



MATERNAL AND NEWBORN CARE

Cesarean section by choice: Constructing a reproductive rights framework for the debate[☆]

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Abstract The question of cesarean section by choice (that is, cesarean delivery in the absence of medical indications) has been hotly debated by the obstetrical profession in recent years. The debate has focused around questions of risks and benefits, and has revolved around questions of obstetrical practice. In this paper, the question will be framed in a reproductive rights context. How does the phenomenon of CSBC (cesarean section by choice) impact women's empowerment? Which reproductive rights might be affected by this question, and what policies are related to its use? FIGO's 1998 statement "Ethical Aspects regarding Cesarean Delivery for Non-Medical Reasons" is revisited, and, in light of these considerations, its contents are endorsed once again.

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1. Introduction

1.1. The phenomenon of cesarean section by choice

In recent years the proportion of deliveries carried out by cesarean section has risen substantially around the world. According to the World Health Organization (WHO), rates increased from 5–7% in

the early 1970s to 25–30% in 2003 [1]. The latest available figures suggest that this trend is continuing. In Canada in 2000, with 330,000 deliveries per year, this means that somewhat less than 100,000 babies were born by cesarean section (C-section) [2], making it the commonest surgical procedure in Canada today. Globally, the numbers are staggering, and, in fact, are more marked in many other countries than it is in Canada. In private hospitals in parts of Latin America, the C-section rate has reached well over 50% [1], and this brings with it a troubling concept in the way birth is viewed: If the majority of births are by cesarean section, what is a 'normal' birth? [3].

Many experts have studied this increase in an attempt to understand the factors responsible for it. Certainly, the proportion of breech babies

[☆] For purposes of this paper, Cesarean Section by Choice (CSBC) refers to cesarean delivery performed for non-medical reasons. Other terms used for this include Cesarean Section on Demand, and Patient-Choice Cesarean Section.

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born by C-section has increased following the release of the Term Breech Trial, which suggested that C-section was safer than vaginal delivery for breech presentations [4]. Also, as the use of forceps has decreased [5]; C-section is now considered the safer alternative for many deliveries even when full dilatation has been reached. Despite these seeming explanations, there remains a significant proportion of the increase in C-section rate that is unaccounted for by obstetrical factors [4,1].

Maternal choice has played an increasing role in the rising cesarean section rate. Trying to quantify the exact proportion of maternal choice C-sections has been difficult in many places, because maternal choice is not widely recognized as an indication for C-section, and as a result, cases are often booked under other diagnostic categories [4]. The reasons behind this phenomenon are complex, and involve social, cultural aspects. Commonly cited reasons include [3]:

1) fear of pain in labor; 2) uncertainty of outcome and fear of emergency intervention such as forceps; 3) fear of fetal distress in labor; 4) fear of future sexual dysfunction, stress incontinence or pelvic prolapse; 5) convenience.

A significant body of literature has reviewed the risks and benefits of cesarean versus vaginal birth. The issues raised are complex, and involve balancing a number of competing interests, in an ever-changing field of evolving information [6–8].

2. Women's empowerment, and reproductive rights in the CSBC debate

The debate about CSBC is occurring in a time when much emphasis is placed on women's empowerment, and sexual and reproductive rights. Women's empowerment, as defined by the Safe Motherhood Interagency Group [9] means 'ensuring that women have an equal place within society so that they have equal access to income, education, health care and other resources and where they can make free informed decisions about their lives in a safe environment.' The Framework of Sexual and Reproductive rights published by IPPF [10] and endorsed in 1995 by a number of international bodies includes a number of rights that are pertinent to decision-making about birth generally, and the CSBC debate in particular. These include, but are not limited to: 1) the right to life and survival; 2) liberty, security, autonomy and confidentiality; 3) information and education; 4) highest standard of

health care and protection; 5) equality and non-discrimination. Ideally, the debate on CSBC must incorporate all these principles, applying the overarching principle of beneficence in a way that will assure that women's empowerment is maximized.

