Health advocate

van de Wiel, Harry B.M.; Paarlberg, K. Marieke; Dermout, Sylvia M.

Published in:
Bio-Psycho-Social Obstetrics and Gynecology

DOI:
10.1007/978-3-319-40404-2_25

Publication date:
2017

Health Advocate: An Obstetrician in Doubt—Coping with Ethical Dilemmas and Moral Decisions

25

Harry B.M. van de Wiel, K. Marieke Paarlberg, and Sylvia M. Dermout

25.1 Introduction and Aims

All healthcare professionals are regularly faced with the following question: "What is the wisest course of action? What is the right thing to do in this case or with this patient?" An inherent part of this kind of dilemma is that it involves pros and cons that are difficult to weigh against each other; evidently there is a broad spectrum of *arguments*. These arguments refer to interests or values that are usually associated with rules for conduct and actions—what we call *standards*. Ethics is an area of study that can help those professionals deal with dilemmas of this kind and find answers to their questions regarding the right course of action and how to implement it.

In this chapter, a phased approach is advocated to manage this argumentation puzzle in real-life situations. According to the biopsychosocial (BPS) model, which is the theoretical basis for the psychosomatic approach and which is discussed elsewhere in detail in this book (see Chap. 22), the first step is to identify the relevance or *impact* of the various arguments so that an initial selection can be made. Impact means a combination of the scale and scope of the standards involved. When all the

H.B.M. van de Wiel (✉)
Wenckebach Institute, University of Groningen, University Medical Centre Groningen, Groningen, The Netherlands
e-mail: h.wiel@umcg.nl

K.M. Paarlberg
Department of Obstetrics and Gynecology, Gelre Hospitals, Apeldoorn Location, Apeldoorn, The Netherlands
e-mail: km.paarlberg@xs4all.nl

S.M. Dermout
Gynaecologist, Gynaecological Centre Dermout and Albicher, Alkmaar, The Netherlands
e-mail: sylvia@dermout.nl

K.M. Paarlberg, H.B.M. van de Wiel (eds.), *Bio-Psycho-Social Obstetrics and Gynecology*, DOI 10.1007/978-3-319-40404-2_25

relevant arguments have been identified, anything that clearly will have no impact can be eliminated. This usually simplifies the puzzle considerably. The remaining arguments must then be weighed up against each other. To do this, the following four generally accepted principles of medical ethics or kinds of *criteria* can be used: autonomy, nonmaleficence, beneficence, and justice. In order to provide adequate arguments for each choice, it is suggested to make an *impact matrix*, showing impact combined with kinds of criteria. If necessary this assessment can be made specific for target groups, since different considerations may apply for patients than for family or treating practitioners.

To illustrate this, this chapter will discuss the use of an impact matrix in the case of a common dilemma in obstetrics: whether or not to agree to a request from a healthy mother for a Cesarean section because she is afraid of damage to her pelvic floor, incontinence, or future prolapse. In succession the following topics will be discussed:

1. Medical ethics
2. The first selection: relevance
3. Applying the principles
4. Assessment
5. Decision-making
6. Discussion and final remarks
7. Tips and tricks

Case History

Marie-Anne Rose is a 28-year-old primigravida consulting you at 24 weeks of gestation. She has been referred to you by her midwife, since she is applying for an elective Cesarean section (CS). The midwife writes in her referral letter that Marie-Anne is healthy and has had an uneventful pregnancy thus far. Marie-Anne insisted on a Cesarean section during intake, and the midwife reports that she could not make her change her mind despite several discussions during the subsequent appointments she has had at her office. The midwife had discussed with her the options of a birth plan and epidural analgesia, but that was not the issue. Marie-Anne is an ambitious lawyer who does not want to run the risk of third-degree perineal tears, subsequent urinary and/or fecal incontinence, and future prolapse. Therefore, she insists on an elective Cesarean section.

She is referred to Gabriella Vermelho, an experienced obstetrician, brought up in the medical tradition of an old Portuguese family of doctors. Gabriella is well aware of the fact that the request of Marie-Anne will definitely not be a “black and white” discussion. Although an elective CS in primigravida women does indeed reduce the lifetime risk of pelvic organ prolapse and incontinence, there are many drawbacks to a CS on maternal request that definitely need to be to addressed as well.

In general one can say that a vaginal delivery is the safest option for the woman and the fetus, unless there are obstetric reasons to decide for a CS. Before Gabriella calls her in, she wonders how she should weigh all these arguments. These are all tumbling in her head asking for attention: What if Marie-Anne gets a third perineal tear with subsequent fecal incontinence if Gabriella and her team refuse to perform a CS? But what if she contracts a placenta previa with placenta percreta next time due to the previous CS? What if she contracts a pulmonary embolism postoperatively after an elective CS? And what is Gabriella's own opinion? She is personally convinced that women should only be operated on when there is an absolute medical reason for it. And according to her opinion, as well as according to the guidelines of her professional association, that is not the case when one wants to avoid some minor risks of a, usually safer, vaginal delivery at the expense of a CS, which is a major abdominal operation.

On the other hand, maybe this patient had a relative who has experiences with fecal incontinence, urine incontinence, pelvic floor problems with sexual consequences. What is wisdom, what is wrong or right, and what should be done?

25.2 Medical Ethics

This case shows that with a medical dilemma there are not only many factors to take into account but also different ways to assess those factors. The area of study concerned with answering the questions "What is the right thing to do?" and "How do we determine this?" is ethics. In recent decades the importance of ethics has increased considerably. Not only is there a growing number of choices, but the importance of accountability—being willing and obliged to account for one's professional actions—has risen significantly. After all, not everything that is possible is desirable, and what is good for one person is not by definition good for another. Something that helps today may have the opposite effect tomorrow. As we saw in the discussion of the BPS model (Chap. 22), medical action is always context dependent, and in principle a diagnosis is always temporary (a working diagnosis). Moreover, it is becoming increasingly clear that research results only provide concrete guidelines for the nonexistent "average" patient: Clinical practice always requires customization.

