Editorial

Caesarean Section on Demand: Dilemma between Ethics and Autonomy

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Caesarean section on demand (CSOD) has recently gained attention as first caesarean is the most important determinant of subsequent caesarean sections. Although vaginal birth is thought to be safer, caesarean section has also become safer with the advancement in the caesarean technique, suture material, availability of antibiotics, heparin, blood products and good anaesthesia.

CSOD can be defined as '*primary caesarean section performed at the mother's request in order to avoid a vaginal birth, without any recognized medical or obstetric indication for the procedure*'. The other terminology used for the same are caesarean delivery on maternal request (CDMR), caesarean by choice, caesarean on consumer request and patient initiated elective caesarean delivery. It is not a recent concept but is now becoming a choice of many working women. Data pertaining to the incidence of CSOD is not available but scanty reports from the developed countries reveal the CSOD rate of 2.5% in United States and 7.5 % among all elective caesarean sections in United Kingdom.[1] High CSOD rate (24.7%) have been reported from China in a cohort of 66,266 women undergoing delivery.[2]

This is high time that we as an obstetrician and responsible health care professional, must look into the reasons for CSOD. The common reasons are fear of pain or repeated vaginal examinations during labour, fear of injury to the birth canal or pelvic floor. Women may be scared of an unpredictable course that may end up in an emergency cesarean or instrumental delivery, fear of fetal wellbeing, birth injuries, previous bad experience or for convenience due to social influences.

In the era of informed consent, ethics and consumer forum, we all acknowledge the patient's right to actively participate in her choice of medical treatments. When there is no hue and cry on the women undergoing knife for all type of cosmetic surgeries starting from nasal plastic surgery to vaginal rejuvenation, why everybody is questioning on women's choice on mode of delivery.

Treating obstetricians should realize that antenatal women do not understand the early and delayed consequences of either mode of delivery and it is their duty to provide an up-to-date information regarding the pros and cons of both. The principle of patient's autonomy should be respected but other ethical principles (beneficence, non-maleficence and justice) need to be taken into consideration. In public sector, with limited availability of resources and greater number of patients requiring emergency or indicated elective caesarean sections, CSOD may be against the principle of distributive justice. Now a day's litigations are not uncommon in cases of adverse maternal or neonatal outcomes. This becomes more likely when an adverse outcome is attributed to the procedure, particularly when the patient had requested for CSOD which could have possibly prevented it. Therefore, documentation of informed consent and reasons for the decision taken should be clearly mentioned in order to avoid legal complications.

American college of Obstetrician and Gynaecologists (ACOG) committee has revised their opinion which states that caesarean section on demand should be condemned in the absence of fetal indications as the vaginal delivery is a safer option.[3] This statement is endorsed by World Health Organization (WHO) and Society of Obstetricians and Gynaecologists of Canada (SOGC) as well.[4] NICE guidelines 2018 also endorse the ACOG opinion and states that there is

increased risk of neonatal intensive care unit (NICU) admissions, longer hospital stay, hysterectomy caused by postpartum haemorrhage (PPH) and cardiac arrest but at the same time there are decreased risk of perineal and abdominal pain, vaginal injuries, early PPH, and obstetric shock.[5] To state that CSOD is a safe option, one should be having a randomized clinical trial comparing the CSOD with the vaginal planned delivery. Most of the studies available have compared the fetomaternal outcome of elective caesarean section with vaginal and unplanned caesarean deliveries which cannot be the true representative of outcome of pregnancies going for CSOD. Whatever meagre studies are there, they have clearly shown no significant difference in the immediate maternal complications i.e. PPH, intensive care unit stay or thromboembolic events. A retrospective study from Canada showed significant difference in the severe morbidity after elective caesarean versus planned vaginal delivery (27.3 versus 9 per 100 deliveries).[6] Counselling is a very important component for the women who are approaching for CSOD. A very common reason behind the CSOD by a woman is the choice of small family size or even a single child but an obstetrician must emphasize the woman's total planned and unplanned pregnancies when the CSOD is chosen during her first pregnancy for the reasons discussed in subsequent section. It is well accepted that there is a tendency to underestimate the final parity at the time of first pregnancy by a couple and the final family size is affected by various social and cultural factors. Counselling must include the increased risk of placenta praevia, placenta accreta, uterine rupture and peripartum hysterectomy in subsequent pregnancies which may lead to severe morbidity and may even cause mortality. At this time, there is insufficient evidence to recommend caesarean delivery on maternal request over planned vaginal delivery for maternal outcomes.

Lower fetal morbidity in the elective caesarean section is another misconception among the women choosing for CSOD. There are few studies comparing neonatal outcome after caesarean and vaginal delivery. It has been shown that transient tachypnea, persistent pulmonary hypertension and respiratory distress syndrome are more after elective caesarean delivery especially when the caesarean is done before 39 weeks.[7,8] Royal College of Obstetrician and Gynaecologists (RCOG) clearly recommends steroid coverage for elective caesarean section before 39 weeks. Neonatal adaption problems in the form of hypothermia and hypoglycaemia have also been reported more commonly when the elective caesarean delivery is performed before 39 weeks.[9]

Whenever the CSOD is requested, all the reasons should be thoroughly explored, and patient should be counselled for vaginal delivery if caesarean section is not justified by giving appropriate counselling to the women or couple. Adequate time should be invested to solve her queries and to motivate her for vaginal delivery. SOGC guidelines recommends the involvement of other members of maternal health care team and at times perinatal mental health specialist may be taken as counsellor to persuade women for vaginal delivery.

It is important to decide mutually on the mode of delivery without any bias, taking into account the ethical responsibilities as well as patient's autonomy.

If despite adequate counselling women chooses for caesarean section, following principles should be followed:

- Appropriate informed written consent should be taken explaining the short term and long-term risks.
- Caesarean section should be performed after 39 weeks with careful calculation of the gestational age.
- If there are significant health risk to patient, second opinion should be taken.
- If obstetrician declines the caesarean section, the women should be referred to another obstetrician after proper documentation.
- Fear of pain of vaginal delivery is an important factor prompting women to choose for CSOD. Women should be offered an option of analgesia during labour to motivate her for vaginal delivery or referred to the centre where the same is available.

Besides the factors discussed above, one must consider the age, body mass index, personal and the cultural values in counselling against CSOD. Counselling, respectful maternity care during delivery with adequate analgesia, minimal per vaginal examinations, adequate labour analgesia and frequent maternal and fetal monitoring would go a long way in reducing the requests of CSOD and will surely reduce the rising caesarean sections rates.

We still think, why GOD has made delivery so painful? Why it takes so much of time to come out of the maternal womb? Why the human pregnancy is of 9 months? Human tendency to conquer the nature

always go in wane. We should not interfere in the natural process of birth by taking out the baby earlier into this world. Have we ever thought that 40 weeks in maternal womb prepares the baby for the outside world? Same way, journey through the maternal birth canal, moulding of the baby might be playing important role in in baby's future tolerance of pain and coping up with environment. Have we ever thought of that …….time will tell !

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