

Should women be able to choose caesarean section?



Rosanna Ching, 4th-year medical student
University of Leeds, Leeds, UK

Caesarean section is one of the commonest operations performed in the UK. The rise in incidence has been partly due to increased importance being placed on the patient's right to choose. This paper, written from a female medical student's viewpoint, looks at whether caesareans should be performed solely because of patient request. The risks and benefits of caesarean sections are reviewed and the balance between patient autonomy and medical paternalism is evaluated. It is argued that the risks of performing a possibly needless operation are important and should not be dismissed, and the conclusion is that caesarean section should be performed only when medically indicated. The majority of young doctors now entering obstetrics in the UK are female, but this does not necessarily mean that there will be a shift in favour of women's rights.

As a young woman I consider many different things important, including fun, fashion, education and my rights (not necessarily in that order). I am just the sort of person who should be a supporter of women's choice for caesarean section. However, I am also a medical student, just entering into the scary world of responsibility. Due to my ever-increasing (I hope) medical knowledge, I could just as easily be one of the protesters against non-medically indicated caesarean sections. To be honest, though, I had not really thought about the topic very much until I did a project on it. It was then that my interest in the matter increased and my opinion was formed.

Caesareans: how many, where and why?

Approximately 600 000 babies are born each year in the UK. In 2002, 23% of these were delivered by caesarean section. It is the most commonly performed surgical operation in the country and the rate has been increasing over the years, although recent data compiled from the two Leeds Teaching Hospitals show that the rate in these tertiary referral centres has now actually decreased to below 20% (J J Walker – unpublished data, February 2005). Many other countries have similar high caesarean rates: the USA has a higher rate than the UK at 26% and South Africa's rate increased dramatically from 16% in 1998 to 23% in 2005, but it is Brazil that 'wins' with a rate of over 40%.¹⁻⁵ It is unclear why different countries have such different rates, but possible factors include women's socio-economic status, the influence of malpractice litigation, women's expectations, financial considerations, convenience and ethnicity. Even when South Africa had a relatively low overall rate of 16% in 1998, the rate among white women was as high as 41%.^{4,6}

Many of the caesarean sections in these countries are emergencies, but an increasing number are due to patient request. It may sometimes be difficult to distinguish these, as the reason stated in the notes may appear to be a medical one, but in reality the staff may have granted a woman's request for a caesarean by simply lowering the medical threshold at which one is indicated.

There are many reasons that may encourage women in thinking that a caesarean section is the correct choice for them. Popular reasons are either a previous difficult vaginal delivery or a previous successful caesarean.¹ Some women choose it to avoid pain, for convenience or even to maintain their vaginal tone. More serious motives behind wanting a section are tokophobia (a fear of childbirth)² or the opportunity for sterilisation.⁷ Some women have a genuine phobia relating to childbirth, and one way to avoid the need for vaginal examination in labour is to request caesarean section. In some countries women do not have the same reproductive rights as they do here in the UK, and a section may be the only way they can have a sterilisation performed. One such example is Brazil, and this may partly explain its high rate of caesareans. I believe that, if a woman requests a section, every effort should be made to understand her reasons. She may have an underlying motive that she is reluctant to share. All aspects of her case should be considered before reaching a decision.

Risks and benefits

The balance of risks and benefits associated with caesareans is the reason why this issue is so hotly disputed. If elective caesareans are actually safer than vaginal deliveries, they would be 'medically indicated and ethically vindicated'.⁸ The question is, though, are they safer?

Having a caesarean section benefits the mother not only by preventing possible damage to the pelvic floor and avoiding a potentially difficult labour, with its physical and psychological sequelae, but also by providing her with the convenience of knowing when her baby is to be born. Risks to the mother include accidents or damage to blood vessels, the bladder or other abdominal organs.⁷ Scarring of the uterus can also lead to possible later complications, such as increased risks of sub-fertility, miscarriage, ectopic pregnancy, or placenta praevia or abruption in subsequent pregnancies.⁷ However, in many societies there is an increasing trend for smaller families, so the potential compromise of a woman's future obstetric performance may not be important to her.⁹ Women who have caesareans may also be more at risk from postnatal depression, with consequent loss of the precious early phase of mother-child bonding.⁶

