The Ethics of Access:
Who Is Offered a Cesarean Delivery, and Why?

BY STEVEN J. RALSTON AND RUTH M. FARRELL

Concerns about the cesarean delivery rate in the United States have been expressed by a number of consumer groups and national professional organizations. In May 2014 *Consumer Reports* published a rating system of fifteen hundred U.S. hospitals and their cesarean delivery rates for low-risk women.[1] That same month the American College of Obstetricians and Gynecologists (ACOG) and the Society of Maternal-Fetal Medicine published a joint statement that recognized that "the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality *raises significant concern that cesarean delivery is overused*" (emphasis added).[2] This statement then offered a series of evidence-based recommendations for "safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery."

At the same time, there has been debate in the bioethics and medical literature about the ethics of what is often called "cesarean delivery on maternal request"[3] and about its contribution to the cesarean delivery rate. Some have argued that CDMR is frequently the result of subtle (or not so subtle) physician coercion of women in labor,[4] and in the Listening to Mothers III survey of postpartum women, by the National Partnership of Women and Children, 13 percent reported feeling pressured by their provider to have a cesarean delivery.[5] While women in labor may be especially vulnerable to such influences, we argue that outside of labor—a context in which physicians are often willing to accede to requests for non-medically indicated cesarean deliveries—physicians should be willing to offer the option of such a delivery when they judge it to be an appropriate procedure and should not make the offer only when patients raise the subject themselves. Indeed, depriving appropriate candidates—for example, healthy women who are good surgical candidates and desire only one or two children—of this information is yet another form of undue, unjustifiable influence on women's decision-making.

Much of the discourse in the bioethics literature on CDMR has focused on balancing respect for patient autonomy with attention to the short- and long-term risks of this procedure to maternal and neonatal well-being. And while there has been some analysis of the social and economic costs inherent in performing cesareans,[6] much of the clinical and ethical analysis has concluded that, given the degree of risk to the mother and neonate from a primary or single repeat cesarean delivery, there is sufficient justification for pregnant women to request and obtain this procedure from obstetricians willing to meet such requests.[7] However, these same analyses often caution that these elective cesareans should *not* be offered to all women, but only to those who initiate the request.[8]

This paper analyzes recommendations that do not promote universal access to these procedures and concludes that such a policy is ethically unjustifiable, as it treats women who do not inquire about such procedures differently. To be clear, recognizing the implications of cesarean sections[9] and efforts under way to prevent primary cesarean delivery,[10] we are not promoting cesarean delivery per se or the idea that all women in all circumstances should be offered an elective cesarean delivery. For some women—for example, those planning large families—this may not satisfy the goals of beneficent care because of the cumulative risks of multiple cesareans.[11] However, for those for whom a single elective

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cesarean delivery may be medically acceptable, using a patient's request for this procedure as the litmus test to decide who should have access to it is unjustifiable.

Cesarean Delivery on Maternal Request

CDMR is a procedure in which a cesarean delivery is performed in the absence of traditional obstetrical indications. Women cite numerous reasons for requesting a cesarean delivery,[12] and some requests are based on misperceptions about the risks of cesarean and vaginal deliveries (for example, the pain of childbirth or neonatal injury) leading to fear or anxiety. In other cases, the request may be informed by the woman's personal experiences. It is always the responsibility of the provider to educate patients about the different routes of delivery based on scientific evidence. As in any other discussion about prenatal-care choices, the patient's needs, values, and preferences should be acknowledged and carefully considered in care planning.

Moreover, it is clear that not all attempts at vaginal delivery are successful and that problems arising in the course of labor can require deviating from initial delivery plans. For instance, there is the possibility of conversion to an operative delivery requiring the use of forceps or vacuum, both of which predispose the patient to perineal injury that can have both short- and long-term consequences. And while data comparing cesarean delivery to vaginal delivery are unconvincing about the former's prevention of long-term perineal dysfunction, there are clear advantages of cesarean delivery over *operative* vaginal delivery for the protection of the perineum.[13] When female obstetricians were asked in a study about their personal preferences for delivery as patients, 31 percent chose elective cesarean delivery for themselves, the vast majority (88 percent) citing "fear of perineal damage" as their reason.[14]

It should also be noted that some attempts at vaginal delivery end with emergent cesareans for fetal distress with subsequent impacts on the physical and emotional well-being of the woman.[15] Furthermore, while there are both neonatal disadvantages and advantages to elective cesarean, the data on decreased neonatal morbidity and mortality (albeit decreases from small absolute risks) are quite robust.[16] Reasons such as these have led some women to prefer cesarean delivery and some physicians to consider discussing elective cesarean delivery with their patients.

We posit, therefore, that although the data on this subject are both wanting and conflicting, there is sufficient evidence to support the notion that CDMR may be justifiable from a beneficence-based standpoint for *some* women. We do not question or minimize the medical issues associated with cesarean delivery; nor do we think that all physicians will conclude from the existing data that CDMR is a reasonable option. Our argument is that, when circumstances exist in which a physician believes that CDMR may be appropriate, making access to this option dependent on the pregnant woman's ability and willingness to initiate a discussion with her physician is problematic and unjustifiable.

