

case study

Is the Patient Always Right?

HA is a twenty-six-year-old lawyer who is nearing the end of her pregnancy, which has progressed without incident. Having read the literature and discussed her options with her physician, she has requested that her child be delivered by cesarean section. Her primary reason for opting for a cesarean is convenience: it will allow her to fit the event into her and her husband's busy schedules. PW,

her physician, believes HA is informed and has every right to choose her mode of childbirth. He also believes that the procedure would prevent possible complications, such as pelvic injury. His colleague, RT, objects, given that no clear-cut medical reason exists for it and that the chance of the next child being stillborn increases after a C-section—a danger in this case, since HA plans on having one more child. He also argues that

some uncertainty exists as to the baby's due date, making premature birth a slight possibility.

Is PW justified in believing cesarean sections should be left to the patient's discretion? Or should doctors be firmer in prescribing the method of birth, despite fears of malpractice suits should procedures done at their discretion not go as well as planned?

commentary

By Anne Drapkin Lyerly

Perhaps the most passionate and intriguing debate currently raging in childbirth methods concerns elective cesarean section. Not only has the permissibility of assent to women's requests for cesarean met with vigorous resistance, it's a resistance curiously shared by practitioners with views otherwise as disparate as adherents to the medical and midwifery models of childbirth.

One might think that the *elective* nature of these cesareans has fostered such resistance. But this can't be it. Medicine is used to dealing with elective interventions, from cosmetic surgery to neonatal circumcision. Though these bring up sensitive issues, the normative boundaries of medicine are not so confined as to exclude all interventions deemed *elective* from medicine's appropriate purview.

What then, about this particular request, gives so many pause? Does the risk-benefit ratio fall so far outside the boundaries of a *reasonable* choice that we should decline, as we would a non-

medical request for limb amputation or other radical surgery? Certainly not. Approximately one in four pregnant women delivers by cesarean. It is a widely practiced, safe procedure. Recent surveys of obstetricians reveal that a substantial minority would *choose* elective cesarean for themselves or their spouses, and the American College of Obstetricians and Gynecologists has issued a statement endorsing its permissibility.

Does the resistance stem from concerns about fetal risk? Undoubtedly we should take seriously the risk of stillbirth in a pregnancy following a cesarean. But we must also understand these data for what they are: derived from a *single retrospective study* calculating an absolute risk for unexplained stillbirth at or after thirty-nine weeks' gestation as 1.1 in 1000 in women who had had a previous cesarean compared with 0.5 in 1000 women who had not. This risk differential—if confirmed—is well within what has traditionally been a range of acceptable risk. Most practitioners are still comfortable, for instance, with supporting a woman's choice for vaginal birth after cesarean despite evidence that it is associated with an incidence of delivery-

related perinatal death of 1.29 per 1000 women—approximately 11 times that associated with planned repeat cesarean. And we must consider these minuscule risks in light of data indicating *benefits* of cesarean for the *index* pregnancy, including a similarly small but significant reduction in neonatal birth injury and infection, avoidance of potential damage of vaginal delivery to a woman's pelvic floor, and a range of other considerations for the woman and fetus.

Given this background, consider HA. Is there something about her *particular* reason for requesting cesarean that pushes it beyond medicine's normative bounds? Some seem to think so. HA's identified reason, "convenience," hardly seems to indicate a meaningful benefit. But convenience is why we order pizza; it is not why we decide when and how to have a baby. And I doubt it is why HA made her request. Far more likely, her request stemmed from a deeply and widely held desire to have some semblance of control over the timing and method of a major life event: childbirth. Surely facilitating women's control in a situation so imbued with

bodily and existential meaning is a benefit well worth striving for.

Though misleading, the term “convenience” is instructive: it intimates why this debate has been so vigorous, yet so seemingly impenetrable. In a society that valorizes maternal sacrifice, and too often ignores the existence of the pregnant woman *as woman*, it is not surprising that her requests for relief or control are minimized, marginalized, and fail to achieve the status of other requests for less clearly justifiable interventions, such as cosmetic surgery. If an adequately informed woman does not want to labor

and push a baby through her vagina, it makes no sense to oblige her to attempt to do so, and then perform the procedure she requested in the first place only if she “fails.”