The domain of ethics that specifically focuses on medical dilemmas is medical ethics. A few examples of typical medical ethics issues relating to psychosomatic obstetrics and gynecology (POG) are:

- May surrogacy be used as a solution to involuntary childlessness or not?
- Will I be helping a woman with chronic abdominal complaints if I agree to her request for a hysterectomy?

- May genital surgery be used to solve aesthetic problems?
- Must I agree to a request for a Cesarean section when there are no obstetric reasons?

Ethics plays an important role in medicine for two reasons. The first is that medical actions, to a greater degree than most other forms of service, often have drastic consequences for the person involved—in this case the patient. The second is that medical actions are nearly always based on choices, and ethics provides arguments on which to base these choices and procedures for making them; these arguments can also be produced later to justify the choices made. In this sense the "what and how" of medicine is never noncommittal; it has, in fact, been discussed verbally and in writing ever since the "foundation" of medicine (see, e.g., Hippocrates). Two main forms of general ethics are distinguished:

- *Descriptive ethics* limits itself to identifying the values (what is considered important) and standards (the behavioral rules based on those values) in a particular population at a particular time.
- *Normative ethics* goes a step further, examining what the values and standards should be and providing practical guidelines; rather than descriptive, it is prescriptive. This chapter focuses on creating practical guidelines and is therefore in the realm of normative ethics, which is about learning to examine the pros and cons of a certain treatment in terms of values and standards. Normative ethics can again be divided into two streams:

- *Ontological ethics*: In the Platonic tradition, this form of ethics assumes the existence of an unassailable, fixed standard. This standard is often derived from a religious or ideological view, whether or not laid down in a written moral frame of reference. A well-known example of ontological reasoning is that abortion and euthanasia are forbidden because God, the Bible, or the Koran forbids them. The advantage is that you immediately know where you stand and that the focus is on the consequences of implementing or not implementing these procedures. The disadvantage of this approach is that any further reasoning or nuance is almost impossible.
- *Deontological ethics*: In the tradition of Aristotle, this form of ethics assumes that what is right is derived from the consideration of the arguments on which certain guidelines for action are based. Abortion and euthanasia can be carried out in well-defined circumstances, whether or not as a last resort, because otherwise the harm done to the person or persons in question is greater.

Although both forms of ethics are still found within medical ethics, over the past few decades in particular, ethics in medicine has made a major shift toward deontological ethics. Due to the growing influence of a science-based approach, often accompanied by the decline of an approach based on orthodox religion, medicine has become increasingly deontological. The basis of the scientific approach is that an event only has or gains meaning in a certain context. Moreover, in science

everything can, in principle, be discussed. Some say the original quote by Descartes was actually *Dubito ergo sum* ("I doubt, therefore I am"). An inherent part of issues of medical ethics is that the literature does not offer any clear-cut answers. What is right, and therefore what provides a guideline for the entire treatment, has become context dependent. This means that treatment must be customized, which makes the work interesting. However, it also means that, at most, ethical guidelines exist only at the meta-level. There are no ready-made answers to the primary question "What is the right thing to do?" What we do have are instructions to help answer the secondary question: "How can we determine what is right?"

Case History: Continued

Gabriella Vermelho (doctor) calls in Marie-Anne Rose (patient) who appears to be a tall and slender person and well dressed like she is just going to work. She tells Gabriella that her partner could not make it to the appointment due to his busy schedule at work. He is the CEO of a bank and regularly abroad. Furthermore, she says that she has decided to take the morning off from work, so there would be enough time today to arrange everything for the Cesarean section she desires.

Doctor: I have read the referral letter from your midwife. Do I understand correctly that you are assuming that we will get everything ready for a scheduled Cesarean today?

Patient: Yes, of course.

D: Well…. I can only decide on planning a Cesarean section, instead of awaiting a spontaneous delivery, after carefully balancing the pros and the cons. Therefore, I first would like to do an intake and assess exactly what your information is concerning the delivery and then try to find out together what will be the best plan concerning the delivery.

P: You say "delivery," but I think you mean "Cesarean," don't you?

D: I said "delivery" on purpose in order to keep open the outcome of the mode of delivery, if you don't mind.

P: Well, in fact, I do mind. I do not want a vaginal delivery, so it will be a Cesarean. We live in a free world and I can choose for myself which kind of delivery I am going to have, can't I? And I don't want a vaginal one—I don't want any damage to my vagina or pelvic floor.

D: We live in a free world indeed. And your independent choice is one of the factors we have to take into consideration, as is your fear of damaging your vagina and pelvic floor. However, there are additional issues that we have to address. I am your doctor. First of all, as an obstetrician, it is my duty to take care that your delivery will be managed in the safest possible way for you and for your baby. Secondly, I want to help you to perceive your pregnancy and delivery as positively as possible. I want you to experience the delivery as a rewarding experience that will be a defining moment in your life and that of your baby. And finally, you see, I am medically responsible for the

outcome. Scheduling an elective Cesarean may be one of the options, but I need your approval for a process in which we both can explore which arguments are most valid in order to make the best decision regarding the mode of your delivery. In fact, this will take more than one appointment.

P: Oh, uhm, I don't know what to say. So we have to first go "through a procedure" as you say? That's really disappointing for me. I was expecting to have it all settled today.

