

Caesarean Delivery on Maternal Request:

A New Zealand Perspective

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Abstract

In many countries, including New Zealand, the caesarean delivery rate far exceeds the current WHO recommendation of 10-15% of live births. This is causing concern amongst a number of parties. One of the explanations for the rate increasing so quickly and to such an extent is Caesarean Delivery on Maternal Request (CDMR).

There have been no studies conducted on CDMR in a New Zealand context to date. This qualitative study explored the perceptions of a group of New Zealand obstetricians' and midwives' on CDMR. The information was obtained via 12 face-to-face semi-structured interviews. The maternity providers were asked if they had ever encountered requests, whether they believed that it was ever reasonable to accede to a request for a caesarean section in a low-risk pregnancy, and whether there was a place for these procedures in the public healthcare system. An ethical analysis followed thematic analysis of the data. The ethical justification for the interviewee's responses was analysed in the light of the four principles of biomedical ethics as articulated by Beauchamp and Childress; autonomy, beneficence, non-maleficence and justice.

The results of this study show that there is no standardized approach to CDMR in New Zealand, raising concerns about equity of access. For this reason the development and implementation of a national care pathway for CDMR is commendable.

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List of Abbreviations

ACOG- American Congress of Obstetricians and Gynaecologists

CDMR- Caesarean Delivery on Maternal Request

LMC- Lead Maternity Carer

NIH- National Institutes of Health

NICE- National Institute for Health and Clinical Excellence

RANZCOG- Royal Australian and New Zealand College of Obstetricians and Gynaecologists

RCT- Randomized Control Trial

VBAC- Vaginal Birth After a Caesarean

Explanation of “Caesarean Delivery on Maternal Request”

“Caesarean Delivery on Maternal Request” (CDMR) is a central term in this BMedSc(Hons), and throughout this thesis it will refer to a subset of an elective caesarean delivery. Elective caesarean delivery includes any planned caesarean section. Elective caesarean deliveries may be performed for a number of foetal and maternal complications, but can include those planned ahead of time that do not have medical indication (e.g. for scheduling purposes). Elective caesarean sections are distinguishable from emergency caesarean sections, as emergency caesareans would be performed in response to an acute medical need and not planned in advance (e.g. a caesarean section performed due to a complication during labour).

CDMR is an umbrella term that can be used in the place of a number of similar terms. These terms include caesarean deliveries for non-medical reasons, caesarean deliveries for non-obstetric reasons, social caesareans and prophylactic caesareans. Planned caesarean delivery is not an equivalent term because this would include those performed for specific medical complications (such as breech presentation).

The reason that CDMR has been used in this report is because it is the way that the clinical situation is most commonly referred to in recent literature, and has been the term adopted by policy statements internationally.

Introduction

In the last thirty years there has been an unprecedented increase in the number of caesarean sections being performed globally (Mazzoni et al., 2011; Suzuki, Yamashita, Inde, Hiraizumi, & Satomi, 2010; Young, 2006). This trend is causing significant concern amongst healthcare providers, funders and the public (D'Souza, 2013; Young, 2006). Presently, in many countries the caesarean section rate exceeds the World Health Organization's recommended caesarean section rate of 10-15% (Soltanifar & Russell, 2012; World Health Organisation [WHO], 1994).

There are a number of theories about why the caesarean rate has risen so dramatically, and these theories have included a focus on an increase in medically complicated pregnancies, physician preference and maternal request (Mazzoni et al., 2011). Of these three factors, most interest has been generated around Caesarean Delivery on Maternal Request (CDMR). Questions have been raised about why a group of women may prefer to have caesarean sections, whether their requests should be acceded to, and whether they are putting themselves in an unnecessarily risky situation. In many other clinical situations evidence can provide a basis for a deciding what is best for the patient when two medically viable options exist (L. H. Harris, 2001). However, a conclusive evaluation of the risks and benefits of each mode of delivery does not exist in this case, because empirical evidence is unavailable which compares the outcomes of CDMR to vaginal deliveries (Kingdon et al., 2009; NICE, 2011). Despite insufficient evidence, as interest in this topic has grown, medical organizations have been forced to release position statements (Kukla et al., 2009). Rather than releasing prescriptive guidelines, many of the statements released by medical colleges and institutions have outlined basic ethical ideas to guide a physician's decision (L. H. Harris, 2001). However, the ethical ideas around CDMR are actually much more complex than what has been published in these documents, and further exploration of these ideas is necessary.

Additionally, although there is growing body of literature globally, very little of this data has been qualitative and no research has been specifically conducted exploring

CDMR in a New Zealand context. Currently the caesarean delivery rate in New Zealand is 23.6% (Ministry of Health, 2010). Although it is known that nearly half of the caesarean sections are elective caesareans¹, it remains unclear what proportion of these are medically indicated and what proportion are occurring on maternal request (Ministry of Health, 2010). In fact, it is unclear whether CDMR is occurring in New Zealand at all. In addition to the lack of accurate statistics, there is also no information on New Zealand maternity care provider's attitudes towards CDMR, and the reasons behind these attitudes.

This thesis is an exploratory study on the attitudes of New Zealand maternity providers towards CDMR. It aims to address two key areas. Firstly, the value that maternity providers attach to requests for caesarean deliveries, therefore gauging how acceptable the procedure is in one area of New Zealand. Secondly, how our current understanding of the risks and benefits of the procedure should be weighted against patient preferences. The study has achieved this through thematic analysis of interview data and an ethical analysis of ideas raised in the interviews.

Each chapter of this thesis will address each aspect of this study separately. Chapter One contextualizes CDMR using the information gathered through an extensive literature review on CDMR. This chapter explores factors like how CDMR became an independent clinical entity, and some of the key points that make it clinically and ethically complex. Chapter Two outlines the methods employed for this qualitative study, including how the interview questions were developed. Chapter Three describes the key themes that emerged from the interviews using a number of quotations to illustrate key ideas and interesting outlying opinions. Chapter Four discusses the themes in greater depth and explores many of the ethical ideas and issues in response to what was raised during the interviews. Finally, there will be a chapter exploring the implications of the research and proposes recommendations for CDMR practice and guidelines in New Zealand.

¹ Elective caesareans entail any caesarean section which is planned in advance

Chapter 1 Contextualizing Caesarean Delivery on Maternal Request

The Caesarean Section Rate

Although the first successful caesarean section was performed in the sixteenth century, it was not until well into the twentieth century that caesarean deliveries were more commonly performed². For most of the last century, the procedure was considered to be very risky and therefore only used under emergency circumstances (Shearer, 1993). Improvements in surgical and anaesthetic techniques, antibiotics, and blood banks led to significant safety improvements. These safety improvements meant that caesarean sections became a more acceptable intervention, and increasingly common (Lavender, Hofmeyr, Neilson, Kingdon, & Gyte, 2012).

In recent years, there has been significant professional, public, and political unease regarding the global rise of the caesarean delivery rate (Green, Evans, Subair, & Liao, 2014; NIH, 2006; Shearer, 1993). In most countries, including New Zealand, the current rate far exceeds the WHO recommendation of 10-15% of all births (Ministry of Health, 2010; World Health Organisation [WHO], 1994). It has long been surmised that a rate exceeding 10-15% not only confers no further health benefit, but unnecessarily increases maternal risks and has resource allocation implications (Betrán et al., 2007; Mazzoni et al., 2011; Soltani & Sandall, 2012). Despite efforts to curb the trend by policy makers and other invested groups, the caesarean section rate continues to rise (D'Souza & Arulkumaran, 2013).

Explanations for the increase in the caesarean section rate include changes to patient risk factors, institutional factors, changes in physician behaviour, and an increase in maternal demand (Bailit, Love, & Mercer, 2004). Studies suggest that the incidence of primary medical indications for caesarean deliveries are not increasing (Bailit et al., 2004; Shearer, 1993). It has therefore been hypothesized that the increase in the rate

² First successful caesarean section is defined as one where both the mother and child survived

may be more attributable to changes in physician behaviour and an increasing demand for caesarean sections from pregnant women (Mazzoni et al., 2011). It is a contentious issue as to which of these two factors is having the greatest impact on the caesarean delivery rate, and further research is needed to gain a better understanding of the contribution that CDMR is having on the caesarean section rate (Mazzoni et al., 2011).

A Brief History of CDMR

In the 1990s there were a number of events that raised the profile of CDMR and led to them becoming an increasingly attractive option for pregnant women. Firstly, there was a growing awareness of the prevalence of urinary and faecal incontinence amongst women, particularly in women who had had children (McFarlin, 2004). This led onto studies investigating the correlation between childbearing and urinary and faecal incontinence. The results of these studies showed that caesarean sections could be partially protective against these outcomes (P. D. Wilson, Herbison, & Herbison, 1996). Shortly after these results had been published a survey of British obstetricians was conducted showing that 31% of female obstetricians who responded would choose to have an elective caesarean section over a vaginal delivery themselves, even if there was no medical indication to intervene in their pregnancy (Al-Mufti, McCarthy, & Fisk, 1997). The results of these studies were distributed widely through the lay media. The events over this time contributed to a growing perception that a caesarean delivery could be as safe, if not safer, than a vaginal delivery (McFarlin, 2004; Sultan & Stanton, 1996). Over the same time, there was growing emphasis on patient autonomy and women becoming more involved in decisions surrounding their maternity care (McFarlin, 2004).

In response to the growing interest and perceived growing demand for elective caesarean sections, a number of position statements were published on the ethics of CDMR (L. H. Harris, 2001). One of the earliest was released by the International Federation of Obstetricians and Gynaecologists (FIGO) in 1999. This committee concluded that because of the very limited evidence it was not possible to show a clear net benefit in favour of elective caesarean sections CDMR was not ethically

justified (FIGO, 1999). This strict position statement based its position on two observations: firstly that “Caesarean section is a surgical intervention with potential hazards for both mother and child”; and secondly that caesarean section “uses more resources than normal vaginal delivery.” This statement outlined two ethical duties that obstetricians had to do no harm, and to be careful stewards of resources. Other position statements were subsequently released, but none were as strict. In fact, many of the opinions contradicted what was previously released by FIGO. Bioethical advice regarding CDMR tends to reflect the different social locations of the bioethicists as well as the committees being advised (Torres & De Vries, 2009).

In 2006, due to the increasing profile of CDMR as a clinical entity, the National Institute of Health (NIH) in the United States held a State of the Science Conference to assess the state of knowledge of CDMR (Mayberry, 2006; NIH, 2006; Young, 2006).³ The aim of this conference was to synthesize the available data on CDMR and develop evidence-based guidelines for this clinical situation (NIH, 2006). An independent panel of eighteen people was appointed to assess the available evidence (Young, 2006). The conference involved thorough literature reviews and public submissions, as well as presentations from experts and researchers in the field (NIH, 2006). Although the aim of this conference was to be able to draw clearer conclusions on best practice, it emerged that there was insufficient reliable evidence to properly assess the benefits and risks associated with CDMR.⁴ The conference statement concluded by stating that women deserved “individualized counselling” based on the risks and benefits of the procedure, consistent with ethical principles and taking into account societal and cultural norms (NIH, 2006). It also outlined the need for research in this area.

Rate of CDMR

Due to variability in reporting systems there is a large variation between estimates on the rate of CDMR (Kingdon, Baker, & Lavender, 2006; Torres & De Vries, 2009). At the

³ State of the Science conferences review available evidence on medical issues and identify critical gaps in literature. A conference is convened when an issue reaches a critical point and NIH funding may need to fund further research.

⁴ Although there was insufficient evidence to come to a sound conclusion, the available evidence suggested that the risk profile between the two modes of delivery was similar.

NIH State of the Science Conference in 2006, presenters cited the rate of CDMR as being somewhere between 2.5% and 18%, but there was little confidence in the reliability of this estimate (Young, 2006). Studies conducted since the NIH State of the Science Conference suggest that estimates closer to 2.5% are most accurate (Bragg et al., 2010; Green et al., 2014; Mazzoni et al., 2011). The reason there is such variation between estimates is due to hospital reporting systems often failing to recognize CDMR as an independent clinical entity, methodological weaknesses in studies, and CDMR being incorrectly recorded as occurring for medical indications (Kingdon et al., 2006). These limitations make current estimates extremely unreliable (Young, 2006). New Zealand also has a problem with estimating the current rate of CDMR due to unreliable reporting, but this will be discussed in Chapter Three.