3. FIGO's position on CSBC

In 1998, FIGO presented its position on this question. Entitled "Ethical Aspects of Cesarean Delivery for Non-Medical Reasons", this paper was also included in the Ethics Handbook in 2003 [11]. It states:

1. The medical profession throughout the world has been concerned for many years at the increasing rate of cesarean delivery. Many factors, medical, legal, psychological, social, and financial have contributed to the increase. Efforts to reduce the excessive use of this procedure have been disappointing.
2. Cesarean section is a surgical intervention with potential hazards for both mother and child. It also uses more resources than normal vaginal delivery.
3. Physicians have a professional duty to do nothing that may harm their patients. They also have an ethical duty to society to allocate health care resources wisely to procedures for which there is clear evidence of a net benefit to health. Physicians are not obligated to perform an intervention for which there is no medical advantage.
4. Recently in some societies obstetricians have had increasing requests from women to be delivered by cesarean section for personal rather than medical reasons.
5. At present there is no hard evidence on the relative risks and benefits of term cesarean delivery for non-medical reasons, as compared with vaginal delivery. However, available evidence suggests that normal vaginal delivery is safer in the short and long term for both mother and child. Surgery on the uterus also has implications for later pregnancies and deliveries. In addition, there is also a natural concern at introducing an artificial method of delivery in place of the natural process without medical justification.
6. Physicians have the responsibility to inform and counsel women in this matter. At present, because hard evidence of net benefit does not exist, performing cesarean section for non-medical reasons is not justified.

4. FIGO professional and ethical responsibilities concerning sexual and reproductive rights and their application to cesarean section by choice

The FIGO Statement of Reproductive and Sexual Rights [12] endorses the principles of medical ethics, namely, beneficence, non-maleficence, autonomy and justice, as being derived from and consistent with human rights. As such, FIGO members are entreated to adopt and promote certain responsibilities. Certain of these are clearly germane to the CSBC question. These include maintaining the highest level of professional competence, assuring conduct that promotes the dignity and security of every woman, refusing to accept practices that violate human rights, and maintaining the highest standard of integrity and honesty. To maximize women's autonomy, FIGO members must support a decision-making process free from bias and coercion, assure respect for women's individual judgment and not only that of their partners or family, and adhere to the principles of non-discrimination. As well, FIGO members must advocate for the rights of women to information and education, and for appropriate resources to ensure the right to the highest attainable standard of care.

Let us now examine the central ethical principles of the debate, and consider the interface with a reproductive rights perspective. The ethical issues central to the debate are the health care provider's duty not to harm (non-maleficence) and to benefit (beneficence) the patient, and patient autonomy. Reproductive rights and these more general ethical principles are intimately intertwined and, when well-applied, will each strengthen the other.

4.1. The right to life and survival

The right to life and survival embodies a woman's right not to be harmed by, or have her chance of survival decreased by, a given procedure. The duty not to harm and to carefully weigh risks and benefits is central to the CSBC debate. To date, the evidence regarding risks and benefits is incomplete, and, given the variability of individual situations, difficult to interpret. At any point in time, we must work with the best possible information we have, realizing that there are many unanswered questions, and that our understanding of the risks and benefits will continue to shift over time.

The risk/benefit equation has been particularly problematic in this instance. This is not surprising

when one considers the complexity of the situation. Many variables influence the outcome for any given woman, and attempts to give a simple numerical risk to any one complication or outcome may not be possible. However, almost all literature suggests that the risk of complications increases with increasing rates of surgical intervention. We therefore must move the discussion beyond a simple litany of possible risks and benefits. This is a complex question, and we should strive to understand it on the basis of its complexity, not expecting to find a simple answer. Since the right to life and survival of the patient imposes a strong duty on the physician, the lack of clarity about risks should make us unwilling to accept CSBC. The benefits must be very strong indeed to allow subjecting the patient to unknown risks even if the patient is willing to make a choice in the dark.

4.2. The right to liberty and autonomy

Autonomy and informed choice is the other central ethical issue in this debate. It includes negative rights (rights to remain free from interference by others) and positive rights (rights to be given something.) Patient autonomy includes the negative right of a competent person to refuse a treatment or procedure. This is related to the duty of a physician to do no harm. There is also a positive right of the patient to access treatment. There is definitely an asymmetry to these rights, with the negative right to refuse treatment being stronger than the positive right to access treatment. If in a particular case the risks outweigh the benefit, the negative right (non-maleficence) is the dominant consideration.

Where a positive right to treatment exists, it goes well beyond autonomy construed as a negative right, freedom from interference. This positive right is not automatic and depends on a number of factors, including the rights outlined above, as well as beneficence and distributive considerations. A positive right to treatment imposes corresponding duties on physicians to provide the treatment.