D: What strikes me is that you seem to be in such a hurry to plan a Cesarean section. We have time enough to discuss this. And you seem to speak very light heartedly about a Cesarean section. Allow me to tell you something about the implications of a Cesarean section. Did you know that a Cesarean section is an "emergency operation" surrounded with additional risks?

P: I thought nowadays a Cesarean is a piece of cake….

D: I wish that were true! A vaginal delivery isn't easy either, but compared to a C-section… (Silence!).

P: What could go wrong then?

D: There are a number of issues in fact, which can differ from person to person… (silence).

P: Such as what, in my particular case?

D: Well, things can go wrong in any case, but to explain the risks to you and especially in order to reach a good balancing of the pros and cons, we do have to go through a "procedure"… (silence).

P: So, it is not wise to choose a C-section right away….

D: Unfortunately no, because, while we would be ready quickly, you wouldn't be really grateful to me afterwards… (silence).

Gabriella repeats these kinds of sentences until Marie-Anne switches from "since you think this is necessary" toward "all right, let's try to find out together what the best solution is for me."

25.3 The First Selection: Relevance

25.3.1 Introduction

To arrive at an adequate assessment of ethical dilemmas of this kind, it is important to realize why the assessment is so complicated. The problem lies partly in the large number of potentially relevant factors, which is why an initial selection in terms of relevance is necessary. This is the only way to create the cognitive space required to weigh the remaining arguments against each other (see later section on *Assessment*).

Following the BPS model, first we zoom out so that we can assess the significance or relevance of certain values. To do this we identify the impact of the various pros and cons. In this context, impact means a combination of the scale and scope of the values and standards involved. The scale is about whether or not a certain

standard applies for every person or, for instance, only for patients or treating practitioners. The scope is about the relative force with which the standard applies, for instance, whether it is enshrined in law or is a matter of personal preference. Then the impact of the values and standards can be placed in a hierarchical order, which usually contains the following four levels:

- Level 1: General social ethical principles, laid down in laws that apply to everyone
- Level 2: More specific principles of medical ethics, laid down in laws that apply specifically to patients and medical practitioners
- Level 3: Even more specific principles of medical ethics, linked to membership of the specific groups of medical practitioners in question (in this case gynecologists, pediatricians, anesthetists, etc.) in connection with the exercise of their profession
- Level 4: Individual principles of medical ethics relating to personal exercise of the profession

25.3.2 Hierarchy

This is a normal hierarchical order of the kind used in many areas of society. The hierarchical structure means that if something is undesirable at a higher level—for instance, because it is prohibited by law—this takes precedence over the fact that something else may be desirable at a lower level, for instance, granting a patient their wish. It is only in very exceptional cases (e.g., with children of Jehovah's Witnesses in relation to blood transfusions) that medical practitioners can deviate from this rule. Constitutional standards take precedence over individual standards and all doctors and patients must obey the law. If there are any contradictions, they nearly always occur at the same level. In such cases a second classification mechanism is required: principles or criteria of medical ethics.

Case History: Continued

D: All right, with your consent, let's go for it. Given your background as a lawyer you must be used to reasoning in complex situations. However, when it's about your own health and baby, it's always different. How do you feel about that?

P: Yes, I am used to complexity all right, but now I am just afraid of being damaged.

D: Apparently so much that you don't mind being damaged abdominally and would willingly opt for a major abdominal operation? A CS could have negative consequences for you and for your baby as well.

P: But you just acknowledged that we live in a free country in which I may make my own choices, so what about that?

D: Well, I really appreciate your agreeing to discuss the matter systematically, which we will do first. I will call this the "initial discussion." When we have finished that, I as a doctor am interested in your opinion as a lawyer about all the aspects involved and whether or not you can overlook this as a patient. This will be a secondary discussion, in order to avoid confusion.

Initial Discussion

D: In this discussion, we have to start by addressing the individual aspects. This might be a bit sensitive. How shall I put it…. If you suffered a major or even a minor complication during CS, how would you react? The more elective a procedure is, the more severe it is psychologically when a complication occurs, since you could have chosen not to have this surgery. By the way, the same counts for a complication if we end up going for a vaginal delivery. You could blame me or my team for not having performed an elective CS. Either way, this might make it difficult. Your request is not an everyday request. As you notice, there are a lot of aspects to address and discuss. Although you as a lawyer are used to addressing issues in a rational order, it might be a complicating factor for me personally if something goes wrong in our decision-making process. I understand that you fear pelvic floor dysfunction after vaginal delivery, but what if something happens during or after the Cesarean section? What if you get severe deep venous thromboembolism? How will we deal with each other? We really need to clarify all risks and benefits of both ways of delivering.

P: Yeah, I see… didn't think of it like that. I do want to trust you in what you do. I am here as, and want to be, just a pregnant mother who is nervous about the consequences of vaginal birth. But I really appreciate the way you structure the process for me. I feel that I'm being taken seriously.

D: I am glad you say that. This is a mutual process, you see. Because, after having discussed the various aspects of the principles of medical ethics, you should also know what is advised by my National Society of Obstetrics and Gynecology. We have a guideline on this issue. And the last thing that I would like to address is that I also personally need to be comfortable with the outcome, since I need to take the responsibility for your health and your baby's health.

P: But I want you to be comfortable too. What if you are not comfortable with the outcome of our discussion?

D: I hope that we'll work through this together and come to a decision we both feel comfortable with. Otherwise, I'm afraid I'll have to hand you over to a colleague.

P: Hm, you are being quite frank with me, aren't you?

D: Well, I think I have to, in order to respect your autonomy on the one hand and "do good" on the other…. If you agree to go on, shall we schedule another appointment to discuss the hard facts and figures in order for you to get to know the risks and benefits of both modes of delivery?