Reasons Why Women Request Caesarean Sections

The earliest study examining reasons why women could have a preference for a caesarean delivery was generated by the first study on obstetricians' preferred mode of delivery (Al-Mufti et al., 1997). The group of obstetricians who claimed that they would prefer a caesarean delivery in an uncomplicated singleton pregnancy made their choices for a variety of reasons. Their reasons (in order of popularity) included fear of perineal damage during delivery, long-term sequelae (such as urinary incontinence), negative effects on sexual function, fear of damage to the baby, and desire for scheduling the delivery.

Subsequent studies have explored the reasons provided by other women who have a preference for caesarean sections. The information that has since been generated corresponds closely to what was found in Al-Mufti's study. Some of the most common reasons that women indicated they want a CDMR for are fear of pain, previous traumatic birth, mental health reasons, lack of control during vaginal delivery, desire for a predictable outcome, and pelvic floor damage which could lead to incontinence or sexual dysfunction (Mayberry, 2006; NIH, 2006; Nzewi & Penna, 2011). All of these reasons listed can be considered maternal reasons for wanting a CDMR. Other studies have spoken about concerns women may have about foetal safety of a vaginal

delivery, but the specific safety concerns for the foetus have not been explored in much depth (Bt Maznin N.L. & Creedy D.K., 2012; Land, Parry, Rane, & Wilson, 2001).

There are numerous theories as to why women may be showing a concern for negative outcomes from a vaginal delivery in a way that they have not before. In one paper it was argued that a main driver behind maternal requests could be hearing “horror stories” through the media or their friends’ experiences, and feeling that a caesarean section might be safer because they feel that it takes away some of the unpredictability of birth (D’Souza, 2013). In another paper, it is argued that women are wanting to avoid long term sequelae such as urinary incontinence because they are living longer and therefore would have to live with these health issues into their old age (Guise, 2001). Not only do vaginal deliveries seem more risky for this reason but the short-term risks of caesarean deliveries are decreasing. There has also been concern that this may be leading to a culture where women believe caesarean deliveries are a safer alternative to vaginal deliveries.

Despite the many apparent reasons that women could potentially request a caesarean delivery, the lay literature still fixates on women choosing caesarean sections for social and scheduling purposes, circulating negative phrases in association with CDMR such as “too posh to push” (Tully & Ball, 2013). This has led to some women who have chosen a caesarean delivery feeling stigmatized, even though they feel the decision they have made is most appropriate for them and their families (de Costa, 2000; Tully & Ball, 2013).

Although there is a relatively large evidence base on why women may request caesarean sections, something which has not been explored in any depth is what reasons are most likely to cause an obstetrician to accede to a request for a caesarean delivery where no medical or obstetric indication exists. This is one of the focus areas of this study.

Evidence on the Risks and Benefits of CDMR

The balance of risks and benefits between CDMR and a vaginal delivery is key to making decisions around the appropriate provision of CDMR, but the evidence is incomplete (Ecker, 2013; Lavender et al., 2012; Paterson-Brown, Amu, Rajendran, & Bolaji, 1998).

A systematic review conducted by Lavender et al. in 2012 attempted to assess the effects on morbidity and mortality, both perinatal and maternal, in planned caesarean delivery versus planned vaginal birth in low-risk pregnancies (Lavender et al., 2012). This recent study reiterated what many other studies have previously stated: that no Randomized Control Trials (RCTs) have been conducted on CDMR and there is therefore no reliable evidence on outcomes to guide practice and policy. This paper concluded that there is an urgent need for studies to synthesize available data to come to clearer conclusions so that clearer guidelines can be developed. This is something that has been widely acknowledged by many people in the field (NICE, 2011; NIH, 2006; RANZCOG, 2013).

As well as there being no RCTs, the observational evidence on the outcomes of CDMR compared to vaginal deliveries is limited and flawed. Because of the poor quality of the available data, studies examining outcomes between elective caesarean sections and vaginal deliveries have to use pooled data from any planned caesarean section instead of only those which occurred purely due to a request (Mayberry, 2006; RANZCOG, 2013). Using pooled data from all planned elective caesareans will result in an inaccurate estimation of the risk due to confounding as many of the women would have required the procedure for medical reasons.

As an alternative to RCTs and using pooled data, proxy studies have been used to determine the likely risk profile associated with CDMR compared to vaginal deliveries (NIH, 2006; RANZCOG, 2013). The most common proxy study referred to in literature is the TERM Breech Trial which compares the outcomes of vaginal deliveries, and elective caesarean deliveries and vaginal deliveries when a baby is presenting in a

breech position (Hannah et al., 2000). This was one of the main papers cited in the NIH State of the Science Conference statement (NIH, 2006). The TERM breech trial showed that caesarean deliveries were not associated with an increase in negative short-term maternal outcomes than to vaginal deliveries, except for an increase in length of hospital stay, but this data is not directly applicable to CDMR (Hannah et al., 2000).

An important undisputed risk associated with caesarean sections is the fact that the operation will change the risk profile for any subsequent pregnancy (Collins, Arulkumaran, & Hayes, 2013). A caesarean section will result in uterine scarring and increase the risk of uterine rupture in any subsequent labour. It also increases the likelihood of placental abnormalities such as placenta accreta and placenta previa (Collins et al., 2013). For this reason, policy and guidelines discourage acceding to a woman's request for a caesarean section if she is intending to have more children.⁵

Cost

There is very limited information on how the cost of a CDMR compares to a vaginal delivery, and there has been no conclusive economic analysis completed to date. Despite the lack of evidence, there is concern in the literature regarding the economic implications of the rising caesarean rate, particularly with caesarean sections that are not medically necessary (Druzin & El-Sayed, 2006). A full economic analysis, despite being very complex, would be necessary in order to come up with definitive figures comparing the cost of the two modes of delivery. This section explain why a full economic analysis would need to take into account the actual rather than intended mode of delivery and a range of associated clinical outcomes to avoid unfair comparisons (NICE, 2011).

An economic analysis would need to be based on actual route of delivery and not just the intended route. It is clear that an uncomplicated vaginal delivery would be cheaper than an elective caesarean section. This is because an elective caesarean would

⁵ This is problematic because there is no guarantee that women will not go on to have further children unless they were sterilized.

require numerous healthcare professionals, resources and theatre time that a vaginal delivery would not. However, there are no guarantees that a vaginal delivery will go to plan and not require medical intervention, which would increase the cost of that delivery. In some circumstances, despite the intention to deliver vaginally, an emergency caesarean section will need to be performed, which may be more expensive than a situation where an elective caesarean section was performed in the first place.

Increasing the complexity of any potential economic analysis further, is the fact that it would need to incorporate the possibility of ongoing costs from numerous adverse outcomes of either mode of delivery. It has also been frequently suggested that caesarean sections lead to poorer maternal and foetal outcomes in the current and subsequent pregnancies, thereby increasing the cost on the public healthcare system in the long-term through needing to treat these avoidable morbidities (NICE, 2011). However, vaginal deliveries are not risk-free and adverse outcomes occur which would also generate immediate and downstream costs. For example, caesarean sections have been shown to be partially protective against pelvic floor dysfunction, and there may be treatment costs to the public system to pay for pelvic floor reconstruction as a result of a traumatic vaginal delivery. However, because there is no evidence that is able to quantify the incidence of pelvic floor dysfunction due to traumatic vaginal deliveries, it becomes a complicated question to ask which of these modes of delivery would be more economically efficient when it comes to preventing or treating the condition as a result of childbirth.

The most comprehensive and up-to-date economic analysis was completed by the National Institute of Health and Clinical Excellence (NICE) when they reviewed their clinical guidelines on CDMR in 2011. After attempting to incorporate many of the factors I have outlined, they concluded that the immediate costs would be lower for a planned vaginal delivery than a planned caesarean section. However, they admitted

that the analysis failed to incorporate many adverse outcomes, such as urinary incontinence, which would inevitably alter the outcome of the analysis.⁶

The fact that there is no unanimous agreement to date on whether an elective caesarean costs more or less than a vaginal delivery has some interesting ethical implications that will be discussed in Chapter Four.

Current CDMR guidelines

Whether an obstetrician should perform CDMR lies in a clinical grey area, as there is no sound evidence on the benefits, costs or risks of the procedure. Despite the lack of empirical evidence, there are many guidelines that have been developed to aid the maternity team when handling CDMR. Organizations who have released such guidelines include NICE and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (NICE, 2011; RANZCOG, 2013). In addition to guidelines, position statements have been released by committees from the American Congress of Obstetricians and Gynaecologists (ACOG) (ACOG Committee on Ethics, 2013). The guidelines which are applicable to New Zealand are the RANZCOG guidelines (RANZCOG, 2013).

In the most recent committee opinion released by ACOG entitled “Cesarean Delivery on Maternal Request” they say that a vaginal delivery should be recommended for patients where no foetal or maternal indications exist for a caesarean section, as a vaginal delivery is safe and appropriate (ACOG Committee on Ethics, 2013). However, they also leave room for the obstetrician to exercise discretion. If the obstetrician decides that a caesarean section would be acting in the best interests of the mother and child then it stipulates that the procedure should not be performed before a gestational age 39 weeks, and should not be motivated by the unavailability of effective pain management.

⁶ Because treatment costs will almost certainly differ between countries, even if the economic analysis conducted in the UK had been conclusive the data would not have been directly applicable to New Zealand.

NICE in the United Kingdom (UK) reviewed its guidelines on CDMR in 2011 (NICE, 2011). These guidelines provide a clear care pathway for handling CDMR. These guidelines clearly state that if a woman maintains her request for a caesarean section after going through the relevant care pathway then a caesarean section should be offered. The care pathway places emphasis on using the full multidisciplinary maternity team, including obstetricians, anaesthetists, midwives and mental health support workers with expertise in perinatal mental health.⁷ The reason all of the health workers are involved in the care pathway for CDMR is to ensure that the reasons behind the woman's request are fully explored, and alternative means of dealing with the concerns are presented and in some cases attempted. Ultimately the care pathway has been configured to ensure that the woman has accurate information to make a fully informed decision regarding a mode of delivery that would promote the best outcomes for her and her child.

RANZCOG's guidelines' target audience is stated to be all healthcare practitioners providing maternity care and patients. However, unlike the NICE guidelines, there is no clear care pathway outlined stating appropriate involvement of each of the parties. Instead, they only address the obstetrician's options, with the guidelines stating the three options that an obstetrician has when a woman requests a caesarean section. The first option is that a caesarean section may be performed so long as the mother's motives have been discussed and explored, and accurate information is given to her and understood regarding the risks and benefits associated with both modes of delivery. The second option is that her request may be declined on the grounds of significant health concern for the mother or foetus, or if the mother appears to not have sufficiently understood the significant risks associated with the surgical procedure to satisfy informed consent. Thirdly, the obstetrician may encourage the patient to seek the advice of another obstetrician for a second opinion.

⁷ The mental health worker would only be used in instances where the woman was displaying anxiety about birth.

It is clear that further research is needed so that clinical decisions and guidelines development can be led by sound evidence. Any policy and guidelines that are developed have to strike a difficult balance between limiting the number of unnecessary caesareans without limiting or denying beneficial care (Sakala, 1993).

Professional Opinions on CDMR

There are differences in opinion about whether it is ever appropriate to intervene with a caesarean section in a normal pregnancy where no clinical indication exists. However, it is not as clear-cut as one group supporting CDMR, and the other group not supporting it in any circumstances. There is a spectrum of opinions that is evident in published editorials.

The spectrum of opinion spans from professionals being very anti-interventionist and viewing caesarean sections as life-saving procedures only, through to CDMR being an appropriate intervention providing the woman is fully informed. At one extreme end of the spectrum, some believe that we have over-medicalised childbirth, as reflected by the extent of the caesarean section rate (Davis et al., 2011). This group is concerned that such a high caesarean rate may imply that women are either incapable or giving birth vaginally or that they are endangering themselves and their children by going through “natural” childbirth (Sakala, 1993). They also carry the view that CDMR is an unnecessary interference, an imposition of risk without benefit, and squandering of scarce resources (Davis et al., 2011; Sakala, 1993). The other end of the spectrum is the group that say that expansions in the area of obstetrics have been driven by a desire to make childbirth safer and less painful for women, and that medicalization is not necessarily a bad thing (de Costa, 2000). This group would argue that providing a woman is fully informed, it would be entirely acceptable to accede to her request for a caesarean section (Paterson-Brown et al., 1998). Although there is a common anecdotal belief that this division in views would exist between two different invested professions; midwives being anti-interventionist and obstetricians being interventionist, there is little evidence to make this claim.