The distinction of negative from positive rights in this context would benefit from illustration. For instance, a right to remain unharmed may be stronger than a right to be helped. Thus the physician's duty not to harm a patient by an unnecessary surgical procedure may outweigh the duty to help the patient by giving the patient a procedure the patient wants. Consider a non-obstetrical example. Suppose a patient, Mr. P, has suffered a knee injury on the job. His employer has insurance that will pay for a surgical procedure as

well as lost wages. His physician, Dr. D., believes that if the patient simply gives the joint time and physiotherapy, the injury will heal. Mr. P. will receive no compensation from his insurance for time off with physiotherapy, as it only covers post-operative recovery. Mr. P's wife and employer are putting considerable pressure on him to accept the surgery. The risks and benefits of this procedure are not entirely clear, but the surgery has a somewhat lower success rate than the long, slow course of physiotherapy. Dr. D. believes that the surgery is not medically indicated and could possibly harm the patient. Surely Dr. D. would not be morally obligated to perform the surgery simply because the patient chooses surgery. Patient autonomy does not extend so far as to give Mr. P. a positive moral right to this surgery. Beneficence in the sense of a positive right to be helped may well be outweighed by non-maleficence, the patient's negative right to remain unharmed. There are also serious questions about Mr. P's free and informed consent to the surgical procedure. His choice seems forced by others. These considerations relieve Dr. D. of any duty to perform surgery. The right of the patient to decline the surgery if Dr. D proposed it, however, would still impose a duty on Dr. D. to refrain from treating Mr. P.

The physician must not use power and influence to force the patient's choice. The weaker, yet still very important positive rights to support are, nonetheless, needed to fill out the picture. The physician's obligation is not simply to stand back and let the patient choose, but to attempt to ensure that the patient has the support needed to make a choice that is genuinely her/his own. The mere existence of a choice is no guarantee of self-determination. Even if the negative part of the right to autonomy is met there are positive rights under that banner that may still affect the acceptance of CSBC. This brings us to our next point.

4.3. The right to information and education

Patient autonomy also includes the positive right to be informed about the risks and benefits of a procedure and to voluntarily consent to the procedure in the light of the relevant information. A physician has an obligation to present all relevant medical data to a patient to help her/him make a decision that is in her/his best interests. But this should be part of a process of open dialogue between patient and physician, one based on trust and mutual respect. It also assumes that there is good, non-biased and reliable information available to be shared with the patient in question, and that it be presented in a neutral, non-hierarchical and non-coercive fashion.

It is also our responsibility, as outlined above, to assure that women have the best available information, and that they do not make biased or coerced decisions. Surely, then, if a woman requests a C-section due to fear of pain in labor, for example, it is our duty to address her fears and counsel about available pain control options. If a C-section is requested for fear of fetal distress, it is our responsibility to counsel her that vaginal birth is safe for the vast majority of babies, and that C-section may bring with it its own risks to the baby.

Beyond information, ideal care would include emotional and social support to counter some of the oppressive forces now driving requests for C-sections. For example, women may be forced to request C-sections by husbands who believe their wives' sexual function will be impaired by normal delivery. Social structures that accentuate the positive and empowering nature of childbirth need to be strengthened. Positive rights to information, education and empowerment are embodied within the sexual and reproductive rights framework, and should be actively pursued as part of our responsibility as advocates for women. In its comments on empowerment of women, FIGO accepts the duty of the medical profession to promote the needed social change to approach this ideal. It also commits us to improving the conditions under which women give birth around the world. Empowerment and adequate support might greatly reduce the apparent attractions of CSBC.

4.4. The right to the highest standard of health care and protection

In a technological age, the highest standard of care is often confused with the most technologically advanced care. Yet the two are clearly not be the same. In places where cesarean rates have risen sharply, there are more complications. Temporally, as the C-section rate has risen, so have the rates of adverse events. The ideal rate for C-section may be subject to dispute, but most would agree that present rates in many parts of the world are too high. For pregnant women, the highest standard of care may well be that rate which affords emergency intervention when required, but supports natural processes for the vast majority of births.

4.5. Equality and non-discrimination

It may seem obvious that the principles of ethics be equally applied to women, but globally, this is not always the case. We still find decision-making in obstetrics often bypassing these basic tenets. By invoking the right of equality and non-discrimina-

tion, we insist that the same consideration must be given to women patients, whether or not they are pregnant.