P: All right, let's do that. I will do my best to bring my husband as well.

D: That would be great.

D: Since this is the end of my working day, we have some more time. As I have mentioned before, as an obstetrician I am interested in your professional expertise regarding legal and ethical issues. Do you have some time left?

P: Well, yes, it is interesting that you are interested in my professional opinion as well.

D: Let's discuss this systematically as well. Yes, we all have individual rights. A person is free to decide what, where, and how he or she leads his or her life. But when it comes to medical procedures, other values need to be weighed as well. You are still an autonomous person with the wish for an operative delivery. And you need to consent to every procedure I propose. However, if you propose a treatment, I have to weigh this professionally as well. I don't want to perform an operation that would do more harm than good.

P: But I have a baby to squeeze out through such a small canal! Isn't that reasonable enough?

D: Well, I wanted to show you that with a request like this the doctor has to go through a procedure. And that is what's happened with your request too. You need me, or if not me another obstetrician, to perform a CS. I cannot just stop at the first medical ethical consideration "autonomy" and do what you ask me to do.

P: All right, I get that, but which other considerations do you have to take into account?

D: The next one is "do no harm," or "nonmaleficence," which means that the outcome we arrive at together must not harm you or your baby. The third principle is "do good," or "beneficence," meaning that the mode of delivery we choose must seem to be the best way to go in terms of minimizing risk and achieving the best outcome for you and for your baby. This means that I have to inform you extensively about the risks and advantages of both CS and a vaginal delivery.

P: I see… are these the most important ones?

D: No, there is one left, this is more a general, societal, but also an important personal criterion. The last and fourth principle is "justice." This principle lets us weigh whether a procedure, say a CS, which is a more expensive delivery than a vaginal delivery, may weigh heavily on scarce healthcare funds.

P: Wait, I'm sorry but I really don't care. This is about me and my baby. I have paid my insurance for years. So do I now get to benefit from it or not?

D: As I said, this last principle partly addresses more a societal view. If all women were to deliver operatively, this would have a huge impact on both the costs and the organization of deliveries in our country. All women would need to be delivered by obstetricians in hospitals then.

P: Yes, I see, in general… all right, that is also an aspect of course. Well… yes…in my field it is usually more about balancing facts with each other. It is difficult for me to transfer that knowledge to this situation.

D: All right, it has been a long talk already. Please think about it and we will continue at the next appointment.

P: That's fine with me.

If individuals become patients or as a result of training and choice of profession they become medical practitioners, the focus shifts from the law that applies to civil society in general to medical principles. This change from level 1 to level 2 means that different kinds of principles and criteria become relevant. Whereas level 1 centers mainly on civil rights and values (freedom, equality, etc.), level 2 concentrates on the following four ethical principles:

- The principle of respect for autonomy, a principle derived from the level 1 value of freedom.
- The principle of nonmaleficence, also known as *primum non nocere*, meaning "first do no harm," based on the level 1 value of human life as the highest good.
- The principle of beneficence, which is the original basis of healthcare delivery in the general sense. The key values are solidarity, helpfulness, mercy, and compassion.
- The principle of justice, which relates to the level 1 value of equality.

These four principles constitute the core of medical ethics and therefore also the core of this discussion. Although in many cases the four criteria reinforce each other (autonomy and the freedom of choice that goes with it are usually "beneficent" and prevent harm), sometimes contradictions may arise among the four principles. In the case of a psychiatric patient who wants to harm himself or his environment, the principle of autonomy clashes with the principle of beneficence and even more violently with the principle of nonmaleficence. However, the likelihood of contradictions increases considerably if there are different parties who have completely or partly different interests. In the case of Cesarean section on maternal request, the patient's autonomy is limited not only by the autonomy of the doctor and the medical profession but also by the principle of nonmaleficence, risk of short- and long-term complications, and justice—should scarce and expensive healthcare resources be used to grant this wish if the woman has an 83% chance of a vaginal delivery, which is much cheaper?

It is precisely at this level that the interests of everyone involved in a specific situation must be considered with the greatest care, since it is at this level that the reasoning on which the medical treatment provided will be based. The rest of this chapter will in fact focus on this level, but before we examine it in greater detail, we will take a brief look at levels 3 and 4.

25.3.3 Levels 3 and 4

Although the arguments for or against medical action are mainly at level 2, this does not mean that levels 3 (usually formulated in guidelines for the specific discipline) and 4 (personal intuition, moral judgment, conscience) are unimportant. Level 3 is important because many clinical situations do not lend themselves to formal analysis. Often the consequences of certain procedures are unknown or there is no time to complete a formal analysis. In such cases the clinician must be guided by

standards and values covered by terms such as "best medical practice" or "the clinical eye." "Best medical practice" is based on experience, either of the doctor in question or gathered and passed on by the doctor's medical discipline, set out in guidelines and protocols. "The clinical eye" is a concept that largely circumvents analytical testing; it is comparable with the intuition developed in many professions over the years. Years of experience mean that skills and clinical assessments move from being "unconsciously incompetent" before medical training, during specialist training via "consciously incompetent," to "consciously competent," and eventually to "unconsciously competent." Although it is difficult to explain, particularly to people without medical training, in practice the clinical eye plays an indispensable role.

While arguments at this level may never lead to "random" decisions, including in cases of Cesarean section on maternal request, doctors' intuition and instinct may lead to a request being reassessed and possibly discussed in a wider context (reference group) before the procedure is carried out.