The reason that it is important to have an understanding of the difference in opinion regarding CDMR between healthcare professionals is that patients will often rely on the judgment and wisdom of their medical advisors when making health decisions (de Costa, 2000). In the absence of sound evidence it is impossible to recommend the best option for the woman on a purely objective basis. It is therefore more important than ever that midwives and obstetricians are aware of their ideas and biases towards both modes of delivery. This research will explore the perceptions of obstetricians and midwives in terms of when it is reasonable to provide CDMR, and when it is not. It is interesting that few, if any, qualitative studies on CDMR that have incorporated the views of both midwives and obstetricians before.

Ethics of CDMR

Especially where practice cannot be guided by clear clinical benefit or cost effectiveness, clinical decisions must be individualized and based on sound ethical principles. For this reason, there have been a number of papers written on the ethics of CDMR. The most common approach to exploring the ethical issues of CDMR in previous papers has been to use the principles of biomedical ethics presented by Beauchamp and Childress (Beauchamp & Childress, 2009). This principled approach offers a clear way to analyse ethical considerations of many bioethical situations, and therefore can be applied to CDMR as well (Nilstun et al., 2008). These four basic principles are autonomy, justice, beneficence, and non-maleficence. Definitions of these principles are outlined below:⁸

- Autonomy is the ability of a rational individual to make informed decisions without coercion.
- Justice refers to the equal distribution of resources and treatments
- Beneficence refers to the act of doing good, or promotion of welfare
- Non-maleficence can be defined as the act of doing no harm

⁸ As outlined by Beauchamp and Childress (Beauchamp & Childress, 2009).

CDMR brings about important ethical questions within these four domains: should we always do what the woman wants us to do? Is it justifiable to provide CDMR using limited health resources? Considering the lack of empirical evidence, is there a chance that acceding to such a request could lead to more harm than good?

It is important to note, however, that responses to these questions will vary significantly and will be influenced by the respondent's cultural and geographical context; this is evident from the range of views represented in the published opinions of experts and editorials.

Supporters of CDMR may use an autonomy-based argument and say that it is important to respect woman's choice and avoid medical paternalism even if they are opting for a procedure which does not have medical indication (Bewley & Cockburn, 2002). They may also argue that acceding to a woman's request will mean that a potential emergency caesarean section or avoidance of potential negative outcomes from a vaginal delivery (McFarlin, 2004). People opposed to CDMR may argue that is an inappropriate use of resources due to the questionable benefits and potential negative sequelae. Chapter Four will explore the ethical issues of CDMR in more depth. In that chapter I will discuss the ethical ideas raised by interviewees and compare them to the ethical arguments presented in published literature.

There are a number of important reasons to explore the ethics of CDMR in this study. Firstly, there is no published literature on the ethics of CDMR in a New Zealand context, and the way in which the situation is perceived here may be significantly different to other parts of the world. Secondly, some of the literature on the ethics of CDMR, which was published when CDMR was an emerging issue, is now out-dated due to medical advancements improving the risk profile associated with caesarean deliveries. And thirdly, ethical arguments concerning distributive justice need to be contextualized depending on the country which is being dealt with. This is because of the considerable differences in the way that the healthcare is funded between countries, and therefore many of the arguments that have been presented may not apply to New Zealand.

Chapter 2 Methods

To achieve the aims of this study I employed qualitative research methodology. I gathered the perceptions of obstetricians and midwives on elements of CDMR using semi-structured interviews and analysed the resulting data using thematic analysis. The details of how I collected, analysed and interpreted my data are outlined in this chapter.

Ethics, locality and Māori consultation

Category B ethics approval was sought and obtained.

An application was also sent to a Māori affiliate board for further Māori consultation. Although ethnicity data was not specifically being collected in this study, relevant information may be raised during the interviews.

Because this study involved interviewing DHB staff I had to seek the approval of the DHB to conduct the study in Dunedin Hospital, this process is known as locality approval. The purpose of locality is to identify and mitigate governance issues that may arise as a result of conducting the study with particular people at a particular site, in this case staff working in the Southern DHB. Locality was achieved through Health Research South. No locality was required to talk to midwives who were Lead Maternity Carers (LMCs).

These processes were all started in December 2013 and all approval was gained by April 2014. Evidence of having gone through these processes can be found in the appendices.

The interview scheme

The questions that I asked in the interviews centred around key questions; why women request caesarean sections, how common they are, whether it is ever justified to perform a C-section for non-medical reasons, and under what conditions.

The interview scheme had to be concise to prevent the project from becoming too large for the time that I had to complete it. I had to be very aware of the information I was likely to generate by asking each question, and the relevance to my project. I aimed to have interviews that lasted around 30 minutes.

It was decided that LMC midwives and obstetricians had equally important perspectives to ascertain through interviews. This is because they both play equally important roles in the New Zealand maternity care system. Although the obstetricians are the maternity providers that would ultimately perform caesarean sections, both of these parties are involved in counselling pregnant women about their birthing options, therefore both have an influence on whether women are likely to request caesarean deliveries or not.

With the decision to interview both midwives and obstetricians came a few challenges. Because of the different role that each profession plays in an elective caesarean situation, it would be challenging to administer the same semi-structured interview to midwives and obstetricians and elicit information that would be comparable for analysis and discussion purposes. This was particularly important because I was interviewing a small group of people, and there would not be enough data to compare data that was only gathered from the midwives or only gathered from the obstetricians. With this in mind I generated some ideas as to what I should ask the interviewees that would be applicable to both, and ask the questions in a way so that they could be asked in the same way to both groups. For example, instead of asking when they would decline a caesarean section for non-obstetric reasons, which inevitably would have resulted in some midwives saying that this decision could not be made by them, I asked both the obstetricians and midwives when they would not support a decision to provide a caesarean delivery for non-obstetric reasons. Therefore, apart from some of the questions that generated demographic data all of the interviews regardless of whether they were a midwife or an obstetrician were worded in an identical way.

The questions were worded carefully to ensure that they were not leading questions⁹. They were kept as open-ended as possible, and where this was not possible asked the interviewee to explain their answer further once they had given their initial response. Words that were strong and absolute were avoided in the interview scheme, as the interviewees may not have had particularly strong opinions about something and disagreed or agreed due to the way the question was asked rather than their answer reflecting their true opinions.

A draft interview scheme was then generated, which is what I used in my pilot interviews.

Pilot interviews

Two pilot interviews were run: one with a midwife and one with an obstetrics registrar. As expected, both lasted approximately 30 minutes. Through running the pilot I wanted to gauge how the interview flowed, whether all the questions in the interview scheme were well understood, and whether the interviews obtained the information of interest. The information generated from the pilot interviews was not to be used beyond these purposes and therefore was not included in the analysis.

Both professionals who I ran the pilot interviews on whom I ran the pilot interviews gave insightful, thoughtful responses to the questions. Once the interviews had been carried out, they were transcribed and analysed. There was also an opportunity for the interviewee to reflect on the interview and talk about what worked well, and any potential changes that should be made.

Changes to the interview scheme following the pilot interviews

The pilot interviews influenced my final interview scheme, and a number of changes were made.

⁹ Encourage a certain response in the way that a question is phrased.

The first change that needed to be made to the interview scheme was asking the midwives whether they were independent or hospital-based. For the purposes of this project I needed to recruit LMCs, as they will be the midwives who make the decisions relevant to the handling of these cases. LMCs would not consider themselves to be “hospital-based” as this suggests they are the DHB staff that do not take on clients of their own, but are instead full time midwives who work on the maternity care ward of the hospital. A more appropriate question became asking the LMC midwives whether they predominantly assisted in homebirth situations, or whether most the births they assisted with occurred in a secondary or tertiary hospital setting.

I had asked in my draft interview scheme, “how much weight does each of these reasons carry for you?” Referring to reasons women had presented with when asking for a caesarean. This question proved hard to interpret for both interviewees, potentially because the wording was too vague. For this reason, and due to the disruption it caused in the flow of the interview, it was omitted.

Following the pilot interviews I decided that the interview scheme needed to be altered entirely for anyone who had not encountered CDMR before. For those professionals who had not encountered CDMR at all I integrated a question bypass mechanism that took me straight to the questions of interest.

The final interview scheme

Questions for obstetricians and midwives; general information

- What is your occupation? (Obstetrician or midwife?)
- How long have you been practicing for?

Question for obstetricians:

- Do you practice obstetrics in the private or the public system? If you do both, how is your time split between the two?

Questions for midwives:

- Please tell me a little bit about your caseload? (i.e. number of clients)

-Do you predominantly assist in births in a homebirth or a hospital setting?

Questions for obstetricians:

1. What are the most common reasons that women give when requesting caesarean sections for obstetric reasons in your experience?

2. Do you ever get requests to perform caesarean deliveries for non-obstetric reasons? Can you outline what these reasons are?

If the interviewee says yes to question 2 then go onto question 3, if they say no go onto question 5.

3. Are requests for caesarean sections for non-obstetric reasons common? Have you noticed that the requests have become more common over the time you have been practicing?

4. Can women access caesareans for non-obstetric reasons currently in the New Zealand public healthcare system?

5. Should women be able to access caesareans for non-obstetric reasons in the public healthcare system?

6. Is it ever reasonable to provide a caesarean section for non-obstetric reasons? Under what conditions would you find it reasonable?

7. Can you think of a situation where you wouldn't support a caesarean delivery for non-obstetric reasons? Why would you not support a caesarean section in this instance?

8. How should the concerns of a woman's autonomy and the risks of performing a caesarean section be balanced?

9. Does this situation raise any ethical issues or considerations that you have not already spoken about today?

Questions for midwives:

1. Have you ever had any of your clients request to have a caesarean delivery for obstetric reasons? If so, why have they made these requests?

2. Do women ever present to you who want to request a caesarean delivery for non-obstetric reasons? Can you outline what these reasons are?

If the interviewee says yes go onto question 3, if they say no go onto question 4

3. How common is it for women to request caesarean deliveries for non-obstetric reasons? Have you noticed that the requests have become more common over the time you have been practicing?

4. Can women access caesareans for non-obstetric reasons currently in the New Zealand public healthcare system?

5. Should women be able to access caesareans for non-obstetric reasons in the public healthcare system, why?

6. Is it ever reasonable to provide a Caesarean Section for non-obstetric reasons? Under what conditions would you find it reasonable?

7. Can you think of a situation where you wouldn't support a caesarean delivery for non-medical reasons? Why would you not support a caesarean section in this instance?

8. How should the concerns of a woman's autonomy and the risks of performing a caesarean section be balanced?

9. Does this situation raise any ethical issues or considerations that you have not already spoken about today?

In the interview scheme CDMR is referred to as caesarean deliveries for non-obstetric reasons, but these two terms can be considered to have equivalent meanings for the purposes of this project. Despite the fact that caesarean deliveries for non-obstetric reasons were referred to in the interviews, with all interviewees there was a discussion about what exactly was meant by the term, and often used interchangeably with CDMR. CDMR became the way I referred to the clinical scenario as the thesis became more refined- this was because it is a term with more neutral origins and used more widely in statements released by the colleges of obstetrics and gynaecology.

The interview process

Two important factors needed to be worked through before I started the interview process. Firstly, how many people I was going to interview and secondly, which individuals to interview.

Initially I thought that ten interviews would be enough to fulfil data saturation, however due to a miscommunication six midwives were sent invitations to participate and only five obstetricians. To balance numbers out another obstetrician was invited to participate.

I had to be very selective about the individuals I chose to take part in order to gather as many different perceptions as possible. Specific participants were therefore sought on my supervisor's advice rather than distributing information about the study and asking anyone who was interested to respond. Within the group of obstetricians it was important to interview some who worked in the private system and some who only worked in the public system. For the midwives some were selected who practiced in

a hospital as well as a homebirth setting. A mix of females and males were purposely included in the study.

The group of obstetric consultants and midwives who had initially been identified to interview were contacted via a letter of invitation with an information sheet attached. One of my supervisors, Associate Professor Michael Stitely, personally distributed the letters on my behalf so that he could briefly talk to them about the project before offering them an invitation¹⁰. In the letter they were asked to contact me by email or phone if they were willing to participate. In the cases where they did not reply within a week, I sent a follow up email or telephoned. Everyone who I had identified initially as being someone who I would like to interview said they were willing to participate in the project.

Face-to-face semi-structured interviews were chosen to gather the data. A semi-structured approach allowed extra questions to be asked in response to their answers if something unexpected was raised that otherwise may not have been picked up on. This meant that stimulating and complex discussions about the topic could occur. Although not restrictive, the structured questions did give an opportunity for the generation of comparable data, which was important for analysis.