Arguments for Universal Access

Our arguments for universally offering elective cesarean delivery to appropriate candidates fall into two major categories: justice based and autonomy based.

Justice-based arguments. Women who request elective cesarean delivery cannot be distinguished from the population who do not make such requests in any morally relevant way that justifies treating them differently. An egalitarian view of justice or fairness requires that similarly situated people be treated equally and that when we treat people differently, it be for morally relevant and justifiable reasons. Imagine two patients of the same physician meeting on postpartum day one: the first had an elective cesarean delivery she requested; the second had a cesarean after a long labor. On learning about the first patient's outcome, the second one wonders, "Why didn't my doctor offer me an elective cesarean delivery?" Perhaps the answer is that the first patient wanted only one child or was a much better surgical risk; these would be relevant distinctions. But what if the only difference had been that the first woman raised the issue of CDMR with her doctor and the second woman did not, either because she was not aware of it or did not feel comfortable suggesting options that the doctor had not discussed? Is this distinction a morally (or clinically) relevant difference that justifies two different treatment algorithms?

If we predicate a woman's access to elective cesarean delivery on her own request, we are putting the burden of information gathering on her: many women may not be aware that elective cesarean is even a choice available to them. Moreover, we are further burdening a patient with the requirement of needing to raise this issue herself with her care provider, something she may not feel empowered to do, particularly if her perspectives arise out of negative experiences or attitudes about her body or intimate relationships. The medical literature is rife with examples of differing degrees of access to health care that result from educational or health-literacy disparities[17] and the impact of cultural differences on communication in the physician-patient relationship.[18] Thus, under a practice in which pregnant women must raise the topic of CDMR, it is the patient who must seek out information about this option, and then she must raise this topic with her care provider in a manner that may be counter to her personal or cultural inclinations.

Currently, we lack data from the United States on cultural and socioeconomic differences in women who request CDMR and those who do not. Data from Brazil certainly imply that it is wealthier women who are having more cesareans,[19] but it is not clear that this is due to maternal request. Data from Italy actually suggest it is women from lower socioeconomic classes who are more likely to favor this intervention.[20] Regardless of the direction of the bias, the distinction between women who ask for this procedure and those who don't may therefore be based on cultural and racial backgrounds or educational levels. These are not distinctions that should have moral or clinical relevance to physicians making a decision

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about offering a certain kind of care. Such distinctions have no place in modern medical practice.

Autonomy-based arguments. Patients in general need adequate information and resources to make informed decisions about their health care. This is especially important in the context of women's reproductive decision-making.[21] Part of the physician's role is to be an educator and, in this role, to be a resource for medical information and to communicate this information in an understandable manner with a sufficient depth and breadth to meet the patient's needs. It is antithetical to the physician's role to withhold information that is clinically relevant and would affect the decision-making of a patient, as this act severely impinges on her ability to make autonomous choices about her health.[22] This is particularly relevant in the current climate of obstetrics, where individual providers' cesarean section rates are used as a direct quality metric,[23] a factor that may influence physicians away from performing a cesarean. Although many patients seek medical information themselves, not all have access to reliable and accurate resources from which to learn about different prenatal options.[24] Furthermore, requiring a woman to initiate discussions about each of her delivery options runs counter to the physicians' role in promoting patient autonomy: physicians can be sure a patient is enabled to provide her informed consent regarding delivery options only if they are a direct and engaged part of the counseling and decision-making process. Withholding information about these options from patients limits their autonomous decision-making ability and may even harm some patients who might benefit from an elective cesarean delivery.

Finally, it is a central precept of the consent process—a process that undergirds the respect for autonomy and respect for persons so central to our current bioethical framework—that patients be given information about reasonable alternatives to the care being offered. Physicians who believe that cesarean delivery on maternal request is an acceptable option based on the current science and on a woman's needs and preferences have an obligation to offer cesarean delivery to these women and explain why it is an appropriate option. Withholding this information would limit women's choices: they must attempt a vaginal delivery, and only if they are unable to do this safely will a cesarean delivery be offered. The converse of this is also true: if a provider has concluded that cesarean delivery on demand is not a viable choice or not a reasonable alternative, this provider is not obligated to perform this procedure or to discuss it in the counseling process.

Beyond the Individual Patient

One argument for not making elective cesarean delivery more available is to avoid the inevitable downstream effects this would have on our health care system. In theory, more women having cesareans would require more operating rooms, more recovery rooms, more postpartum beds, more anesthesiologists; fewer women having vaginal deliveries would mean fewer trainees learning the skills necessary to be functioning obstetricians. There are real-world cost concerns about allowing the autonomous choices of pregnant women regarding delivery to take precedence over other considerations, such as financial concerns. These analyses are beyond the scope of this paper, but data from the Term Breech Trial suggest that elective cesarean delivery does *not* increase costs compared to a trial of labor.[25]

It is also, as Jan Christlaw argues, a mistake to believe that choice in and of itself is unequivocally desirable, that expansion of options is always worthwhile: "Simply adding an alternative does not enhance empowerment, unless that alternative truly improves the lives of women and their families."[26] Normalizing cesarean delivery may have detrimental effects on women's perceptions of what is "natural" or "normal" about childbirth and will further the medicalization of birth, which may ultimately be disempowering to women.