The same can be said about arguments at level 4. Whereas level 3 focuses mainly on considerations that, although difficult to formulate, are clearly medical, level 4 is about arguments at the personal moral level. Although in principle every obstetrician would be able to perform Cesarean section on maternal request of arguments at levels 1–3, this does not mean that every gynecologist actually does this. Personal values and standards play an important role in practice and certainly deserve to be made explicit. Often this scope for individual choice is also set out in official guidelines, for instance, in terms such as, "Given the particular nature of the procedure, its moral implications, and the interests of those involved, the treating practitioner/team will always be free to grant or not to grant a request for XYZ for their own reasons."

Conscientious objections play an interesting role in the domain of personal values and standards. For instance, on the grounds of conscientious objection, usually closely related to religious considerations (both at level 4), a female doctor may refuse to wear short sleeves or to have certain vaccinations even though these are highly desirable for reasons of hygiene (level 2, nonmaleficence) or to comply with the guidelines of the discipline. Level 4 considerations in particular are limited by considerations of a higher order. To determine the borderlines, other criteria play a role, such as [1]:

1. There must be a serious breach of a profound and sincere conviction of the treating practitioner: The individual must also act in the same spirit in other situations.
2. The objection must be consistent with relevant empirical facts: Homosexuality is not contagious, for example!
3. There must be a plausible moral or religious reason: The individual in question must be able to give grounds for departing from the rule.
4. The procedure or treatment in question may not be an essential component of the person's work: Core tasks or obligations associated with their job may not be refused. For example, conscientious objections to in vitro fertilization (IVF) may

not play a role at a fertility clinic; individuals who have such objections can be refused a job or, if they are already employed, can be dismissed.
5. The burden on the patient must be acceptable: The patient's well-being and safety may not be compromised.
6. The burden on colleagues and the institute must be acceptable: It may not be the case that due to an individual's different standards all the burden is passed on to colleagues or the team.

In short, there is only limited scope for different standards and values at level 4 in health care. This is reasonable, since health care has an important social function that can only be achieved by virtue of a certain consensus about what is right and uniformity regarding the conduct required from treating practitioners as a result.

Case History: Continued

Marie-Anne Rose and her husband Maurice (M) attend the next appointment together 1 week later. You have scheduled double time for this consultation.

D: Welcome, Ms. and Mr. Rose. I really appreciate it that, Mr. Rose, you could join your wife for this consultation. Are you both aware of the purpose of this appointment?

M: Thank you. Yes, I think so: We're going to discuss the pros and cons of a C-section, aren't we?

D: Exactly. Let's go right ahead. Last time I mentioned the different levels that we have to address. I will go through them briefly again, so we all know where we're at. I have a template to fill in for our convenience (Table 25.1) [2–11]. The first level consists of your and the unborn baby's basic rights, the second level the medical-ethical principles (autonomy, do no harm, do good and the last one, justice). Then we'll check our professional guidelines in this respect, and last but not least, we'll take into account how you, and finally, I, feel about the decision. We'll structure the pros and cons from the assumption that we are going to perform an elective Cesarean section.

Having written down all these issues on a paper, Marie-Anne sighs.

P: When I see it laid out like this, I must say that although there is an increased chance for prolapse and incontinence, I didn't realize that my baby would also be at risk from a CS. This neonatal intensive care unit admission didn't cross my mind. On the other hand, I certainly don't want to have a forceps delivery.

D: Well, it is very good that we have put all the risks on a spreadsheet. It seems to make it clearer, doesn't it?

P: Yes, it does.

M: Yes, it is also clearer for me.

P: So, my fear of suffering a prolapse…. There's a 2.2 % chance of this with a vaginal delivery, as compared to 0.2 % with a Cesarean.

D: Yes, that's right.

P: And the chance that my baby will end up in NICU is around 14 % as compared with around 6 % following a vaginal delivery.

D: Yes, it is.

P: So that is a much higher chance than my risk of a prolapse….

D: Yes, but it is about weighing things against each other.

P: I think—don't you, Maurice—reading this… I may go for a vaginal delivery, but I certainly don't want a forceps delivery. In such a case I would like to have a vacuum extraction or a Cesarean anyway.

Table 25.1 The pros and cons on Cesarean section on maternal request

		Pros on Cesarean section	Cons on Cesarean section
Level 1: Values by law		Freedom of autonomous choice for women who want to opt for elective Cesarean section (CS). Right to decide about own body	Given the professional autonomy of the medical professional there is no "freedom" as meant in level 1 as soon as somebody becomes a patient Full autonomy for patients may encourage commercial clinics that offer only CS on maternal requests, which is not desirable Allowing full freedom for maternal CS on request may give rise to socially unacceptable higher rates of CS in the population Contradiction or tension with other ethical principles addressed at level 2
Level 2: Medical ethical principles	Autonomy	Experience autonomy Women's birthing experience is important and goes along with women's satisfaction and experiences of care Do something, defending one's own interest, or even "rights" Desire of women to be able to decide for themselves	The health professional also has an autonomous choice in light of his/her professional standards Not delivering a baby by oneself but "being delivered by the doctor" Too strong a dependence on healthcare providers Once started, there is no way back Much more burden than expected Different delivery from most women Feelings of guilt, because this solution contributes to decreasing acceptance of vaginal delivery (VD) Feelings of guilt when complications occur

(continued)

Table 25.1 (continued)