Interviews were conducted in various places including people's practices, offices homes and the Bioethics Centre. I did everything I could to make it convenient for them, including being very flexible with times I was able to interview. Once I had introduced myself in person and asked if they had any questions about the project from the information sheet, I asked them to sign a consent form.

Every interview was audio-recorded so that they could later be transcribed, before carrying out the analysis. Interview times varied in length, but none of them went beyond an hour. The shortest interview took thirty minutes. This variation in time was

¹⁰ He is a colleague of all of the interviewees

due to the semi-structured nature of the interview, and the fact that everyone responded differently to the open-ended questions.

Once all twelve participants had been interviewed my supervisors and I were satisfied that data saturation had been achieved. Saturation is a tool used in qualitative research to ensure that adequate and quality data has been collected. By the time twelve interviews had been conducted common themes had clearly emerged. These themes will be discussed in the next chapter.

I personally transcribed each interview and sent it back to each participant to ask if they would like anything to be omitted, amended or added. No major changes were made to any of the transcripts. I was clear throughout the entire process that the only people who would see the transcripts were my supervisors and me. Potentially identifying information was removed from the transcripts, including the demographic data, before even handing it onto my supervisors to preserve as much anonymity as possible. The raw data, including interviews and audio recordings have been stored according to University of Otago policy.

Information about the participants

All twelve people who were initially sent invitations chose to take part. This number does not include my pilot interviews. Once all twelve interviews had been conducted my supervisors and I were satisfied that data saturation had been reached.

All of the participants lived and worked in Dunedin, New Zealand. This is important for a number of reasons. The people who practice obstetrics in this part of the country may have different opinions and perceptions to other people in the country as a result of multiple factors. In Dunedin there are very few private obstetricians, and only one who currently offers intrapartum care. A further potential difference to other parts of the country is that there is no private hospital which offers an obstetrics service, and all caesarean sections must be performed at Dunedin Public Hospital, regardless of whether the practitioner is private or public. This is highly relevant to my discussion, so will be further explored in Chapter Four.

Ten of the twelve interviewees were female, and two were male. Both males represented in the group were obstetricians.

Demographic factors of those people interviewed will now be outlined: the obstetricians' information first, and then the midwives'. The data collected from each of these groups was slightly different.

Six obstetricians were included in the study. All of them were consultants. Consultants were chosen to be interviewed over obstetric registrars. This is because consultants would have the final say as to whether to accede to a woman's request for CDMR, rather than leaving the decision to a more senior clinician.

The clinicians were highly experienced, and I say this for a number of reasons. One of the best indicators of experience was the number of years that the participants had practiced. The range of years of experience spanned from 6 years as a consultant to practicing for nearly 40 years. The average of time spent practicing as an obstetrician was 26 years.

Although the time spent practicing is one indicator of how much obstetrics experience they had, how much of their clinical caseload is made up by fertility or gynaecology is also relevant. Some interviewees speculated that the time spent practicing obstetrics, rather than other aspects of their job, may also impact how likely they were to have been experienced CDMR. There was variance in the few people who chose to speak about it.

Another important factor that was likely to have some influence on how they viewed caesarean deliveries for non-obstetric reasons was whether they practiced in the private or public system. One of the six obstetrics consultants interviewed practiced obstetrics worked entirely in the private system. Another of the obstetricians had a part time role in the public system, but the overwhelming majority of their time was spent in the private system. Many of the obstetricians either carried out a very small

amount of private work currently or had worked predominantly in the private system in the past.

Six midwives chose to participate in the study. All of them were LMCs.

They were also a highly experienced group of practitioners. The time that they had been practicing ranged from 5 to 32 years, although there are some complicating factors that means this is not reflective of their accrued experience. For example, they all had hugely variant caseloads.¹¹

Further demographic data will not be provided because of privacy. Dunedin is a small city, and it may be easy to recognize people who chose to take part if any more information is given. All quotations included in this thesis have been anonymised.

Generalizability

Generalizability or applicability of the study results is an important issue to raise because this is qualitative research. The extrapolation of the findings beyond the current time and place and into other settings and situations may be problematic because the views represented in this study are embedded within a certain social context. This does not mean that the research is not relevant to any other situation beyond Dunedin in 2014, however the applicability of this information should be at the discretion of the reader.

In this study, responses from the interviewees have been used to explore ethical considerations surrounding CDMR. There will inevitably be other factors, considerations, and implications that I have not incorporated into this thesis, and therefore further research would be required to guide current policy and practice in this area.

¹¹ The number of women that they booked varied significantly

Thematic Analysis

The method utilized to analyse the data was thematic analysis. Thematic analysis is a commonly recognized and utilized as a research tool in qualitative studies, but it is often poorly demarcated and rarely acknowledged as a method in its own right (Boyatzis, 1998). Thematic analysis involves reviewing a data set to find repeated patterns of meaning or themes. It is more commonly utilized within another approach to analysing qualitative data, such as grounded theory. Thematic analysis allowed me to provide a rich and complex account of the information without having to develop theories, which would be an implied commitment of a grounded theory approach (Braun & Clarke, 2006).

A key paper to guide my thinking around methodology was Braun and Clarke's paper *Using Thematic Analysis in Psychology* (Braun & Clarke, 2006). This proved a useful paper as it discussed when it would be appropriate to use thematic analysis method, as well as providing a guide as to how to effectively conduct the analysis.

I will briefly discuss the way I identified, analysed and reported common themes from the interview transcripts. I firstly transcribed each interview to familiarize myself with the data set and during this stage already began to generate ideas about patterns within the data. Although some of these ideas followed the questions I asked in the interview, there were also patterns in what was spoken about which didn't seem to "belong" to any particular question.

The next stage was to code the data. Coding involves moving the data into meaningful groups (Tuckett, 2005). Although coded data aligned closely to what was eventually decided on as the themes, interpretation of the data had not occurred yet. The data was then analysed further, and the ideas grouped into themes.

An idea becoming an identified theme was not necessarily dependent on the number of times something was spoken about (Braun & Clarke, 2006). Any idea raised in the interview that captured an important element of my research question was drawn out

as potentially being relevant. The development of themes required my personal judgment. If the same interview transcripts were to be reviewed by a different person or theoretical position this would result in additional and different reading and theme development (Roulston, 2001).

Eventually I was able to identify and articulate the essence of each identified theme and sub theme. To illustrate points further, particularly vivid examples and quotes were chosen that encapsulated elements of key ideas. These were eventually included in the next chapter, thematic analysis.

What I am likely to look for due to my background

Before I start the thematic analysis chapter I must talk about my background and the influence the way I interpreted the information gathered in this study. I am medical student who has just completed my third year. This will have some influence on the questions I ask, how I engaged with participants and the themes I identified. I am not consciously aware of the effect that this may have had on the research I am completing, but am aware that this will affect how the information is perceived and presented.

Chapter 3 Thematic Analysis

This chapter will cover the themes that emerged during the thematic analysis process. This chapter is broken into sections including: Caesarean Deliveries for Non-Obstetric Reasons, Validity of the Request, Distributive Justice, Non-maleficence, and Autonomy.

Caesarean Deliveries for Non-Obstetric Reasons

Interviewee's definitions of "non-obstetric reasons"

To open this chapter I will firstly explore what the phrase "caesarean deliveries for non-obstetric reasons" meant to the interviewees¹². This is key to interpreting the rest of the information gathered from the participants. In each interview, I asked what the phrase meant to the participant. The following quotation is a particularly comprehensive response incorporating a number of important elements:

So non-obstetric reasons for me would be that there is no risk by having a vaginal delivery to the mother or the baby as an elective procedure. Therefore doing the elective caesarean section is an invasion if you like of the pregnancy, an artificial delivery which isn't indicated because the risks may outweigh any gain. But when you say, non-obstetric, there can be medical reasons, including the woman's mental state and her sexuality, or feelings that she wouldn't cope by having a vaginal birth with publicity of that. And it may be that some people's perception of risk is greater than what is recognized by consensus of specialist or others. In which case they may be asking, because they feel in their hearts that it is better for them. And I think you have to take those requests very seriously, because there may be things that they are not able to share with you that are causing them to have that concern...So we are really talking about those who, despite the average amount of information a woman receives, and access to information that is peer

¹² In the interviews I referred to CDMR as caesarean deliveries for non-obstetric reasons. I have explained in the previous chapter why these two different terms were used.

reviewed and accepted as a truth, they still feel they want a Caesar more than a vaginal delivery at the end of the day, despite the inherent risks that go with having surgery.

Interviewee 6

Highlighted in this response is that there might be a difference between a non-obstetric and a non-medical reason to have a caesarean section. With a non-obstetric caesarean delivery, there may still be other health concerns. For example, mental health concerns are not obstetric indications, but by denying a woman's request when such concerns exist may cause significant harm to her health, making it a medical indication to perform a caesarean section, even though this reason may not be directly related to the pregnancy. One other interviewee in particular explored their interpretation of non-medical caesarean deliveries:¹³

I think non-medical for me is ...where the woman insists on having a caesarean section, or perhaps the provider, with no documented medical rationale for why [a vaginal] birth otherwise wouldn't succeed.

Interviewee 5

Another interviewee spoke about how a non-obstetric reason may merge into an obstetric indication:

What about a psychosocial indication where there is sexual abuse or women cannot tolerate the idea of a vaginal examination for example? And they are real. They are not imagined. And you have that pelvic floor which is hypertonic. And you know that they are going to have a difficult labour. You know that. You just do. That to me is an obstetric reason, although it has stemmed from a psychosocial one. You know what I mean? You kind of merge, the psychosocial reason merge into real reasons really.

Interviewee 3

¹³ This was part of a wider discussion which compared how caesarean sections for non-obstetric and non-medical reasons would differ

One interviewee completely disagreed that there was such a thing as a “non-obstetric caesarean delivery”, arguing that they had only ever encountered obstetrically-indicated caesarean deliveries on maternal request. Even if there were no current indications to suggest that this person would not safely be able to have a successful vaginal delivery, they still felt that they were obstetrically indicated:

If you take the time to question the women as to why they have made that decision to have a planned caesarean at 39 weeks or more you will usually find that it is for foetal reasons. That they are wishing to minimize the risk to their child.

Interviewee 4

The valid issues which they spoke about in this quotation included shoulder dystocia, birth asphyxia, babies ending up with injuries due to difficult forceps deliveries, and pelvic floor damage if we are using maternal reasons as indicators as well. The interviewee went on to say:

Most couples who are requesting a caesarean section are requesting it for foetal reasons, not maternal reasons. So that is where I have a problem with your wording, because they are obstetric and medical reasons. OK, you could say that they are prophylactic, because they are being done in a preventative way, to prevent an issue. Which is reasonable isn't it? We do cervical smears all the time to decrease the chance of a women having cervical cancer. We do mammograms to decrease the chance of a woman developing advanced breast cancer. These women are requesting caesarean sections to decrease the chance of their child having a problem. So as I say, I think it is important to phrase it, and to ask why somebody is wanting a caesarean section. Because there is always a reason if you take the time to ask.

-Interviewee 4

After a discussion about what exactly was meant, for the rest of this interview where I would usually ask about “caesarean deliveries for non-obstetric reasons”, I would

speak about “prophylactic caesareans”. This interviewee was happy with this so long as I qualified that that the caesarean was not being performed for some arbitrary reason, but rather because they want to have a caesarean to avoid a negative medical outcome for their child, or themselves. From this interviewee’s perspective, the request could therefore be considered a medical request. This interviewee felt that if people suggested that there was such a thing as a non-obstetric reason to perform a caesarean that they hadn’t taken enough time to thoroughly explore the woman’s request and find out what the real reason was behind their request:

If you are going to say prophylactic caesarean sections for foetal and maternal wellbeing, then you have to qualify that. Because I am saying that they have got a medical reason.

Interviewee 4

Another interviewee thought that classing requests into obstetric and non-obstetric reasons was not particularly helpful, and instead evaluating each person’s case individually and working out whether the woman’s request had grounds to provide a caesarean section or not made more sense.

New Zealand Maternity Culture

Many people spoke about the New Zealand maternity culture and how this may affect the way that caesarean deliveries on maternal request would be perceived.

A common idea was how supportive both midwives and obstetricians were of vaginal deliveries in New Zealand:

In New Zealand they like to see women, the doctors and the consultants, like to see primip’s¹⁴ to get into delivery suite and give it a go. And I really love that attitude.

Interviewee 11

¹⁴ First time mothers

The reverse of this, which was covered by other interviewees, was the low level of acceptance towards elective caesarean deliveries and the fact they had traditionally been “frowned upon”.