Caesarean section can benefit the baby by avoiding risks associated with vaginal deliveries, particularly hypoxic ischaemic encephalopathy and cerebral palsy, which are associated with prolonged and difficult labours. Unexpected intra-uterine death occurs in 1 in 600 pregnancies that extend beyond the due date, and carrying out a scheduled section would eliminate this chance.⁹ Possible adverse effects on the child could be due to its being delivered too early, leading to complications of prematurity such as respiratory distress syndrome. This risk falls dramatically if the woman is already in labour before caesarean section, and is also reduced if the elective section is not performed before 39 weeks' gestation. The use of routine ultrasound dating scans in early pregnancy helps to ensure that the risk of inadvertent preterm delivery is low.^{7,9-10}

These are important realities to consider, but according to the published literature and in particular the information on the Internet it seems generally accepted that the health risks to both mother and baby are lower with vaginal delivery than with a non-medically indicated caesarean. With a vaginal delivery, though, there is always a chance that an emergency section would be needed, perhaps near the end of the labour. This complicates the risk-benefit calculation, which therefore has to be between having an elective caesarean and a normal labour that may require an emergency section.

There are always risks when performing a caesarean, but when an emergency section is indicated during labour, the risks of operating on the mother are higher than those of an elective caesarean. The risks of persisting with the labour, however, are even greater for both mother and baby than those of having the section.

If the mother and child are not in trouble, the known risks of caesareans remain greater than those of allowing labour to progress naturally. If a section is requested for personal reasons, such as simply to maintain vaginal

tone, and is not deemed necessary by the medical staff, some would argue that the mother is being selfish in that she is putting her baby in unnecessary danger.¹¹ The risk to the baby is not large, however, and when risks are small we, as health professionals, have a moral duty to uphold patients' rights to choose. Therefore perhaps we can say that medically we shouldn't carry out women's choice caesareans, but ethically we should.

Patient rights versus patient health

This topic is fraught with controversy and ethical dilemmas, the main competition being between patient autonomy and the doctor's wish to act in patients' best interests.

Autonomy is defined as the right to self-govern and act 'freely in accordance with a self-chosen plan'.¹² Respecting patients' autonomy involves 'refraining from interference with others' autonomous beliefs and actions'.¹³ Are we, therefore, ignoring a woman's basic right to choose her own course of action if she asks for a caesarean section and is refused? The law states that everyone has the right to refuse medical treatment, but does not give them the right to demand it.^{7,8} On the other hand, does this not give women the right to refuse a vaginal delivery? It is, after all, a procedure not without risk. Therefore, women who request a caesarean are not so much demanding an operation but refusing the alternative, which it is surely within their rights to do.

The opposing concept to autonomy is paternalism. This is defined as 'overriding or ignoring the preferences of patients in order to benefit them or enhance their welfare'.¹³ It is paternalistic of a doctor to decide what a patient needs and then to give it to her without discussing it with her. The patient may not agree with the course of action for some reason and should be allowed the choice of refusal. This is what respecting her autonomy means.

When acting paternalistically, a doctor is often simply upholding his oaths of beneficence and non-maleficence – to help those in need and to do no harm.¹³ It is the responsibility of the doctor not to only help his or her patients medically but to also safeguard their rights. It is nearly impossible, though, to promote all their rights as these rights often contradict each other, as in the scenario discussed here. If a woman requests a section it would uphold her autonomy to carry it out, but it may cause her harm. If the request is refused because the doctor thinks it is safer to avoid surgical intervention, this is paternalism but it is also protecting her health.

Conclusion

Being a medical student I know I have a lot to learn, and most will come from experience, but even with my

passion for women's rights I don't think women should be allowed to pick and choose caesareans without medical indication. After all my research on the matter I think that the risks of performing a perhaps needless operation are important and should not be dismissed. I do not think that more concern should be given to patient autonomy than to non-maleficence, although I would make an exception to this rule if it were honestly believed that a woman would be adversely affected in some way by not having a caesarean section. This may be an old-fashioned opinion in some people's eyes, but after discussing this project with my fellow-students I'm sure that it echoes the opinions of other future doctors.

The world of medicine is changing, in the UK at least, as more women, and fewer men, than ever before are graduating as doctors and the majority of those now entering obstetrics are female. Approaches to medicine are also changing, with more emphasis being placed on patient choice. These trends, though, will not necessarily prompt a change in practice more in favour of women's rights. I am female and interested in obstetrics as a future career, but I believe caesarean section should only be carried out when medically indicated. Times are changing, but that does not mean we should sacrifice the health of our patients for fashion and convenience.

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