There is, however, an important distinction between autonomy (choice) understood as a negative right, freedom from coercion, and self-determination. To be truly self-determined, an individual has to be fully empowered, and aware of all available options. A fully empowered woman, therefore, will make her choice understanding the benefits of vaginal delivery, having confidence in her body, not facing economic pressure, and not being worried about possible cosmetic effects. A fully empowered woman will consider her bodily integrity, and her life-long reproductive career, along with other aspects of her physical, spiritual, social, and cultural well being. It becomes apparent that optimizing obstetrical care involves advocating for (original word) more than surgical excellence. It involves creating and supporting all the structures needed to ensure empowerment, from good antenatal care, to reasonable maternity benefits for women.

Embedded within these principles are wider, and perhaps more amorphous questions of human rights. Specifically, how do we, as physicians, assure that we maximize respect for the reproductive and sexual rights of our patients? Would that not mean championing autonomous decision-making on the part of our patients? It would, at first glance seem obvious that allowing CSBC as an additional choice would actually expand the choice of women, and therefore be empowering, but genuinely free and informed choice does not come from simply adding alternatives.

5. Applying reproductive rights: summary

In general, when we consider the rights related to reproduction that have been recognized by FIGO, we see that CSBC is not supported as a right derived from these human rights. Indeed, it is a practice that may well be contrary to the best interest of women, and to the duties of the physician in the majority of cases. The strongest right remains that of life and survival, the corresponding duty being non-maleficence.

6. Feminist thoughts on CSBC

The control of reproduction has been a central theme of feminist writings for decades. At the center of much of the writing is the concept that

‘the personal is political.’ In other words, we must interpret our own experience in the cultural context in which we live, but at the same time recognizing that what happens to women’s bodies happens to women generally. Addressing the question of new reproductive technologies, ‘Our Bodies, Ourselves (1994) says, “We must judge the value of technologies in the context of the social, political and economic setting. Medical procedures are to be evaluated not on the benefits they bring to individual women, but on the political effect they have on women as a class. Medicine is no longer a scientific matter: it belongs to ideology” [12].

Questions of birth, including its management and control, have also been widely discussed in feminist literature. Mary O’Brien’s *Politics of Reproduction*, 1981 is one of the classic works [13]. The concept of birth and motherhood as ‘production’, worthy of economic compensation arises as a central theme in her work. Many feminist writers have, moreover, criticized the obstetrical literature for its tendency to ‘disembody’ pregnancy, that is to think of the uterus as a vessel for reproduction without truly considering the humanity of the woman involved. There is ample evidence that this tendency exists, although more recent obstetrical work strives to correct this error and move toward a more materno-centric view of pregnancy. Nonetheless, the concept of mother as vessel may have been a requisite precursor to the CSBC debate.

With the advent of many new technologies the question arises as to their effect on choice. Susan Sherwin addresses this issue in her essay, “Feminist Ethics and In Vitro Fertilization” [14]. She argues that, although IVF may benefit some women, the desire for infertility services emerge from social arrangements that are deeply oppressive to women. Women, she argues may feel coerced to undergo these technologies, as opposed to accepting their infertility.

One can see that the same concerns about social determinants of the woman’s choice could arise in the question of CSBC. If a woman did not request a C-section, or refused one if offered by her physician, is she morally responsible if a fetal problem does ensue? Does that same scenario hold for the practitioner who refuses to honor a request for a C-section? Is this true even if statistically a poor fetal outcome is very unlikely at vaginal birth? In that case, could a woman be coerced into accepting an unwanted C-section? If so, the very existence of the option may create a problematic ethical dilemma, and may in fact, restrict the freedom with which choice can be made. Even if women

are able to avoid such obvious coercion, it is not unlikely that a woman would be severely criticized for choosing a natural birth over C-section if there were a poor fetal outcome. The social pressures such criticism induces may overwhelm women's self-determination.

7. The human face of the debate

It is useful to think of actual scenarios, similar to those that we may have encountered in our practices, to illustrate these points.

7.1. CSBC based on personal preferences

Consider a young woman with a career who wants to schedule birthing to be minimally disruptive. She believes that C-section will interfere less with her schedule than the uncertain onset of labor. To be truly informed, however, she would have to factor in the longer recovery time, and the possibility of complications in future pregnancies, neither of which may have been included in the informed consent process in her doctor's office. Her partner believes that it is in his interest that she has a C-section; as he thinks that his wife's sexual function will be better preserved, although this supposed fact as well is not supported by the literature [15]. This dual pressure may be very difficult for this or any woman to face. How well informed can her choice be if she is encumbered by such pressures? She is, in certain relevant respects, in the same position as Mr. P. in our earlier example.