Some interviewees compared the New Zealand birthing culture to other parts of the world where the caesarean rate is considerably higher than New Zealand:

Well in lots of places all around the world like Brazil...they are sectioned all the time over there. Iraq was another place. Lots of places that just automatically offer an elective caesarean section, and I would hate to see that happen here in New Zealand without a doubt.

Interviewee 11

One participant spoke about the demand for vaginal deliveries from the women who utilize maternity services and this being one of the factors that drives our maternity culture:

My main problem is pointing out to people that their dreams and aspirations of a normal vaginal birth are just never going to happen, and I am terribly sorry, but you have to get onto a different goal there... So [for] most of our population, that is what they want. The glowing uncomplicated vaginal birth.

Interviewee 7

An important factor which will have a considerable effect on how this clinical situation is perceived is the philosophies of those people who are key players in the maternity care system. Many acknowledged the significant role that midwives play in our country's system:

The maternity care system in New Zealand works.... or the maternity care is mostly midwife led.

Interviewee 8

It is therefore highly relevant to this study that many midwives spoke about how “unnecessary intervention” is incongruent with midwifery philosophy. To many midwives, caesarean sections can be life-saving when things go wrong during a vaginal birth. However, they strongly believe that the intervention should only be used when it is absolutely essential.

It was easily observable over the course of the interviews that caesarean deliveries are not readily accommodated by the current New Zealand maternity care ethos in cases where no obstetric indication exists.

Perceptions of caesarean deliveries for non-obstetric reasons

From the interview transcripts I was able to ascertain an overall impression on interviewees’ perceptions of CDMR and many of the ideas and connotations associated with the topic. It seemed that Caesarean Deliveries for Non-Obstetric Reasons were associated with a few key words that followed a similar track. Interviewees commonly mentioned words like “unnecessary”, “easier”, “unethical” and “costly” in relation to the topic. People often spoke about them being performed for “no reason”. They even referred to the way the media had portrayed this clinical situation:

It comes to mind just what has been in the public media: “too posh to push”. So that is the first thing that comes to mind.

Interviewee 9

Many participants spoke about how elective caesarean sections had been glamorized by the media and portrayed as the easier option, which may have led to an increase in the number of requests:

Caesarean section is a known intervention, and in the public’s view, what I see of the public’s view, it tends to carry little risk. And it’s not widely understood in terms of its risks. And I think that women still consider it to be the easier option.

Interviewee 5

Encountered situations

Many of the requests for caesarean sections that had been received by interviewees were linked to fear or anxiety. Fear surrounding childbirth, incontinence, perineal damage, pain, or traumatic injury to their child during a vaginal delivery were all anxieties behind encountered requests. Although childbirth makes many women nervous, it seems that there are some who are exceptionally anxious, and may request to have a caesarean delivery for this reason.

Two of the interviewees spoke about the requests they had had from woman who had experienced a previous traumatic delivery. One interviewee explicitly stated that in such circumstances there were no obstetric indications to act. However, they did say that there may be minor secondary physical concerns or complications from a previous delivery that could be recorded as the primary indication to perform a caesarean section. Another interviewee spoke about a case where a woman had significant anxiety due to a previous traumatic birth experience. This interviewee said it was hard to reassure the woman in this case because they were never able to guarantee that the second birth was going to be any easier. Although these were the only examples that were given, there was scepticism from some about how valid the indication to perform a caesarean section was in some cases. A few of the midwives interviewed said that obstetricians seem to find a reason to “pin it on”, despite the fact that this medical condition may not have interfered with the woman’s ability to have a successful vaginal birth.

Perception vs. encountered situations

There was an obvious mismatch between how the interviewees perceived CDMR and what actually occurred in practice. It seems that interviewees had encountered a range of requests for caesarean sections which they regarded as non-obstetric, but none of the interviewees had actually encountered requests for scheduling purposes or just because it was considered to be the easier option.

Although people often spoke about women potentially requesting caesarean deliveries purely for scheduling reasons, no one spoke about encountering these requests in Dunedin. This interviewee elaborated:

There is a third group which I don't believe we get to see which are people who would choose it for convenience; it best fits their lifestyle. And that is really because they want a certain time and day or want certain people present, so it's easier to circumnavigate nature by electing a date, and a mode of delivery.

Interviewee 6

After that particular response I went on to ask why it was that they thought that we didn't see this group, and they spoke about these requests being "filtered out" by the initial point of contact in the maternity system, the midwife or GP. They felt that due to the acknowledgement that there are limited resources that CDMR is not encouraged.

While some interviewees speculated that caesarean sections may be performed for scheduling purposes or just because it was perceived an "easy option" more commonly in the private system, both private obstetricians who I interviewed had never encountered such requests.

Frequency of requests

All interviewees said that CDMR was very uncommon. This aligns with findings from previous research. No one was able to indicate exactly how many cases they had seen in the past year, or had an idea of how commonly these cases had occurred over the time they had been practising.

Different interviewees reported different perceived frequency of requests for CDMR. Interviewees felt that there were a number of factors influencing whether or not they encountered requests. These factors differed between midwives and obstetricians.

Many of the midwives said that they predominantly served a particular community and then spoke about factors that made it more or less likely for that particular cohort to request caesarean deliveries. For example, one midwife spoke about the fact that the community of women they looked after would not request one due to an assumption that they would need to go through the private system to obtain one, and that many of her clients would not be able to afford this. Another midwife spoke about only doing homebirths currently, and therefore had not encountered these requests. Even if they had not dealt with any or many requests within their clientele, they often spoke about these cases in colleagues' caseloads.

Obstetricians had a variety of explanations for why they felt they were unlikely to encounter requests. For example, one obstetrician said that they usually did not deal with daytime obstetrics and you may see more cases during the day or another felt that they dealt predominantly with high-risk obstetrics. There was a lot of speculation that the requests might be more common in private settings, and although the private obstetricians alluded to the fact that it might be slightly more common in their situation there was nothing to suggest that the frequency of these was significantly greater in this setting.

If people made a comment about whether the frequency of the requests was changing, they either said it was too hard to know or that the requests were increasing in frequency. No one spoke about the requests decreasing in frequency. It would be interesting to explore whether the requests have become more frequent over time, and if so, to explore why this is the case. One interviewee hypothesized that the requests had not become more frequent because more people desired one, but rather because it had become more acceptable to vocalize this preference for a caesarean section:

I think that is because people have felt more able to make that request and talk about their feelings. And I suspect that those thoughts have been out there for a long time but women have not been able to, or parents, neither the mother or father of the child, have been able to

voice that. But I think as people have become better informed, they feel more able to speak for themselves.

Interviewee 4

Another interviewee who also thought the requests were increasing in frequency, who had had a series of requests from Latin American women, and therefore felt that increasing immigration may be driving the trend.

Two interviewees who had spoken about the number of requests increasing over the time they had been practising spoke about it being an unexpected subgroup driving the increase in frequency. They both said that they would have thought that older women planning a single birth would be more likely to request, but did not observe this in their practice. They also did not think there was a particular cohort that was more likely to request a caesarean delivery for non-obstetric reasons.

Although a request for a caesarean delivery was very uncommon, interviewees said that it was more common for women to raise the idea of having a caesarean section during consultations. In these cases they believed that it did not mean that they wanted to avoid having a vaginal birth. This point is summarized by the following quotation:

It's not a common request. I mean, occasionally as we go through the pregnancy people might say "oh, I am a bit nervous about, you know, could I just not have a caesarean?" They are just testing the waters rather than saying I want to have a caesarean section and I am not prepared to have a baby any other way.

Interviewee 10

Inaccurate Records

Although interviewees were asked about the frequency of CDMR, nobody was able to provide definitive figures. Interviewees felt that the statistics that are currently kept do not reflect the true number of requests. There were a variety of factors that

contributed to this, which the vast majority of interviewees spoke about at some stage.

Some interviewees felt that there were instances where the caesarean section would be recorded as being performed due to an obstetric or medical complication, when in fact the decision was made almost entirely because of the pregnant woman's request. They said in these cases that it was more likely that they would find a medical indication that they could "pin it on" and record this as the reason for performing the caesarean section. In turn, the records would not be entirely reflective of the truth.

Three interviewees spoke about it being very unlikely that they would ever record the indication for these cases as "caesarean delivery on maternal request". One particular obstetrician spoke about a hypothetical situation where a woman was requesting a caesarean delivery due to a previous traumatic vaginal birth had resulted in another of her children having a shoulder dystocia. In these circumstances they said it would be highly likely that her request would be acted on in light of her previous experience and the notes would say "previous shoulder dystocia, caesarean section recommended and agreed upon", when it was actually the mother's request that would have led to that procedure rather than a recommendation with medical grounds. But this interviewee felt that if you recorded it as maternal choice in the notes that it may not be considered acceptable by management, as illustrated by this quotation:

People don't like it, which is why we don't do it. I've written ["maternal choice" as the indication for a caesarean section] and got into trouble recently...I wrote it, and when someone asked me why I was doing a caesarean section for maternal choice I said...well, it was for a VBAC and I said "but it's not because I say that she needs it, it is because she wants it, so it is maternal choice." And part of why I was doing it was to be difficult, you know, just to stir. Not for the woman, for the unit. But it makes it hard, and you don't want it to be hard for the woman and you

don't want it to be hard for the midwife. So it is easier to just not bother¹⁵

Interviewee 7

There was also another reason that may lead to current statistics being inaccurate; the acknowledgement by some participants that sometimes the truth behind why someone would want a caesarean section over a vaginal delivery may not be disclosed. There were two illustrative cases where the interviewees felt that the reason given was not the truth as to why they did not want to have a vaginal delivery. One interviewee spoke about a case where a client claimed to have a medical condition that would affect her ability to safely have a vaginal birth. This midwife referred her client having never heard of this condition before, and the request was declined by the antenatal clinic. The midwife felt that the client had made up a medical condition in an attempt to secure a caesarean section. Another midwife spoke about a similar scenario. In this case a client had reported symptoms that she knew would probably result in her having an elective caesarean section. The more she was asked about certain symptoms by doctors the more she would report them, and the result of this was that an elective caesarean delivery was performed. There was a meeting by the healthcare team who took part in this case, and it was unanimously felt that the woman's intention was to secure a caesarean delivery.

¹⁵ In this case, the choice existed for the woman because she had previously had a caesarean section. This interviewee questioned whether this should be considered a medical reason, or whether this was a choice made by the woman against a vaginal delivery.

Validity of the Request

When it is acceptable to act on the request

Most interviewees felt that it was very plausible that a woman could present with a concern where it could be considered a valid reason to accede to her request for a caesarean delivery. Some interviewees encountered cases like this in practice.

Six interviewees spoke about mental health concerns being a completely acceptable reason to accede to the woman's request. Significant anxiety, depression, or Post Traumatic Stress Disorder were all conditions that were spoken about, although I suspect that the scope of the phrase "mental health" covers more than these three disorders. Some interviewees spoke about this being a medical indication for a caesarean section, and this would imply that for these individuals mental health was included in their definition of health, and is as much of a valid indication to act as a physical obstetric indication. In some interviews people said that if the woman was "genuinely anxious" or had a "valid concern" that it would be reason to act, however, this would be very difficult to judge objectively.

Just looking at things from a purely obstetric point of view, if we look at stats relating to mortality and morbidity, there is no doubt that a normal delivery with no problems has the best outcome. So we should advocate best practice. Once you start developing problems, obstetric or medical problems, and a person who has depression to such an extent that she is considering suicide, I would regard that as a valid indication to accede to her request.

Interviewee 8

Linked to mental health, three interviewees spoke about patients who had been sexually abused. All interviewees regarded it as an important factor to explore, and if the woman felt that she really could not have a vaginal delivery then they would accede to the request for this reason:

Usually post-abuse is what I have seen and when a woman has been abused and feels that either touch or intervention in her vagina or labial area causes her to have psychosis... Or if she feels that is too traumatic to have that sensation. And those women find it easier to have a caesarean section... But they certainly talk about the option and some women choose to have a caesarean, and some women choose not to.

Interviewee 5

Three of the interviewees had encountered requests for cultural reasons; specifically requests from women who were originally from Latin America. In all of these cases the request resulted in them having a caesarean section. One of these had occurred in the public system, but by the time the request was granted it was for mental health concerns due to significant anxiety.

They have never met anyone who has had a vaginal birth prior to coming to New Zealand. That is the quote that they always say. None of their friends, none of the people they know, in their families, nobody has ever had a vaginal birth. So they do not even consider vaginal birth as an option really.