		Pros on Cesarean section	Cons on Cesarean section
	Beneficence	1–4 % chance of third-degree perineal tear as compared to 0 % with CS [2] Long-term (20 years postpartum) problematic incontinence 11.2 % after VD versus 6.3 % after CS [3] Lifetime prolapse surgery is more frequent in women after VD (2.2 %) versus CS (0.2 %) [4] Forceps delivery gives the highest chance on lifetime prolapse surgery (14.3 %) [4] Levator defects have been found in 15.4 % of women with VD in history [5] Women with planned CS reported a higher satisfaction score regarding birth experience 2 days after birth compared with women having a planned vaginal birth and this effect remained 3 months postpartum [6] Potential short-term maternal benefit: less maternal hemorrhage [7]	Risk of fecal incontinence is not more prevalent in women after VD as compared to after CS (6 % in all women), except for women who underwent forceps delivery in which the risk for fecal incontinence doubled [8] After CS there is a 20 times higher chance of wound infection as compared to vaginal delivery [9] After CS a ten times higher risk of endometritis (8 % in CS versus 1–3 % for a vaginal delivery) [6] After CS, 2 times higher risk for deep venous thrombosis and pulmonary embolism (0.03 % in VD versus 0.06 % in CS), but in other study no difference was found [6] After CS 0.2–1.5 % versus almost 0 % uterine rupture in next pregnancy with 1.2 % chance for perinatal death in case of uterine rupture [10] After CS 0.65 % versus 0.26 % for subsequent placenta previa with 0.16–0.3 % versus 0.004–0.01 % risk for placenta accreta/increta/percreta in general. This condition increases the risk for postpartum hemorrhage, sometimes necessitating emergency hysterectomy with increased risk for severe maternal morbidity or sometimes mortality [10] More women who had a planned vaginal birth were breastfeeding at 3 months postpartum compared with women who had a planned CS. This finding was statistically significant [6]

Table 25.1 (continued)

		Pros on Cesarean section	Cons on Cesarean section
	Nonmaleficence	Good monitoring of the process from indication to operation, so the patient feels taken seriously and also feels the possibility to say "no," even under peer pressure Prevention of commercial practices in private clinics	Protection of people against themselves when they have insufficient notion of the risks to be expected in this medical or psychological area NICU admission more prevalent in CS (13.9 % versus 6.3 %) as compared with vaginal delivery [6] Patronizing, limiting autonomous choice Possibly going for a vaginal delivery that will cause harm to the mother, due to pelvic organ damage, third- or fourth-degree perineal tears with lifelong consequences CS inevitably leads to abdominal scarring, which increases the risk for hematomas, wound infections, neurinomas, and unaesthetic scarring that may need plastic surgery later in life
	Justice	Insurance fees have been paid, so the insurance has to pay for it Obstetricians have the professional right to decide what is right for their patient	Costs as calculated by the NHS: the costs of birth and "downstream" costs found that a planned vaginal birth was approximately £ 700 cheaper than a maternal request CS [6]

(continued)

Table 25.1 (continued)

		Pros on Cesarean section	Cons on Cesarean section
Level 3: Best medical practice (WHO 2015, NICE guideline 2011, ACOG committee opinion 2013)		When a woman requests a CS, explore, discuss, and record the specific reasons for the request [6] If a woman requests a CS when there is no other indication, discuss the overall risks and benefits of CS compared with vaginal birth and record that this discussion has taken place. Include a discussion with other members of the obstetric team (including the obstetrician, midwife, and anesthetist) if necessary to explore the reasons for the request and to ensure the woman has accurate information [6] For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS [6]. An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS [6]. In cases in which CS on maternal request is planned, delivery should not be performed before a gestational age of 39 weeks [7]	CS are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons [11] CS should ideally only be undertaken when medically necessary [7, 11] The effects of CS rates on other outcomes, such as maternal and perinatal morbidity, pediatric outcomes, and psychological or social well-being, are still unclear. More research is needed to understand the health effects of CS on immediate and future outcomes [11] Standard antibiotic treatment during CS is required, which may increase the already evolving threat of antibiotic resistance of bacteria If a woman requests a CS when there is no other indication, discuss the overall risks and benefits of CS compared with vaginal birth and record that this discussion has taken place. Include a discussion with other members of the obstetric team (including the obstetrician, midwife, and anesthetist) if necessary to explore the reasons for the request and to ensure the woman has accurate information [6] When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner [6] Ensure the healthcare professional providing perinatal mental health support has access to the planned place of birth during the antenatal period in order to provide care [6]

Table 25.1 (continued)

		Pros on Cesarean section	Cons on Cesarean section
Level 4: Doctor's own norms and values and norms		In general, there is more lifetime risk of prolapse and incontinence Third-degree perineal tears will not occur in CS	Absolute lifetime risks for prolapse surgery and incontinence are low and CS is not completely protective against prolapse and incontinence CS is more expensive and weighs more on scarce healthcare funds NICU admission more prevalent in CS

CS Cesarean section, *VD* vaginal delivery, *WHO* World Health Organization, *NICE* National Institute for Health and Care Excellence, *ACOG* American Congress of Obstetricians and Gynecologists, *NICU* neonatal intensive care unit, *NHS* National Health Service

D: I think that is a reasonable request. We can make a birth plan and put this in it, so the whole team knows where you stand. And I will record the issues we just have discussed.

P: All right. I think I am fine with this. It's a bit strange to change my opinion. But it has been very helpful to record the pros and cons systematically. Thanks!

D: You are very welcome! Let me summarize the process we have participated in. You entered my office with an explicit wish to deliver by Cesarean section. Together we've discussed the different aspects and pros and cons of a Cesarean for your personal situation. And together we've found out that the risks of a Cesarean in general are not outweighing the advantages of a vaginal delivery. Is that correct?

P: Yes…that's correct.

D: All right, whenever you or your husband has any questions or doubts, please let me know. We'll see how the rest of your pregnancy proceeds. In the end, most women deliver vaginally in good health.

P: I hope so….

D: We'll be taking care of you as much as we can to support you!

25.4 Applying the Principles

In this section we will apply the various principles of medical ethics to the dilemma of CS on request. The pros and cons of CS on maternal request are illustrated in Table 25.1 under level 2.

