality
- Asphyxia
- Encephalopathy
- Birth injury
- Infection
- Urinary incontinence
- Anesthetic complications
- Subsequent previa
- Birth injury
- Infection
- Hemorrhage
- Urinary incontinence
- Anesthetic complications
- Subsequent previa
- Breast feeding
- Favors C/S
- Favors VD
Newer Data

Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term

Shihli Ng, Robert H. Utter, K.S. Joseph, Moosun Hae, J. O. Beauchamp, Bebe L. Macnaughton, Michael S. Kremar
For the Maternal Health Study Group of the Canadian Perinatal Surveillance System

Table 2. Morbidity rates, adjusted ORs and adjusted absolute risk differences* associated with low-risk planned cesarean delivery versus planned vaginal delivery among healthy women in Canada, 1999-2005

<table>
<thead>
<tr>
<th>Type of planned delivery</th>
<th>No. (%)</th>
<th>Rate per 1,000 deliveries</th>
<th>Value (% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesarean</td>
<td>172 (2.7)</td>
<td>15.7 (1.7 to 21.0)</td>
<td></td>
</tr>
<tr>
<td>Any perinatal complication</td>
<td>12 (2.5)</td>
<td>1.9 (0.1 to 6.9)</td>
<td></td>
</tr>
<tr>
<td>Any hysterectomy</td>
<td>21 (2.5)</td>
<td>0.4 (0.1 to 1.3)</td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>1,569 (97.3)</td>
<td>1.1 (1.0 to 1.2)</td>
<td></td>
</tr>
<tr>
<td>Medical adverse event</td>
<td>18 (0.6)</td>
<td>0.1 (0.1 to 0.2)</td>
<td></td>
</tr>
<tr>
<td>Abortion</td>
<td>6 (0.6)</td>
<td>0.1 (0.1 to 0.2)</td>
<td></td>
</tr>
<tr>
<td>Obstetric admission</td>
<td>3 (0.4)</td>
<td>0.1 (0.1 to 0.2)</td>
<td></td>
</tr>
<tr>
<td>PPH</td>
<td>26 (0.6)</td>
<td>0.1 (0.1 to 0.2)</td>
<td></td>
</tr>
</tbody>
</table>
Beneficence

• The jury is out
• Good randomized data is lacking

• Not clear which route is clearly the best choice for patients in terms of health consequences (to either mother or child)
  • Especially if only 1 or 2 children planned

Justice

• Equitable Distribution
• Allocation of scarce resources

Costs

• Which is more expensive?
  • Elective Cesarean Section
  • Planned Vaginal Delivery

• Cost Analysis is difficult at best
• Data are not convincing that one is cheaper or more expensive than the other
  • Term Breech Trial
### Autonomy

- Self-determination
- Self-governance
- Informed Consent

### Informed Consent

Women should have all the material information relevant to their clinical situation so that they can make a good decision *for themselves*.

### Autonomy: Negative vs. Positive Rights

- **Negative Rights**
  - Leave me alone!
  - I don’t want chemotherapy
  - I don’t want that surgery/treatment/medication
  - Don’t touch me!

- **Positive Rights**
  - I demand that you treat me!
    - Cut off my arm
    - Make me beautiful
    - Perform a cesarean section
Autonomy

- Is a request for a C/S analogous to:
  - A request for plastic surgery?
  - A request for a mutilating surgery?
  - A request for an abortion?
  - A request for a circumcision?

Circumcision

- Little data to support its medical advantages
  - Exception: HIV?
- Not recommended by AAP
- Yet, universally offered
ACOG (2004)

- If the physician believes that the cesarean delivery promotes the overall health and welfare of the woman and her fetus more than vaginal birth, he or she is ethically justified in performing an elective cesarean delivery
  - ACOG, “Ethics in Obstetrics and Gynecology” 2004

ACOG (2007)

**Cesarean Delivery on Maternal Request**

**Recommendations**
- Cesarean delivery on maternal request should not be performed before gestational age of 39 weeks has been accurately determined unless there is documentation of fetal maturity.

ACOG (2008)

- Given the lack of data, it is currently not ethically necessary to initiate discussion... about elective cesarean delivery
- There is no obligation to initiate discussion about procedures the physician does not think are medically acceptable...
  - Ethics Committee Opinion 395: Surgery and Patient Choice
ACNM

- "Regrettably, the opinion issued by the ACOG Committee on Ethics may lead to an increasing level of distrust ... The purported benefits of cesarean section on demand are unproven ...."  
  - American College of Nurse Midwives

International Cesarean Awareness Network

- ICAN Online  
  Many Women  
  Many Visions  
  One Scar  
  One Purpose

FIGO

- At present, because hard evidence of net benefit does not exist, performing Caesarean section for non-medical reasons is ethically not justified.  
  - FIGO 1998
NIH Consensus Panel (2006)

• Until quality evidence becomes available, any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical principles.