Interviewee 7

Two interviewees spoke about it being completely justifiable to act in cases where women were concerned about the risks to her child through a vaginal delivery. In a case that was described, a woman was very anxious about birth asphyxia. The woman herself suffered from epilepsy and attributed her condition to her mother's traumatic delivery when she was born where she had to be resuscitated. And in this case the obstetrician agreed to the request because the woman wanted to decrease the risks to her child, particularly as they had been affected by the condition themselves.

Another two interviewees spoke about what they referred to as "soft indications" other factors that had some impact in the decision of whether to perform a caesarean section, but were not recorded. Soft indications may include, but are not limited to,

maternal age or someone who had required fertility treatment. This quote summarizes what was meant by this:

It's like when we do a caesarean section for so called foetal distress or failure to progress or something like that. It's seldom that the foetal distress was that dire that the only option was caesarean section. But if the woman has made really slow progress to how ever many centimetres she is, and the CTG is non-reassuring, and she is 40 years old and she's had IVF to get that pregnancy and, you know, you add all of these things in. And that is all put into the mix in the decision making of "well actually, I think caesarean is the best thing for you now because we're actually getting nowhere, the baby's probably getting tired and this is a so called "precious pregnancy", not that they aren't all precious pregnancies but...So I think all of those soft reasons are often not documented. But they do contribute to the decision-making as to why a woman might have a caesarean section, and those are caesarean sections for what are considered obstetrical reasons, and it might be put down as either foetal distress or failure to progress, but what are all those other reasons that actually went into the mix?

Interviewee 10

Conditional Acceptance

Although there are circumstances where interviewees felt it would be acceptable to provide a CDMR, there would still be additional terms that would need to be satisfied before the procedure would be performed.

Firstly, the elective caesarean must occur no sooner than 39 weeks gestation or else the risk of respiratory distress in the infant would be too high. This is in line with what RANZCOG recommends (RANZCOG, 2013).

A second condition was that there should be no plans to have further children, or potentially one more child. This is because the risks of a caesarean section, such as

placental abnormalities, increase with each subsequent procedure. The difficulty with satisfying this condition is that it is very hard to guarantee that a woman will not have further children. There are instances where it is highly unlikely that a mother will conceive again, like if it is an older mother or if there have been fertility issues. Cases with these factors seemed to make the procedure more acceptable to some.

Another condition is that informed consent must be satisfied. One of the issues that interviewees spoke about was the lack of balanced information available to women, and this is something that will be covered in Chapter Four. In this process, the interviewees commonly spoke about wanting the opportunity to thoroughly explore the woman's reasons behind her request, and the opportunity to debate and refute any misinformation.

Interestingly, although all interviewees felt that mental health would be an entirely acceptable reason to provide a caesarean section, they still felt that this reason was dependent on involving other healthcare professionals who were specialized in this area being involved. There were differing opinions on whether this multidisciplinary approach was currently happening:

I think it is very reasonable to provide what we ought to be offering. In terms of a multidisciplinary approach, having whatever the issue is being acknowledged, having the appropriate specialties involved and having it very clearly documented that that is the reason behind it rather than somebody just putting their name on the line and saying "we will just have this baby by caesarean please". How we do it currently, I don't think it's useful. And I think that the women get the impression that there is an obstetric reason that they are having a caesarean section, whereas I think they need to understand more that it is not.

Interviewee 5

The final condition for accepting caesarean deliveries on maternal request was that it should not be standard care. Although interviewees felt that there were reasons to

provide caesareans for non-obstetric reasons, it should not be a rite of passage for every woman who requests the procedure. There were concerns about precedent setting and the “slippery slope” argument was brought up in two interviews along with arguments on cost, risk, and changing the New Zealand maternity culture.

When interviewees would not support the request

Three interviewees thought that it was never acceptable to provide a CDMR. In these responses, the interviewees drew comparisons between elective caesareans and other elective procedures such as cosmetic surgery. One of these interviewees felt that the procedure could not be performed in the best interests of the mother or baby because there are significant risks for both that should not be overlooked. The third interviewee felt that they should not be offered for both of these reasons, and because it did not agree with her philosophy to intervene unnecessarily. Despite their personal opinions, these three interviewees all said that they would fulfil their professional obligations to support the woman to ensure she got the care that she needed.

Although the rest of the interviewees accepted that there might be valid reasons to act, it was equally acknowledged by this group that there were reasons and circumstances in which they would not support or accede to the request.

The first instance in which people would not support a caesarean section was if the woman was asking purely for scheduling or cosmetic purposes. All interviewees who raised this thought it would be unreasonable, and it was made clear that they certainly should not be available in the public system for these reasons.

Three participants spoke about not supporting requests where certain conditions were not met. These conditions have been spoken about in the previous subsection. Two interviewees explicitly spoke about not supporting the request if the woman was asking for the procedure to be performed before 39 weeks gestation. Another condition that was spoken about was not performing the caesarean where the woman was not fully informed or misinformed.

Interviewees spoke about the broad grounds on which they would decline most requests rather than specific requests a woman may present with. A few interviewees considered CDMR to be an unnecessary use of resources, whereas others thought that the potential for harm was too great to justifiably support CDMR. This quotation from an interview illustrates the latter of these two reasons:

I can see why women would ask for a caesarean section, to avoid labour and have a quick fix. But I would find it difficult to do because I am aware that there are complications, both short and long term, of having surgery which isn't essential. If it's indicated, that's different. But if it's not essential I think you are almost breaking your code of practice.

Interviewee 6

CDMR vs. current “medical indications”

Many interviewees challenged whether some caesarean sections currently occurring for “medical grounds” are actually being done for maternal choice. The example that was commonly spoken about was the choice that women could make following a caesarean delivery as to whether they wanted to have a trial of labour or an elective caesarean:

Is there an obstetrical indication for a woman with a previous section requesting a caesarean for the second time? You know, the first baby may have been breech, and the second baby is head first, well grown, everything is good for a trial of vaginal birth but she has had a previous caesarean section. And the obstetrical indication for repeat caesarean section that you put down is “previous caesarean section”. Now is that an obstetrical indication or is that actually a choice? And it is quite possibly a choice because there is no obstetrical reason.

Interviewee 10

Interviewees also challenged the grounds on which decision is made, as the increase in risk of an adverse outcome for these women is minor. Participants thought that there would be some non-obstetric requests that would be more valid than those who had been offered one because they had had a caesarean delivery previously:

It's ethically unacceptable for someone to request a caesarean for maternal choice because she's 38, but it is OK to choose it because someone has had a previous caesarean, which to me makes no sense whatsoever. Which I think is what happens... "This is OK but that is not" for arbitrary reason, which doesn't really stand.

Interviewee 7

Distributive Justice

Current availability in the public system

Eight interviewees thought that CDMR were currently available in the public system while four were unsure. Although it was acknowledged that these were rare occurrences, seven interviewees had personal experience of them occurring in the public system in New Zealand, not all of these occurring in Dunedin

It was felt that in Dunedin even if a caesarean section is performed by a private obstetrician that these procedures are still partially publically funded. This is because there is no private facility where caesarean sections can be performed in Dunedin and therefore all elective caesareans would occur in a public hospital with public resources and publically funded midwives. So in fact, all of the caesarean sections performed for non-obstetric reasons in Dunedin will occur in the public system even if they are paying for private intrapartum care:

Even if someone has privately funded obstetric care, they still have publicly-funded midwifery care, and still use a publicly-funded hospital bed. So I suppose it is offered really.

Interviewee 5

Differences in accessibility

Interviewees frequently spoke about requests being handled differently across the country, and even between practitioners at the same city or hospital. This theme deals with the issue of equity of access and will be explored further in the discussion.

One of the factors that seemingly will determine whether a woman can obtain a CDMR is where in the country she lives, and how commonly requests are acceded to in that place. Four interviewees mentioned that they felt it was more common in other places in the New Zealand, such as Auckland. From what they had heard from colleagues who worked there it seemed the rate would be much higher. Two interviewees accounted this to a larger private obstetric practice in this city.

Yes, depending on where they are. Some places yes, and some places no. If you are in Auckland you can. You can basically walk in and say you want a Caesar and that is pretty much it. And partly that....well, where the caesarean is done makes a difference.

Interviewee 7

Another issue that two interviewees spoke about was that access to the procedure might be different even within the same DHB or hospital. It seems that who the referral is sent to will have a significant effect on whether the request is acceded to or not. This interviewee spoke about how they had accepted requests in the past. The following quotation also implies that if a woman is referred to someone else in the same hospital the request may be handled differently:

Well in this hospital I think it depends on which obstetrician you end up seeing, in terms of what happens. The two cases that I have had in the last couple of years were purely, absolutely, for maternal choice with no obstetric indication at all.

Interviewee 7

Whether they should be available in the public system

A related idea to whether CDMR were currently available in the public healthcare system was whether it is acceptable to provide the elective procedure within the constraints of public healthcare funding. Just because elective caesarean deliveries were considered to be more expensive than a vaginal delivery by most interviewees, it did not necessarily mean that it was never acceptable to provide one in the public system.

Whether it was acceptable depended heavily upon the reason for the requests. One obstetrician said:

Is there anything wrong with choosing to have a baby by caesarean section when there are significant risks of having a baby at 43, when you may have fibroids or other issues? Now there may not be an

obstetrical indication to do a caesarean section, but I believe if that is what they would prefer to have a safe delivery of that baby then I don't have a major problem with them choosing that.

Interviewee 10

The interviewee was asked for clarification as to whether they would find this acceptable in the public system, which they did.

Some interviewees felt that if a woman had a valid concern but could not afford to fund the procedure herself then we should be compassionate and allow for it to happen in the public system. This interviewee supported this view:

Do I, am I incredibly pro-vaginal birth and think caesarean section is a bad thing inherently? What's my dream? Is it that 100% of people have caesarean or that 100% of people have vaginal birth? My dream is that 100% of people have a vaginal birth. Definitely. That is the camp I come from. But I am also realistic. And I think that you also need to be realistic and provide one on one care to the woman, taking all of her risks and benefits into consideration. And I think in that situation, the public service needs to provide those women with what they need.

Interviewee 7

Another participant argued that obstetrics should be no different to other areas of medicine where we avoid unnecessary intervention, especially as it is considered to be more expensive than a vaginal delivery by most. They felt that the public purse should be used with transparency and integrity, and if it was decided that it was not affordable in the public arena then it should not be allowed to happen as the resources could be better utilized in a different way. This was supported by the following statement:

Working in the public sector we also have to consider that we are dealing with limited resources and those resources have to be allocated appropriately. So if I make a blanket statement, I don't think that the

public healthcare system in New Zealand can afford to have caesareans on maternal request for different reasons...In the private sector, where people pay their own way, I think that is different. It is your money, your choice. It is your right to request the caesarean section. It the right of the practitioner, if there is no medical reason, to refuse.

Interviewee 8

Cost of an elective caesarean section

There were differing opinions about whether an elective caesarean section cost more than a vaginal delivery or whether the cost has been overstated for elective caesarean sections. Although most interviewees either felt that an elective caesarean was more expensive or did not indicate their thoughts on this matter, three interviewees challenged the commonly held belief that they were more expensive. These three interviewees felt that the cost of an elective caesarean would either be on par with a vaginal delivery or cost less in if we take into account the long-term implications of a complicated vaginal delivery.

If there is a resource issue, that it is more expensive for the community to have caesareans electively, then that does become a secondary argument. But I don't know anyone who has made that economic analysis. That it is more costly. In fact, I think it would be the other way around. In fact my gut feeling is that if you did a proper economic analysis you would come up with the argument that caesareans might be cheaper.

Interviewee 3

These issues will be discussed further in the next chapter.

Non-maleficence

Risks of a caesarean section

There were significant differences in how the risks of a caesarean section were perceived by different interviewees:

Discussing the risks and benefits of a caesarean section is really subjective. So what I'm going to say are the risks and benefits of caesarean section are, and what a private obstetrician is going to say, or a person who just does home births is going to say, are three quite different stories.

Interviewee 2

Interviewees fell into two groups when it came to the perceived risks of caesarean sections. One group thought that the risks associated with elective caesarean deliveries are as low, if not lower, than a vaginal delivery:

I think that an elective caesarean, and it has been shown for some time now, is as safe as a vaginal birth in terms of risks to the woman and the baby. And therefore, I guess if there is, or because there isn't an increased risk compared with a normal vaginal birth, and we only know that a woman is going to have a normal vaginal birth after the event, therefore I don't think there is a significant concern about risk associated with caesarean section. That is the first caesarean.

