APPROPRIATELY FRAMING MATERNAL REQUEST CAESAREAN SECTION

ABSTRACT

In their paper, 'How to reach trustworthy decisions for caesarean sections on maternal request: a call for beneficial power' Eide and Bærøe present maternal request caesarean sections (MRCS) as a site of conflict in obstetrics because birthing people are seeking access to a treatment 'without any anticipated medical benefit'. While I agree with the conclusions of their paper – that there is a need to reform the approach to MRCS counselling to ensure that the structural vulnerability of pregnant people making birth decisions is addressed – I disagree with the framing of MRCS as having 'no anticipated medical benefit'. I argue that MRCS is often inappropriately presented as unduly risky – without empirical evidence – and that MRCS is most often sought by birthing people on the basis of a clinical need. I argue that there needs to be open conversation and frank willingness to acknowledge the values that are currently underpinning the presentation of MRCS as 'clinically unnecessary' – and specifically there needs to be more discussion of where and why the benefits of MRCS that are recognised by individual birthing people are not recognised by clinicians. This is important to ensure access to MRCS for birthing people that need it.

In their paper, '*How to reach trustworthy decisions for caesarean sections on maternal request: a call for beneficial power*' Eide and Bærøe present maternal request caesarean sections (MRCS) as a site of conflict in obstetrics.[1i] They explain that – in MRCS - birthing people are making a request for a healthcare intervention 'without any anticipated medical benefit,' and that since obstetricians have a 'right to act in accordance with their professional integrity and make adequate medical decisions in line with their specialist knowledge and

[i] It is important to note that as well as maternal request caesarean sections being difficult for many birthing people in the UK to access, it is equally the case that in Western hospitals (emergency) caesareans – often where a person's genuine autonomous preferences might be against caesarean – are a significant problem. It is important in analysis to be attentive (as much feminist literature is) to the fact that caesareans are both denied to those people who prefer them and simultaneously impressed on persons who would prefer not to have them. In both of these circumstances substantial harm is caused to individuals who are denied genuine choice in childbirth. See Romanis 2020. I am grateful to an anonymous reviewer for encouraging me to highlight this point.

clinical judgement' they may wish to refuse to provide the intervention and there occurs a potential conflict.[1] Their paper considers how this conflict should be managed by a proposed framework of 'ethically justified decision-making' that centres on the exercise of 'beneficial power'.[1]

I agree with Eide and Bærøe that birthing people are 'placed in a situation of structural inferiority' in making the decision about birth modes and that there is a need for reform in birthing services.[1] Obstetricians do 'hold the power and control the content and scope of the dialogise and the right to refuse to provide' MRCS – which can increase the vulnerability of a pregnant person making birth decisions.[1] Making improvements to birth counselling to improve trust and address the power imbalance is imperative. In this response, however, I challenge the framing of the authors' call to action. In beginning their piece focusing on the example of conflict, the authors make assertions about MRCS that are empirically unfounded. While the authors do not explicitly suggest that MRCS *always* involves a conflict between birthing people's preferences and professional integrity, by framing their entire discussion around a situation they state 'can be described as a situation of opposing autonomous claims… [where] one party must be subjected to the will of the other',[1] the reader is given the impression that conflict between personal autonomy and professional integrity is not an uncommon occurrence where caesarean is requested.

I broadly agree with the reforms the authors suggest to ensure the counselling about modes of birth process promotes trust: including the promotion of information exchange, that counselling is specific to the individual and avoids authoritative technical terms, and is undertaken with the express objective that people feel no pressure to conform to vaginal

delivery – amongst others.[1] However, first and foremost, the framing of MRCS as an 'site of potential conflict' must be addressed to avoid reforms being superficial.

Empirical evidence does not support the assertion that MRCS is not 'clinically indicated' and thus it is *not* a procedure that inevitably engages a physician's 'professional integrity' in the way assumed.[2,3,4] Refusing to accept that MRCS *is* a conflict between respecting preferences and professional integrity goes much further towards addressing the lack of access to MRCS experienced by many birthing people.[3] Eide and Bærøe's informed counselling reforms are difficult to implement without first addressing the myths surrounding MRCS,[3] precisely because – as the authors acknowledge – obstetricians retain the power to control the dialogue.