• Cesarean delivery on maternal request is not recommended for women desiring several children.

ACOG and NIH: Bottom Line

• If a woman asks about elective C/S:
  • And you try to talk her out of it
  • And she understands the risks/benefits
  • Then it is OK to do it
    • i.e. it is ethically justifiable

• Just don’t offer it to all women

Expert Conclusions

• Cesarean on demand is ethically justifiable when patient makes request, is fully counseled and informed, and physician is willing to accede to the request.

  • Minkoff, Chervenak, McCollough and others
The Paradox

- Why is it ethically justifiable to perform an elective cesarean on a woman who asks for one…
- …but not justifiable to offer all women this same management?

Imagine 2 Patients

- Patient A
  - Healthy, full term
  - Labors for 22 hours, pushes for 3 hours
  - C/S for failure to progress

- Patient B
  - Healthy, full term
  - Requests elective cesarean section
  - C/S performed at 39 weeks

A Conversation

O: Hmmmm, I wonder why my doctor didn’t offer me that option… :-(
A bias?

- Women who request C/S will be:
  - Better educated
  - Wealthier
  - Whiter?
- Ultimately classist and racist to only offer elective C/S to women who request it?

Imagine

- Tell patients about these treatment options only if they request them:
  - Male circumcision
  - Abortion for a fetal trisomy
  - Postpartum tubal ligation

Inconsistencies

- Maternal Risks
  - Acceptable
    - Pelvic floor dysfunction
    - Increased risk of hemorrhage
  - Unacceptable
    - Death
    - Infection
Inconsistencies

- Fetal risks
  - Acceptable
    - Amniocentesis
    - Shoulder dystocia
    - Birth asphyxia
  - Unacceptable
    - Iatrogenic prematurity
    - Slight increase respiratory morbidity
    - Death

Inconsistencies

- How can C/S on Demand be medically acceptable sometimes (and thus ethically should be offered)...

...and medically not acceptable (and thus should NOT be offered)?

Ralph Waldo Emerson, 1803-1882
Inconsistencies

“A foolish consistency is the hobgoblin of little minds.”

– Ralph Waldo Emerson

What to tell patients?

• Both methods of delivery are safe.
• The chances of having a bad outcome are small, no matter what.
  • Assuming a normal, healthy woman
• Risks of cesarean increase with each subsequent surgery.
• Pain control is available.

What Questions Should A Patient Ask?

• Am I more likely to die if I have a planned vaginal birth or a planned cesarean?
• Is my baby more likely to die or suffer injury if I have a planned vaginal birth or a planned cesarean?
• What will be my outcomes in future pregnancies?
If a patient persists...

- Get a second opinion.
- Refer to hospital policy.
- Do the right thing.

Stillbirth

Fretts & Usher, 1997
Prevention of Stillbirth

- Where are we heading??

- Elective cesarean section at 39 weeks
  - OR
- Elective Induction of labor at 39 weeks
We are a risk averse culture, at least as far as babies are concerned
How Much Danger is Too Much?

Who Decides?

• Doctors?
• Midwives?
• Patients?
• Ethicists?
• Insurance Companies?

My conclusion?
### Should all patients be told this is an option?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Yes</td>
<td>• No</td>
</tr>
<tr>
<td>• Equal access to information</td>
<td>• Without good data, vaginal delivery should be favored</td>
</tr>
<tr>
<td>• Absolute risks are low</td>
<td>• Long-term benefits are not clear</td>
</tr>
<tr>
<td>• Ability of provider to sway patient is great</td>
<td>• Long-term harms clear with multiple C/S</td>
</tr>
</tbody>
</table>

### My Conclusions

- Above all: Trust women to make good decisions for themselves
- All women should be told elective C/S is an option if:
  - They only want one child
  - They have no medical or surgical contraindication to abdominal surgery
## My Conclusions

- If you’re going to offer this to some of your patients, then you should offer it to all.

- If you think it is reasonable to offer it to some, then *in your opinion* it is an acceptable alternative to vaginal delivery, and patients should be informed of it.

## Alternative

- If this is too costly...
  - Let it be a luxury healthcare item
    - Like yearly MRIs
    - Or concierge doctors
  - Let women pay for it if they want it.
  - But offer it to everyone.

## Another alternative

- Offer it to all women
- But only if they agree to participate in a randomized trial
Worries

• Maybe just by offering it, we make it seem legitimate and women will opt for it who otherwise wouldn’t.
  • Study proposal

• Women electing C/S will end up delivering prematurely
  • See Term Breech Trial
    • 39.3 v 39.6 weeks

More Worries

Study Finds Babies Born Just Weeks Early

Children born in the 37th or 38th week of pregnancy are at higher risk of dying before their first birthdays than those born after 39 weeks of gestation.

Obstetrics & Gynecology.
June 2011 - Volume 117 - Issue 6 - pp 1279-1287
Author, John M. MD, MPH.
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