Interviewee 10

The other group was more likely to talk about the rare but potentially life-threatening risks associated with caesarean deliveries:

Any abdominal surgery is major surgery. Therefore the blood loss is heavier, anaemia is more of an issue, and here they are trying to lactate and heal and care for an infant and possibly children at home too. And possibly other things may get nicked along the way too, you can get extension tearing, which is dangerous. And you can get the bowel and

all of that sort of stuff, which isn't ideal...and then increasing DVT's and pulmonary emboli. I mean they are life-threatening things, aren't they? They are unlikely to occur, and we manage them well, but they still do occur from time to time.

Interviewee 1

When speaking about the risks of the procedure, interviewees were likely to concentrate on the risks and implications for subsequent pregnancies and births.

I think that would be my main concern if we were looking at repeat procedures. There is increasing evidence that there is maybe some increased risk with that, and that is something that I would discuss with the woman when they are making that choice of a caesarean birth with a non-obstetrical reason. They need to be aware that they may be increasing their risk of future complications, not necessarily in this particular birth.

Interviewee 10

The risks associated with a caesarean delivery were not the only potential harms discussed; five of the six obstetricians interviewed also spoke about the risks associated with a vaginal delivery:

There are risks of a vaginal birth. And I think we are pretty negligent as a specialty by not actually informing women of the risks of a vaginal birth.

Interviewee 4

People who spoke about the risks of vaginal delivery included shoulder dystocia and hypoxic ischaemic encephalopathy, leading to the child's disability. Pelvic floor dysfunction, specifically urinary incontinence, was the most spoken about potential sequelae of a vaginal delivery; however it was generally felt that this is a complex issue with many potential causes, and is not just caused by having a vaginal delivery.

Presenting the risks to the woman

Because of the lack of consensus on the risks of a caesarean section there was concern by some that there was scope for coercion in the way that information was presented to pregnant women on their options:

We are very selective as a profession, and I am talking about obstetricians, gynaecologists, midwives, and any medical or paramedical profession. We are selective in the way we weight risks and what information we give...We tend to give information to try and persuade people to follow the course of action that we think they should take rather than giving them the whole of the information and allow them to decide what course of action they want to take.

Interviewee 4

Autonomy

Autonomy vs. resource constraints

Many interviewees felt that the main conflict between ethical principles was a contention between the individual autonomy of the woman and resource constraints. Many felt this was an expensive and unnecessary procedure, and healthcare dollar could be better spent providing benefit to a greater number of people.

One of the obstetricians felt that if a woman's request was declined due to resource constraints in the public system that an alternative route to fulfilling her request must be given in order to satisfy autonomy. The alternative route would likely be going through the private system. Her concern was that if we were unable to do this that the patient may become significantly anxious, which would not be good for maternal or foetal health. If this were to happen, there would be significant mental health concerns the obstetrician would have medical grounds to perform an elective caesarean, but arguably more harm than good may have been done in the process. The obstetrician spoke about her experience with this:

By the time they got to 36 weeks and I saw them in the clinic, I had made them so sick by not promising them a caesarean, that I was mortified. And one of them I was seriously worried about her mental health, and the other one having learnt from my prior experience I didn't push as hard. Anxiety's a bad thing in pregnancy, for both the mother and the baby. It is not something we should be doing.

Interviewee 7

Autonomy vs. risks

Most people interviewed agreed that non-maleficence was not the main factor in contention with the woman's autonomy. It was felt that the risks were relatively low especially if the procedure was performed after 39 weeks gestation.

The risk profiles of an emergency and elective caesareans are very different:

With an elective caesarean you prepare the woman ... she is physiologically not in labour. She is fasted, she is prepared. So the risk of aspiration pneumonia is very low, if not non-existent all together... Anytime that a woman has an emergency caesarean that is a risky thing to do.

Interviewee 3

Interestingly, it was felt by more than one obstetrician that the risk of an unanticipated emergency caesarean might provide grounds for a woman to request for an elective procedure well in advance of labour. The following interviewee described this:

I mean if you look at the mortality and the morbidity from the point of view of maternal/ foetal and you look at statistics, a normal birth with no intervention is the safest for mum and baby. The second safest is a planned elective caesarean. The highest risk is an emergency caesarean. So if you plan for number one, and it doesn't work out, you end up with number three. So this is something where thinking people opt for number two.

Interviewee 8

Autonomy as the primary consideration

Two of the interviewees felt that autonomy outweighed all other concerns, such as risks and economic burden in almost all cases. These interviewees felt that because a vaginal delivery is not free from its own risks, or its own potential costs, a woman should have the right to explore the risks and benefits of both modes of delivery and at least be able to voice her preference. One of the people who held this opinion felt this way because the woman and her family are ultimately the ones who would live with the consequences of anything going wrong during a delivery, and therefore should feel empowered to make what she feels is the best choice for them, with the support from the obstetrician. The two interviewees who felt this way differed in opinion on whether this is appropriate in the public health system.

One interviewee put forward an argument about autonomy that followed a significantly different train of thought to anyone else. This participant felt that we live in a day and age that women have a choice as to whether they want to be pregnant or not. They outlined all the opportunities a woman had to either prevent herself from becoming pregnant, from birth control to sterilization, to having a termination if she unwillingly became pregnant. But they then said that once the woman became pregnant and decided that they wanted to keep the baby, she suddenly did not have a choice as to how she wanted her baby delivered. This interviewee felt that if autonomy was the primary concern, following this logic, should they not have the choice about mode of delivery? I will discuss this further in the next chapter. It should be noted that the interviewee acknowledged that autonomy was not the only concern. Appropriate resource allocation and the inherent risks that go along with having surgery were other issues that were spoken about.

This interviewee felt that the high caesarean rate increased the weight of a woman's request and gave more weight to her request:

I think we would be hard pressed in today's climate to try and push people away from considering a caesarean for a non-obstetrical indication when we are recommending a caesarean for 35% of the patients who are having their babies. Our caesarean rate is high by, well, I don't know whose standards you want to say, but it has been increasing and if we can't give them a guarantee that they can actually achieve a vaginal birth safely in a lot of situations then I don't think we are in a very good position also to be talking about what they might be requesting.

Interviewee 10

Informed Consent

Some interviewees challenged the premise of a woman being able to satisfy informed consent for a CDMR. They felt that the woman's autonomous decision to have an

elective caesarean instead of a vaginal delivery must be based on experimental evidence. However, as has already been covered in Chapter One, there is extremely limited evidence comparing the outcomes associated with an elective caesarean delivery against a vaginal delivery. The lack of high-quality evidence partially accounts for the high degree of variability in practice and acceptance of the procedure.

Due to the lack of evidence, a lot of a woman's decision will be based on the information available from the Internet, other people's accounts of their experiences, and what she is told by healthcare professionals. A difficulty with this is that the advantages and risks associated with an elective caesarean will be perceived very differently between healthcare professionals, even within the same healthcare profession.

Because of the lack of corroborated information available to the woman and practitioners, some interviewees felt the weight of the woman's request for the elective procedure should be decreased.

We do things for the sake of mother and child, but we have to be sure that what interventions we do are authenticated by evidence. It must be evidence-based practice. And to this date, I am not aware that there is any evidence that not allowing a woman to proceed to a normal outcome is to the benefit of the woman.

Interviewee 6

There were situations that obstetricians had encountered that were a reflection of a woman being ill-informed about what she was asking for. This obstetrician spoke about her reaction to a woman who was requesting a caesarean section because it was the "easy option":

Now I think that my job is to educate them, to make them understand that they don't want a caesarean section. So I would not cart blanche say "no you can't have one" probably. I would probably sit down and

have to explain why I wouldn't do one. But I think there should always be a reason why you are doing it which is justified and has logic behind it. And I think we do harm, we do caesareans when there isn't.

Interviewee 7

Potential Conflicts of Interest

In order for a woman to truly give informed consent, there is a series of considerations that must be satisfied. These include her decision being free from coercion and the information disclosed by the care provider being truthful and unbiased. Five interviewees spoke about potential conflicts of interest that have the capacity to compromise both of these factors.

Three midwives spoke about how a woman's decision to have an elective caesarean section would potentially reduce the midwife's income. Community midwives are paid in three modules. They are paid for antenatal, intrapartum and postnatal care. If a woman decided to have an elective caesarean that it would significantly decrease the amount they were paid for that woman's intrapartum care, which is the largest payment module of three. The following comment was made in relation to this point:

The more and more women who are having elective caesarean sections is impacting the community midwives income and probably attitude as well.

Interviewee 5

Two obstetricians spoke about how it would be much easier to perform an elective caesarean section than aid a woman through a complicated vaginal delivery where intervention was required, or perform an emergency caesarean section. Both of these obstetricians immediately followed this statement by saying that this to be a factor in their decision, but it still remains a potential conflict of interest.

It's much easier, honestly, to go and do a caesarean at 9 o'clock in the morning than it is to do a vaginal birth. It's much easier...I don't think it's right, but it is much easier.

Interviewee 7

Although a significant proportion of participants discussed these factors, no one spoke about particular instances where benefit to the practitioner affected the decision a woman made regarding her mode of delivery.

Professional Autonomy

A dimension of autonomy that was raised by three interviewees was professional autonomy. It was argued that professional autonomy plays an important role in the decision making process. They felt that healthcare professionals should feel comfortable that their actions were not putting the patient in the line of unnecessary risk. Below I have included two illustrative quotations with regard to professional autonomy:

Because the professional also has a say in that, whether or not they feel safe carrying out the procedure, or how they feel for their professional practice also needs to be taken into account. They've got rights as well.

Interviewee 12

Autonomy, we talk about it, but I quoted someone the other day who said "no, you have to do what the woman wants" and I said, "no I don't, I really don't. I don't have to do a hysterectomy on someone because they walk in saying that they want a hysterectomy, I don't. I can say no. The protocols, the guidelines, my skills, my ability, do not allow that to happen. Therefore, my recommendation is in my hands, and the safest thing for you is this, and you can't make me do something that does harm to you." The problem with caesarean is that, in most circumstances, we are not talking about a particularly big risk for them.

Interviewee 7

Rights

Many interviewees did felt that women had every right to *request* an elective caesarean, but the healthcare team reserved the right to decline the request. In this

way it was implied that there was no entitlement to the procedure for any individual. Interviewees commonly spoke about their request needing to be balanced against many other factors:

I think they have the right to request them. I think the provision of a poor resource, or a poorly resourced area, such as elective surgery in obstetrics and gynaecology has the risk of more work in the future if you do unnecessary caesareans. It has more risk of creating more work, therefore creating more economic consequences in the short term.

Interviewee 6

One interviewee felt that there was a significant difference in the weight of a request because in the case of CDMR the individual is requesting a procedure, rather than declining one. This interviewee felt that a woman's decision to decline a procedure carried far more weight than requesting a given procedure, such as an elective caesarean:

For me as a woman I have the right to say, "no, you are not doing this. I understand but I am not going to do this, or I am not going to be involved or I am not going to have a caesarean section". And I have the right as a professional to say, "this is what I advise" or "this is what I recommend, I am going to document that I recommend this". So I think that the woman who is in control of her body has the right to refuse things. But I don't think going in and saying "I have the right to this operation" in terms of a caesarean section.

Interviewee 12

Autonomy and midwifery philosophy

A cornerstone of midwifery philosophy is to support the woman's choice. This issue relates strongly to autonomy. Many felt challenged by the hypothetical situation where a woman was made aware of all of the risks of a caesarean and benefits of having a vaginal delivery, but still would prefer to have a caesarean section.

If you believe in a woman's right to choose, then you must believe in her right to choose what you don't want. So, because I believe in a woman's choice and control, I do accept that some women will choose what I don't like. Does it make me like it any less? No. But I do believe in women's right to choose. However, I would be more comfortable if there was better information out there. Because I just don't think that there is.

Interviewee 5

This quotation is from an interviewee who articulated this particularly well, but the idea was conveyed by many other midwives: just because the woman is choosing something different to what they would, does not mean that they would not respect their decision in a professional way.

Chapter 4 The Ethics of CDMR

All interviewees in this study acknowledged that a woman's request for a caesarean section should be validated and explored. However, they also voiced that a woman's request should not be the sole justification for providing a caesarean section, and that there were other factors to consider. These other factors can be categorized into the core ethical principles: autonomy, beneficence, non-maleficence, and justice, therefore taking a principlist approach to this ethical analysis. This approach will allow for a discussion of the important factors that need to be balanced in order to respect the needs and rights of the woman and her child with regard to CDMR

In this chapter I will explore considerations relevant to autonomy, justice, beneficence, and non-maleficence. In the next chapter I will talk about the application of the ideas discussed to clinical practice as well as policy development.