So, is PW justified in thinking that cesareans should be left to the patient’s discretion? My short answer is yes, of course. But what we mean by discretion is critical: choice in the context of genuine support and informed consent. To facilitate this, important lessons should be taken from each of the strange bedfellows that argue against surgery. Obstetrics reminds us we need to remain

vigilantly attentive to both risks and benefits. These must be communicated in a way that women understand the magnitude and applicability of risks and benefits to them. Midwifery reminds us that women often come to decisions about childbirth with unwarranted fear of pain, loss of control, abandonment. Presenting a positive view of childbirth, attended and empowered, whether operative or vaginal, is the only way women will achieve the sovereignty over childbirth they deserve.

commentary

by Peter Schwartz

We begin with the assumptions that a physician wants to do what is best for his patient and provide the care that the patient wants. Although it is generally held that the obstetrician has two patients—both the mother and the fetus—clearly the rights of the mother in caring for herself trump care for the fetus, if there is a conflict between them.

The debate over elective cesareans has focused on the benefits some women perceive in the procedure. These include excellent pain control during delivery, the avoidance of vaginal and introital trauma, and better ability to manage one’s life. Normal natural labor’s six-week window within which birth can occur, coupled with a six-week postpartum period, can play havoc with job planning and planning for postpartum assistance.

The potential benefits of primary elective cesarean section are often weighed against the risk that a scheduled cesarean section will bring the baby into the world prematurely, the risk of a prolonged post-delivery recovery, heavier interpartum and postpartum bleeding that could require transfusion with its attendant risks, and an increased risk of infection.

But in recent years this risk-benefit calculation has changed. Physicians now give greater weight to the patient’s pref-

erences, even when these run counter to the patient’s good. Also, data on prevention and treatment of the complications of cesarean section continue to improve. Some believe that vaginal delivery poses a substantial risk to the soft tissues of the pelvis and can contribute to urinary incontinence later in life. And better pain treatment has shortened recovery time following a cesarean section.

Finally, although it has long been known that a cesarean section baby is more likely to have transient tachypnea of the newborn (a usually mild event), an elective cesarean section at term would decrease such risks to the fetus of postmaturity syndrome and intrapartum mortality and morbidity. The risks and benefits may now be almost equal, or at least close enough that natural delivery and cesarean section are reasonable health care alternatives. This would suggest that obstetricians offer elective cesarean section as part of informed choice.

However, two issues demand further consideration. First, although future fetuses have no apparent moral rights, both mother and clinician should be aware that there is an increase in mortality and morbidity for fetus and mother with each *repeat* cesarean section. Therefore, in a young woman having her first child and anticipating two, three, or more pregnancies, the beneficence model starts to weigh heavily against elective cesarean section.

Second, the obstetrician may have a significant conflict of interest in provid-

ing informed choice to the patient. An elective cesarean section may increase reimbursement to the physician, decrease the time spent caring for the patient, and decrease medical legal liability.

Few legal actions have alleged unnecessary cesarean section, while many have alleged failure to provide cesarean section. The risk of liability might be especially high if a bad outcome resulted for a patient who had requested primary elective cesarean section.

In the case of HA, I would strongly urge her to opt for vaginal birth. If convenience is very important to her, I would suggest a scheduled induction of labor after thirty-nine weeks gestation, rather than a primary elective cesarean section. Although not risk free, induction of labor with an 80 percent chance of vaginal delivery would obviate maternal risk of cesarean section, fetal-maternal risks in subsequent pregnancies, and it would satisfy convenience issues for the mother. But if the patient were, say, thirty-five years old, having her first pregnancy, and anticipating no further pregnancies, I would feel that elective cesarean section is a reasonable alternative and would support her wishes.

If HA were planning three or more pregnancies, given the current evidence regarding risks of repeat cesareans, I would not consider her request a reasonable health care alternative, and I would refuse to support it. I would not, however, be prepared to defend my honor against a peer who concurred with her wishes.