The realities of MRCS

Eide and Bærøe's conception of the MRCS as a possible site of conflict between the autonomous claims of health professionals (related to integrity) and birthing people's preferences begins with the discussion of the dangers of *caesarean* for birthing people. The authors acknowledge that 'There are no available evidence from randomised control trials comparing outcomes of vaginal vs caesarean delivery for low-risk women lacking obstetric indication.'[1] And yet, they continue, 'Still, CS is in general associated with increased risk for short-term and long-term health complications for both mother and child'.[1] Even if we do not take these assumptions to be central to the arguments the authors make about power imbalances in the relationship between professionals and birthing people (though one assumes that this must play a key role since doctors as professionals are able to gate-keep what treatment is recognised as *clinically appropriate* in a given context), my response is still

significant in pointing out the error in these assumptions about the claimed 'increased risk' of MRCS. The pervasive mischaracterisation of MRCS in debate about how requests are managed is a problem in itself that it is important to correct.

While the authors have acknowledged it, they commit a *non sequitur* in concluding that because caesareans (note they neglect to say – *emergency* caesareans) are associated with increased risks, *MRCS* must carry increased risks – without explanation.[ii] As many have pointed out, however, that ignores the realities of the confounding variables in the data – in particular the emergency circumstances that likely indicated the caesarean.[2,3,4,5,7] MRCS likely has much better outcomes than unplanned caesareans[2,4] – because it is performed in non-emergencies[5] – meaning that the birthing person and newborn are not already in distress, surgeons are less stressed[2] and safety protocol is better adhered to.[4,6] Further, in stating that the risks of complications are higher following *caesarean* the authors fail to consider risks in the proper context.[2,3,4] That is, they fail to acknowledge that the risks associated with vaginal delivery are also relevant – especially since many people who seek to opt for MRCS do so to avoid specific risks associated with vaginal delivery.[2,3,8]

This brings us to the framing of MRCS as 'clinically unnecessary',[1] which has been increasingly disputed in ethical[2,3,4,9] and clinical literature,[10,11] and by organisations supporting birthing people's rights in birth.[8] The vast majority of requests are made by people with underlying health conditions they fear may be exacerbated by vaginal delivery or

[ii] Eide and Bærøe also commit an additional *non sequitur* in discussion of rising caesarean rates by implying this is associated with an increase in requests - despite the studies they cite in no way commenting on the incidence of MRCS (only reporting that *caesareans* are increasing in incidence). There are good reasons to believe that it is *not* MRCS behind the rise (Romanis 2020).

later emergency caesarean, and by individuals with experience of previous traumatic birth or other traumatic experience (e.g., sexual assault).[8] The threshold for what 'counts' as 'clinical need' – in the hands of individual obstetricians - can often disregard the subjective experiences of individuals seeking access to MRCS. As Romanis and Nelson have argued, 'health indications for caesarean can be much broader than an immediate physical health need, and in considering clinical indications in childbirth health should be considered holistically'.[4] This means paying due attention to individual circumstances – rather than only looking at removed (and often flawed) data sets about *physical* health – and considering the ''request' element of MRCS when analysing harm. Significant harm is caused to individuals when doctors ignore their requests in place of clinical judgement'.[2]