In this area the most important changes in arguments at ethical levels occur at levels 1 and 2, since some of the people involved do not perceive themselves as patients. They are not and do not feel ill and can usually function as full members of society (level 1) but are now being treated as "patients" at level 2 because the procedure involved is surgery. So why all this patronizing? The fact is that as

regards autonomy, a surgical procedure—and with it access to medical resources—inevitably entails stepping down from level 1 to level 2. This means that in general the limitation in autonomy as a result of, or for the purpose of, a CS on request is accepted and felt to be reasonable, in spite of the emotional objections it may evoke.

We will discuss the medical ethical principles in greater detail in the following sections.

25.4.1 Autonomy

Although the state exercises some control over people's behavior, in the Western world it is very reticent to do so. In terms of autonomy in relation to giving birth, it is important to notice that there is a difference between positive and negative liberty. Positive liberty is the freedom to fulfill one's owns wishes, e.g., to give birth in the way a woman wants. Negative liberty is the freedom from external restraint, e.g., a gynecologist who points out the dangers of a CS. Women who are going to give birth have to rely, for the fulfillment of their wishes, on one or more third parties, such as medical practitioners and health insurers. As soon as an individual turns to a gynecologist for medical treatment as a patient, that individual's autonomous position as a member of society (at level 1) lapses; they have now become a patient at level 2. In doing so they have "voluntarily" relinquished the core values at level 1 and must now comply with the frame of reference at level 2. The medical practitioner is now also in charge and the patient can no longer claim his or her rights as a consumer: "I ask; you do what I say" or, from the doctor's point of view, "Your wish is our command." Practitioners can certainly aim to retain level 1 rights as much as possible. The argumentation (both pros and cons) contains frequent references to level 1. However, once the doctor has become "the boss," he or she has a duty to respect the autonomy of everyone involved and is responsible for observing this respect with due regard for other ethical principles (including those at level 2). Since several parties are involved—mother and fetus, including, in the background, the medical discipline in question and civil society—this is no easy task. Safeguarding autonomy for all parties with due regard for other principles makes high demands in terms of time, energy, and communicative skills.

25.4.2 Beneficence

The intention of a CS on request is for it to contribute to the patient's well-being and that of her fetus or perhaps more accurately for it to remove an obstruction to well-being. It has been shown above that this view is too limited: the well-being of the patient's environment, society (including future patients), and treating practitioners, who may not be harmed either. It is only if this criterion is met that a practitioner can agree to a CS on request.

25.4.3 Nonmaleficence

The motto *primum non nocere* ("first do no harm") seems simple, but in fact it actually raises many problems. Another motto—*in dubio abstine* ("if in doubt, refrain")—is also apparently hard for many practitioners to adhere to. The term "interventionism" is sometimes used to refer to the idea that it is easier to do something than to do nothing and have nothing to offer. One of the factors involved here is that "doing nothing" can be interpreted in different ways. Whereas doctors and nurses ask if they can do anything for the patient, psychologists and chaplains ask how they can help. Different considerations have to be constantly weighed against each other to ensure the best outcome for the patient. This is why the role of the principal treating doctor is so important. He or she is in charge of the treatment process and usually also the person who, in the case of a CS on request, will be performing the actual procedure. The principal treating doctor is responsible both as a representative of the discipline and as the individual with the ultimate responsibility for carrying out the procedure. It is a good idea for the principal treating doctor to seek sound advice from the multidisciplinary team regarding nonmaleficence, as this is the best way to guarantee that opinions are formed with due care and that decisions regarding ethical dilemmas are evidence based and supported by society.

25.4.4 Justice

In many countries in the world, Cesarean sections on request are carried out on a large scale. Several arguments can be derived from the principle of justice for and against the standard introduction of an option for a CS on request.

In the past, if someone was pregnant, then—depending on the person's view of life—that was the will of God, a quirk of nature, or karma. This is an outdated view, given that semen processing, intracytoplasmic sperm injection (ICSI), tubal surgery, intrauterine insemination (IUI), in vitro fertilization (IVF), reconstructive surgery after sterilizations, egg donation, and in some countries high-tech surrogacy in certain conditions are used to fulfill people's desire for children. So why should a woman not be able to decide for herself how she wants her child to be born?

The UK National Institute for Health and Care Excellence (NICE) guideline on Cesarean section stipulates that a treatment team is always free, after extensive counseling about the pros and cons of a CS on request, to ultimately agree to a request for a CS [6].

25.5 Assessment

After identifying all possible values and standards and then selecting them according to relevance, the next question to answer is how to arrive at a balanced assessment on the basis of the remaining values and standards. A handy way to compare arguments is the two-column technique [12]. You make two columns on a sheet of

paper or a digital spreadsheet with the headings “advantages” and “disadvantages.” Then you fill these columns in with the values and standards remaining after your selection. If it turns out that in your first selection you forgot one or more arguments or wrongly discarded them, you can still add such arguments in your two columns at this point. Then you rate all the arguments, both pros and cons. This makes it clear where your focus must be in your ultimate assessment and what you can regard as “secondary” advantages or disadvantages. Secondary matters are not necessarily unimportant; they may play a decisive role if there is a “draw” as regards key issues. This results in a complex hierarchical framework in which the arguments (pros and cons) and their relative weights become apparent, including any tensions that may exist between them.

Pros and cons of CS on maternal request are illustrated on the different levels in Table 25.1 [2–11].