Finally, one could argue that there is an inherent conflict of interest for the physician in offering a procedure that has great advantages for the provider: convenience of a scheduled surgery versus participating in a prolonged labor. It may even be more lucrative to perform a cesarean. Providers, however, face such conflicts daily, and these can be resolved by strict adherence to the principle of beneficence: keeping the patient's interests paramount. All these arguments are important—even crucial—when we consider the ethics of elective cesarean delivery. They inform our discourse on what we can afford—economically and culturally—as a society; how we want our obstetrical health care system to look; and the ways in which women view their bodies, childbirth, pregnancy, and reproduction. But these arguments do not help us decide *to whom* we should offer elective cesarean delivery, but *whether* we should offer elective cesarean delivery at all. If we have decided that elective cesarean delivery can be justified for a subset of women (for example, those who are good surgical risks and who are planning on only one or two children), then all women similarly situated should have equal access to this option.[27]

Requiring a woman to initiate discussions about each of her delivery options runs counter to the physicians' role in promoting patient autonomy.

Implications for Clinical Practice: The Practicalities

We suggest the following approach: first, providers should decide for themselves if the available data support offering elective cesarean delivery to some subset of women. If an individual physician feels that the data do not support this or that the data are still unclear or are insufficient to draw a conclusion from, then the physician should not feel obligated to offer elective cesarean delivery. No physicians should have to perform a surgery they think is not clinically or ethically justified.[28] For these physicians, a referral to another provider who may be willing to meet the wishes of a patient would be a reasonable option if, after counseling, she continues to request a cesarean.

But if after weighing the data, physicians conclude that some patients might benefit from this procedure based on discussions with patients about their preferences and beliefs, then this procedure should be made available. In this case, elective cesarean should be incorporated into conversations with pregnant women when planning for their delivery and the kinds of experiences they wish to have or avoid. Just as the option of epidural analgesia is generally made available to all patients for labor pain—not only for those who request it—the option of cesarean delivery can be included in counseling about approaches to labor and delivery. There may be concerns that the mere suggestion of this as a choice will bias women into thinking that the care provider thinks it is indeed a good choice or the preferred choice. While this is an interesting empirical research question, obstetricians have sufficient experience with nondirective counseling about other procedures (such as amniocentesis) during pregnancy to allay this fear.

One final concern is raised by the recurrent discourse on who the ideal candidates for CDMR are—those desiring only one or two more children. Given that 50 percent of all pregnancies are unplanned[29] and that young women who request tubal ligation not infrequently come later to regret the choice,[30] how sure can we be that women who say they want only a few or no more children will not, in fact, change their minds? Empirically, we can answer this question by longitudinal studies of women who choose elective cesarean delivery. But from a practical standpoint, what is required from us ethically is not to throw up our hands, paralyzed by our inability to know the future, but to address these uncertainties in our consent-process discussions with patients and in our research.

Modern obstetrics may be suffering from its own success. We have made maternity care incredibly safe, and cesarean delivery is now associated with decreased complication rates. It has become easy to argue that an elective cesarean delivery is a reasonable option for some women. However, to withhold this option from women merely because they lack the education, information, or the willingness to ask their physicians for it is not ethically tenable and has no reasonable justification in an egalitarian society and health care system.

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2. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine, "Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery," *Obstetrics & Gynecology* 123 (2014): 693-711.

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14. R. Al-Mufti, A. McCarthy, and N. Fisk, "Survey of Obstetricians' Personal Preference and Discretionary Practice," *European Journal of Obstetrics and Gynecology* 73 (2007): 1-4.
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This essay is part of a series on teaching bioethics, edited in collaboration with the Presidential Commission for the Study of Bioethical Issues.

Bioethics Casebook 2.0:
Using Web-Based Design and Tools to Promote Ethical Reflection and Practice in Health Care

BY JACOB MOSES, NANCY BERLINGER, MICHAEL C. DUNN, MICHAEL K. GUSMANO, AND JACQUELINE J. CHIN

The idea of the Internet as Gutenberg 2.0—a true revolution in disseminating information—is now a routine part of how bioethics education works.[1] The Internet has become indispensable as a channel for sharing teaching materials and connecting learners with a central platform (such as a professional society's website or a course page on a university's web portal) that houses materials to support an online or hybrid curriculum or a traditional course.[2] A newer idea in bioethics education reflects developments in web-based medical education more broadly and draws on design principles developed for the Internet.[3] This approach to online bioethics education requires thinking about web-based learning as an engaging, potentially immersive experience (in contrast to clicking through a webinar or

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