7.2. CSBC from a clinician-centered perspective

Consider the case of a clinician who receives a request for CSBC from a woman whose insurance will only cover her medical costs and recovery time if surgery is done. As in the case of Mr. P. and the joint replacement that we considered above, CSBC may well involve pressures on the physician to perform a C-section not because it is medically indicated but because it is in the financial interest of both the patient and himself.

Consider another scenario that commonly arises. A patient who desperately wants her own doctor to be involved in her delivery requests a C-section be done prior to his departure to an international meeting. A CSBC could be scheduled to suit the patient and the physician. While this may be very tempting, it seems obvious that it may not be in

the best interest of the woman, and that appropriate support could empower her to seek better alternatives.

7.3. CSBC from a societal perspective: influence of media and popular culture on choice

Women are beset by powerful social pressures from partners with uninformed ideas about sexual function following natural childbirth and from movie stars promoting C-section as a mark of the rich and famous. If the rich and powerful choose it, it must be somehow preferable in the minds of those influenced by the star system. The caché of CSBC and its effect on the public psyche are dangerous to a truly informed choice.

A related point is that body image is a commodity in some cultures in the developed world. Plastic surgery may be marketed with CSOD. The prevalence of anorexia is an indication that the selling of the nulliparous young woman as the feminine ideal is truly successful. This too muddies the waters where information for pregnant women is concerned. Medicine should not be an ally of these forces but ought to provide a countervailing set of supports on the side of genuine choice. This is consistent with the FIGO statement on empowerment of women and consistent with the goals of education and information, as well as equality and non-discrimination.

7.4. CSBC: a global perspective

In 1995 when the IPPF drafted its framework for Reproductive rights, it was aimed above all at redressing some of the inequities that still plague the women of the world. It aimed to address the roots of the vast disparity of maternal mortality between the developed and developing world. In countries such as Canada, the maternal mortality rate is stable at around 4–5/100,000 where as in certain African countries the rate still hovers around 1000/100,000, partly because of a global maldistribution of resources. Those who strive to lower maternal and infant mortality around the world are working toward the implementation of basic emergency obstetrical care for all women. Clearly, the question of CSBC is one that only a privileged minority in the world and their physicians need address. By applying resources to do C-sections that are not medically indicated, we distract from the greater challenges of obstetrical care. CSBC remains in the realm of privilege. Unnecessary surgery in the developed world seems all the more unjustified

when necessary surgery of the same kind in the developing world is commonly unavailable.

8. Conclusions

CSBC remains a complex issue that goes far beyond a simple question of autonomy. Risks and benefits must be examined in the light of reproductive rights, and decisions must be made with the aim of maximizing the empowerment of women. Simply adding an alternative does not enhance empowerment, unless that alternative truly improves the lives of women and their families.

Gender imbalance and other forms of disempowerment may be exacerbated if CSBC is allowed without adequate support or information. Women may feel pressured to undergo CSBC for reasons of fetal well being, or reasons related to cosmetic or sexual factors, all of which would actually decrease their empowerment and self-determination. Information presently given to women about risks vs. benefits must be the best available if given in a strictly medical context without the needed social and cultural supports. The debate over CSBC presently has historically tended to address only narrow practice issues, without addressing the wider implications for women's empowerment as defined by FIGO. This has been partly because the wider issues are much more difficult to quantify and study. A reproductive rights framework helps us move beyond these clinical considerations to look at the wider picture. Vested interest of practitioners in surgical procedures, for reasons such as medico-legal risk, convenience and insurance coverage must be addressed, and remedied, as there will continue to be the possibility that conflicts of interest will occur.

FIGO's statement on empowerment of women also entails a positive right of women to the support of physicians and other professionals. We are bound to do whatever we can to maximize the empowerment of women, and protect their sexual and reproductive rights in any way we can. This includes being aware of the possible negative effects of CSBC on childbirth.

If we consider the rights recognized by FIGO carefully, we see that they fully support FIGO's position on Cesarean Delivery for Non-Medical Indications, introduced in 1998, and reiterated in 2003.

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