25.6 Decision-Making

When all the arguments have been identified and selected for true relevance and the pros and cons have been rated, the next step is to arrive at a rational final assessment. In an ideal situation, at least in terms of the Western Enlightenment tradition, a well-considered decision is made as follows:

- Clarify the nature of the dilemma: Give an explanation about the problem situation and the need to make a decision. In our case it is about performing or not performing a CS when there is no medical indication.
- Identify possible options: In principle this situation is about an elective CS as opposed to a normal vaginal delivery.
- Assess the options in terms of pros and cons.
- Make a final choice.
- Make arrangements for the implementation of the decision that has been made.

25.7 Discussion and Final Remarks

The multistep model discussed previously assumes that people can take time to make a choice or reach a decision and that they have all the information they need to do so. Reality is different, partly because the prior sketched-out model of well-considered decision-making, based on the Western Enlightenment tradition, is not always the dominant culture. Moreover, usually decisions are made on the basis of a limited amount of information and certainly not always after careful considerations of all the pros and cons. Furthermore, emotions often play a distorting or obstructive role that makes it difficult to weigh effectively. Interestingly enough this all may lead to a new kind of psychological coping mechanism: anticipatory prevention of remorse or regret [13].

Tips and Tricks

In order to help patients make their own decisions in a sound way, a few guiding principles should be kept in mind, such as:

- If you are a midwife and you are carrying out antenatal checks, it is important for you to pick up what a pregnant woman wants in good time. Then you can discuss this with a gynecologist you have a good working relationship with so that a referral can be given at a point when the gynecologist still has enough time to have the conversation with the pregnant woman.
- Decision-making is a process that often takes place collectively. Avoid being forced—for instance, through time pressure or emotional pressure—to act in a single moment. Take the time and make sure you have an adequate sounding board. This is why you should spread the decision-making across several consultations and ensure that information provision is a coordinated team activity.
- Solutions do not appear out of the blue. They are based on information from an analysis of the problem. Often these steps are intertwined. After an initial orientation, solutions are devised and choices considered. On the basis of these ideas you can gather new information for further analysis. Then you can reject some choices, modify solutions, or come up with new alternatives. For you this means that you have to take care that you are not deluged with information, but gather it carefully, guided by the questions you still have. In this way you can create time and space to get to the bottom of the dilemma and the need for a decision.
- Every decision is preceded by an assessment of the pros and cons of the possible solutions. Even if only one solution is left, because all the alternatives have been eliminated, you will still have to opt for this solution yourself.
- Remember that conditions are attached to every conclusion or choice. Sometimes, unfortunately, they only become visible when you know what you want, and sometimes that may lead to reconsideration.
- Once you have all the facts straight, in theory making a decision should be a piece of cake. If the patient and you have a clear pro or a clear con, it is obvious what she should do. If you end with a "draw," it is even easier: Apparently it does not matter what is chosen. Flipping a coin may be helpful.
- Another factor that sometimes makes it hard to decide is when there is a heterogeneous group of stakeholders. In principle you repeat everything set out above at a slightly higher aggregation level, with conclusions from the points of view of those involved (the patient, the individual treating practitioner, the discipline or disciplines in question, and the civil society) as the input.

Acknowledgment Based on the thesis of the third author: Dermout SM. De eerste logeerpartij, hoogtechnologisch draagmoederschap in Nederland. University of Groningen (RUG), The Netherlands; 2001.

References

1. Bolt I, van Dijk G. Ruimte voor gewetensbezwaren is beperkt. Medisch Contact. 2015;7:300–2.
2. Fernando RJ, Sultan AHH, Kettle C, Thakar R, Radley S. Methods of repair for obstetric anal sphincter injury. Cochrane Database Syst Rev. 2006;3:CD002866.
3. Gyhagen M, Bullarbo M, Nielsen TF, Milsom I. A comparison of the long-term consequences of vaginal delivery versus caesarean section on the prevalence, severity and bothersomeness of urinary incontinence subtypes: a national cohort study in primiparous women. BJOG. 2013;120(12):1548–55.
4. Leijonhufvud A, Lundholm C, Cnattingius S, Granath F, Andolf D. Risks of stress urinary incontinence and pelvic organ prolapse surgery in relation to mode of childbirth. Am J Obstet Gynecol. 2011;204(1):70.
5. Dietz HP, Steensma AB. The prevalence of major abnormalities of the levator ani in urogynaecological patients. BJOG. 2006;113:225–30.
6. Royal College of Obstetrics and Gynaecology (RCOG). UK National Institute for Health and Care Excellence (NICE) clinical guideline on Caesarean section (CG132). 2011. https://www.nice.org.uk/guidance/cg132.
7. ACOG Committee on obstetric practice. Cesarean delivery on maternal request. The American College of Obstetricians and Gynaecologists; 2013 Apr. Report No.: 559.
8. Macarthur C, Wilson D, Herbison P, Lancashire RJ, Hagen S, Toozs-Hobson P, ProLong study group, et al. Faecal incontinence persisting after childbirth: a 12 year longitudinal study. BJOG. 2013;120(2):169–78.
9. Smaill FM, Gyte GML. Antibiotic prophylaxis versus no prophylaxis for preventing infection after cesarean section. Cochrane Database Syst Rev. 2010;1:CD007482.
10. Dutch Association for Obstetrics and Gynaecology. Dutch Guideline on Pregnancy after previous Caesarean Section. 2010.
11. World Health Organization. WHO statement on caesarean section rates. Geneva: World Health Organization (WHO); 2015.
12. van de HB W, Wouda J. Communicatie in de palliatieve fase. Houten: The Netherlands: Bohn Stafleu Van Loghum; 1999.
13. Het imperatieve karakter van de medische technologie en de betekenis van geanticipeerde beslissingsspijt. Nederlands Tijdschrift voor Geneeskunde. 2015;131(26):1128–31.