When we consider the realities of MRCS – namely, that it is less risky than it is often portrayed to be and that clinical need motivates most requests – the portrayal of MRCS counselling as a site of conflict highlights a real problem. Most requested MRCS will have an anticipated clinical benefit for the service-user. Healthcare professionals have considerable 'discretionary power' over people's health, because of the position they occupy in the professional-patient relationship on the basis of their 'special knowledge, judgement and discretionary space to provide care'.[1] Where doctors are recommending against MRCS, there needs to be an open and frank willingness to acknowledge the values that underlie that decision-making – and specifically where and why the benefits recognised by individual birthing people are not recognised by obstetricians. In particular, there needs to be investigation as to why birthing people's mental health perhaps is not respected as it ought to be. Moreover, the pervasive framing of MRCS as a site of conflict between professional integrity (because it is a 'risky' practice) and personal autonomy actively perpetuates harm in making the decision harder for people to access, and reinforces the notion of a doctor as a

gate-keeper,[2,3] rather than sharing in decision-making. Given the evidence demonstrating that MRCS is not significantly riskier than other birth choices when considered in context, a caesarean request should not be considered as a decision in which the professional considers their integrity threatened in considering/performing the procedure.

Framing the request

As Eide and Bærøe, highlight it is generally presumed that while patients have a right to refuse treatment, they do not have the right to *demand* treatment that is *not clinically indicated*.[1,12] This is also the legal position in England and Wales.[13] Challenging the perception of MRCS as 'clinically unnecessary' is consequently important, and it is critical that in addressing MRCS it is not dismissed as a request made in the absence of a clinical reason without question. This will matter materially in terms of access (and rights to access), but also in terms of how counselling about mode of birth is approached by healthcare professionals who – as noted – have considerable power in how these discussions are framed. This is not an argument that obstetricians should perform every caesarean requested – but that the request needs to be taken seriously and the reasons for the request be appropriately considered. In particular, attention must be paid to the likely reality that many requests *are* based on clinical need when thinking is appropriately holistic.[3,4] This again, is why it is so important that we do not continue to use the characterisation of conflict between patient and professional as the quintessential example of caesarean requests.

In their discussion of important commitments in an ethical MRCS decision-making framework, many of the criteria that Eide and Bærøe identify can only be (or are better) realised if MRCS is *not* inappropriately framed as 'clinically unnecessary'. Eide and Bærøe's

objective is to consider how the power imbalance between professional and patient can be best equalised – but so doing is difficult without better appreciation for the nuance in MRCS decisions from the perspective of patients, and challenging the traditional professional-perpetuated frame. For instance, take the first criterion the authors mention that describes the importance of knowledge exchange and reciprocity in counselling.[1] This is a crucial aspect of ensuring epistemic (testimonial) justice[14] whereby birthing people are also afforded the respect of being 'knowers' in the context of birthing decisions. The pregnant person brings a considerable amount of knowledge to their decision about MRCS, much of which relates to its clinical necessity (such as past traumatic experiences). However, if MRCS continues to be framed as primarily 'clinically unnecessary' based on closed and gate-kept readings of medical necessity – and the conflict narrative unchallenged in both academic work and clinical circles – there may not be adequate space made for the kinds of knowledges that patients bring to the discussion because it necessarily remains more focused on traditional clinical justifications. As the authors note, in consultations professionals have considerable power to determine the frame within which conversations take place. Trust in healthcare providers is considerably undermined where people feel that they are not listened to, and that the clinical judgement of the healthcare professional is completely divorced from their lived experiences, or does not recognise aspects of their subjective experience that are principal.

Relatedly, the second criterion proposed explains that dialogue 'must be carried out without any agenda of pressuring the woman to opt for vaginal delivery'[1], but where MRCS is routinely characterised as 'clinically unnecessary' it is difficult for professionals to avoid importing implicit biases about what constitutes clinical need into the counselling they provide. As one final example, the fourth criterion the authors suggest considers the importance of counselling being attentive to individual needs (by avoiding authoritative and

inaccessible jargon), considering the individual, and ensuring that the probability of complications is communicated with the certainty of evidence. Unless the misconceptions about the evidence surrounding MRCS and the values brought to decision-making in obstetrics about what constitutes clinical need are openly challenged and scrutinised (and individual practitioners are encouraged to be transparent) it is difficult to see how such reform can be brought into practice. All of the suggestions made by Eide and Bærøe are indeed crucial in ensuring more patient-centred care, but to accomplish this we need to begin by dismantling ideas about what constitutes 'clinical need' in birth choices and of conflict between professional integrity and birthing people's preferences in MRCS.

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