Autonomy

Across the healthcare sector of the western world there has been a shift in recent years away from medical paternalism, toward a patient-centred approach where patient autonomy is more highly valued (Annandale, 1998; Savulescu, 1995). A systematic review looking at patient participation in decision-making found that patients wanted to be involved in treatment decisions when more than one effective treatment option existed (Guadagnoli & Ward, 1998). There is evidence that obstetrics is no exception to this shift in medical culture, and that some women want to be more involved in their delivery decisions, including their mode of delivery (Tranquilli & Giannubilo, 2004). The fact that CDMR has become a recognized clinical entity shows that some women are voicing a desire to have a caesarean section as an alternative to vaginal delivery. This presents a complex dilemma to physicians and midwives: how do you incorporate patient preference where there are no medical indications to intervene in an otherwise normal pregnancy? Where it has been established that a woman has made a well-informed request, should it be entirely up to her as to which mode of delivery she wants? Such questions have been raised during the interviews and in existing literature. I will be exploring these issues in the following section.

Respecting a person's right to self-determination has become a dominant idea in bioethics (Stirrat & Gill, 2005). Equating autonomy with "one's right to choose" has arguably become the principle's most common understanding in healthcare, but it can actually be interpreted in multiple ways (Tauber, 2003; Ursin, 2009). Other approaches to autonomy are more relational, and others emphasize the importance of rationality in order to consider a status as autonomous (Gillon, 1985). According to some interpretations of autonomy, a woman's autonomy may be respected if understandable information is presented to her, there is no coercion, she is competent, and she gets to choose the mode of delivery she most wants. If another interpretation is used, respecting a woman's autonomy may entail providing understandable information, allowing choice, but also involves encouraging critical reflection upon her reasons for wanting a CDMR. This has important implications for

incorporating patient choice, the Doctor-patient relationship as well as the midwifery partnership model.

Differing ideas about autonomy

Most interviewees felt that the woman was exercising her autonomy so long as she was well informed and able to make a choice about her mode of delivery. Although most of the interviewees spoke about a vaginal delivery being an ideal outcome, the mode of delivery itself was not perceived to be promoting or detracting from a woman's autonomy. What was more important to autonomy was the ability to choose a mode of delivery that was best for her and her child.

As already stated, autonomy can be interpreted in different ways. Interestingly, this came through in the interviews in the way that midwives and obstetricians conveyed entirely different ideas about what autonomy meant to them. I will use a quotation from the interviews to illustrate this point.

How can a woman be autonomous when she is undergoing a surgical procedure? You can hardly be autonomous in the sense of contained and on your own

Interviewee 1

Based on what this interviewee said, performing a caesarean section when it is not medically indicated could be seen as inconsistent with respecting a woman's autonomy. This interviewee was a midwife. Some of the core principles of midwifery are to promote birth as a natural process, and to only use medical intervention where it is required. Independence from medical intervention could be seen as acting "autonomously" (Freeman, Timperley, & Adair, 2004; Kukla et al., 2009). Therefore a choice to medicalise birth and create dependence on medical practitioners may be viewed as a woman undermining her "autonomy" because it takes the process of birth further out of her hands and into a setting where she does not have full control of what is happening. Midwives showed concern at surgical birth becoming the norm as it could create a culture where women were not confident in their ability to give birth vaginally. The increased reliance on doctors and institutions would make the process less independent and therefore less autonomous (Kukla et al., 2009).

Because the majority of interviewees spoke about autonomy in the first of these two ways, this is how I will be referring to autonomy.

A woman's right to choose

This section is concerned with whether a woman has a right to choose a caesarean section, and therefore decline a vaginal birth. Four interviewees challenged whether women were entitled to a caesarean delivery with no medical indication. It was felt that she did not have a right to access one for a non-obstetric indication, particularly when other considerations were taken into account; namely distributive justice, non-maleficence, and professional autonomy.

One interviewee spoke about a woman having a right to decline an intervention during her birth, but not having a right to demand a caesarean section in the absence of obstetrical or medical indication. This corresponds strongly to the idea of negative and positive rights. The right to *decline* intervention is a negative right, where as the right to *access* a certain treatment is a positive right (Nilstun et al., 2008). There is a generally accepted view that a negative right (in this case a pregnant woman's choice to decline intervention) outweighs other considerations in most circumstances (Cuttini et al., 2006). However the strength of a positive right, in this case demanding that a caesarean section should be performed despite the lack of medical indication, is generally accepted to be weaker than the right to decline treatment (Christilaw, 2006; Gail A Van Norman, Stephen Jackson, Stanley H Rosenbaum, & Susan K Palmer, 2011). If a positive right did exist there would be an obligation on the obstetricians and the midwives to facilitate and perform a caesarean section.

Despite conceding she may not have the right to CDMR, four interviewees explicitly stated that they felt the woman had a right to request the procedure. Although it may not be stated anywhere that a woman has the specific right to request a caesarean section, it is stated in the Health and Disability Commissioner's Code of Patient Rights that a woman has a right to make an informed choice regarding their treatment (*HDC code*, 1996). Choice is defined in the code as being "a decision to receive services". The healthcare provider according to the code of patient rights has an obligation to

provide her with the information that she needs to make an informed choice, and she also has the right to ask for the healthcare professional's recommendation.

Professional Autonomy

The fact that there is no obligation on the healthcare provider to perform or facilitate a caesarean section in the absence of medical indications has important implications for professional autonomy. Most interviewees said that they did not have to do what the women wanted if they did not feel that it was safe practice as they viewed their role as more than just being technicians or informants of risk. Some interviewees went on to speak about the duty of the physician to not simply facilitate or perform a caesarean, but to explore such requests. They may find that they can empower the woman about her capabilities to deliver her baby vaginally or alleviate her concerns in an alternative way that did not involve performing a caesarean section.

Although a woman may be well informed of the risks and implications of a caesarean section, the obstetrician may still decide that it is not justifiable to accede to her request. Even though she is informed of the risks, and accepts these, the obstetrician may still decide that they would be putting the woman in a position of unnecessary harm and decline the request on the grounds of non-maleficence. But what if the woman insists on having a caesarean section? Legal battles have ensued overseas regarding patient treatment requests, although not specifically regarding CDMR. The ruling on cases in the UK have been that doctors are not ethically or legally obliged to provide treatment requested by any patient if they consider it to not be his/her best interests (*R (Burke) V General Medical Council and Disability Rights Commission (interested party) & The Official Solicitor (Intervener)*, 2004).

In the UK, the NICE guidelines recognize that doctors have a "right to decline a request for a caesarean section in the absence of a medical indication" (NICE, 2011). Whereas in the RANZCOG guidelines, an obstetrician can decline on the grounds of health concerns for the mother and baby or if the mother's understanding of the risks and benefits does not enable informed consent (RANZCOG, 2013). It is also important to

note that neither of these guidelines contain a prohibition on the woman to seek a second opinion.

Informed Choice

A fundamental element in respecting a woman's autonomy is ensuring that she is adequately informed about her options through educating her about the risks and implications of her choice (Williams, 2008). As outlined in the previous subsection, according to the New Zealand HDC's code of patient rights, every health consumer has the right to make an informed choice (*HDC code*, 1996).

A major difficulty with deciding whether a woman is sufficiently informed about the risks of CDMR when requesting a caesarean delivery is that there is no consensus on the outcomes associated with the procedure as compared to a vaginal delivery (Ecker, 2013; NIH, 2006). As numerous interviewees said, depending on which midwife or obstetrician she sees, she will get a different account of the facts on the risks of a caesarean section. According to present literature, obstetricians are more likely to "underestimate" the risks of a caesarean delivery than midwives, whereas midwives are more likely to voice their concerns about the risks (Monari, Di Mario, Facchinetti, & Basevi, 2008).¹⁶ The concern with this is that who she talks to will change her opinion of the risk profile that she associates with the procedure, which may lead to a different decision about the mode of delivery she wants.

It is also important that the limitations in the available evidence are acknowledged, as to make a truly informed decision about the preferred mode of delivery (Williams, 2008). Also due to the lack of consensus that exists it may be advisable that care providers to use a common source of information for the process of educating a woman about the implications of having a caesarean delivery.

A woman not only needs to be informed about what she is deciding for, she also must be informed about the alternatives she is deciding against. There are many

¹⁶ It is interesting that this paper would claim that obstetricians would "underestimate" risk, because no empirical evidence exists to determine what the true risk is. They may be referring to the fact that they provided lower estimations of risk compared to midwives

alternatives that can be offered depending on what her specific fears are, including anaesthesia if she is afraid of pain, or even counselling for psychological issues. The physician or midwife can only inform her of the appropriate alternative options if they have a firm grasp of the true factors that led to her request. It is therefore imperative that a space is created in consultations to allow her reasons to be openly explored.

Involving patients in delivery decisions

According to the RANZCOG guidelines, if after a full discussion of her reasons a woman still maintains a request for a caesarean delivery, her request can be acceded to as long as she is able to demonstrate that she is well informed (RANZCOG, 2013). There are varying opinions in existing literature about the extent to which a woman should determine her mode of delivery after demonstrating that she is well-informed.

A published opinion in the British Medical Journal argues that so long as a woman is well informed of the trade-offs that exist through opting for a caesarean section then she should have a right to choose the mode of delivery she finds most suitable (Paterson-Brown & Fisk, 1997). This paper's primary justification rests on the fact that there is no evidence to suggest that an elective caesarean is any more harmful to maternal and foetal health than a vaginal delivery. Therefore, according to her values and priorities, she should have the right to choose.

Other parties believe it would be inappropriate for a healthcare provider to present the facts and allow the woman to choose between the two modes of delivery (Guise, 2001; Savulescu, 1995). In fact, some have gone as far as saying that this would be absolving an important duty that physicians owe to their patients (Ingelfinger, 1980; Stirrat & Gill, 2005). It is important to note that the papers that have put this argument forward are not suggesting we revert back to a paternalistic model of healthcare either, they are only acknowledging the duty that healthcare professionals have to provide a recommendation to patients on what will be most likely to lead to the best outcome.

Julian Savulescu, an Australian bioethicist, published a paper examining some of the shortcomings of a doctor merely being a “fact-provider” (Savulescu, 1995). He argues that doctors have a duty to decide what the patient ought to do with medical factors with their personal values in mind, and communicate this to the patient. By allowing a thorough discussion with the patient, the physician can draw attention to relevant facts that a woman may have not encountered, misinterpreted, or been misinformed about. They may begin to see factors in a new light, or see that there are alternative ways of managing factors that she could be concerned about. In fact, he argues that by engaging in a discussion with the woman about whether or not to provide a caesarean delivery the process could lead to a choice becoming a more active expression of autonomy by establishing the rationality behind their choice.

Interviewees did express the desire to engage in a thorough discussion with a woman requesting a caesarean section to establish the woman’s perceived advantages of a caesarean section over a vaginal delivery. None of the interviewees felt it was appropriate to lay out the options in front of the woman and allow her to choose, but they all spoke about various ways they could involve the mother in the decision making process to arrive at a safe and ethically justified decision about the mode of delivery. They all felt that their role went beyond being a fact provider, and required them to make a professional recommendation. This was clearly evidenced by this interviewee:

I find though, that if I don’t manage to talk them out of it, that I don’t think the obstetricians will. The obstetricians are just there to key it in really.¹⁷

¹⁷ Although not the point here, this quote shows that midwives and obstetricians may perceive each others’ roles differently. None of the obstetricians spoke about being a technician who is just there to key in the procedure and also conveyed that they would in most cases feel it was not in the woman’s best interests to surgically intervene if

Both midwives and obstetricians spoke about working together with the woman to establish what the best mode of delivery was for her. Midwives were very likely to talk about the “partnership model”. This partnership model emphasizes the importance of midwives working alongside the woman in making decisions about her pregnancy and birth (Freeman et al., 2004; Pairman, 2006). It is felt that in doing this a client can reach the best outcome for them. Obstetricians spoke about involving patients in the decision, but did not refer to any particular model of care or type of doctor-patient relationship.

Preference for a surgical birth

Studies have shown that if women were given the option of having a vaginal delivery or a caesarean section that most would opt for a vaginal delivery (Bt Maznin N.L. & Creedy D.K., 2012). However, it also shows that there are a small minority of woman who have a preference for a caesarean delivery (Bt Maznin N.L. & Creedy D.K., 2012; Mazzoni et al., 2011). Therefore it cannot be assumed that *all* women have a preference for a vaginal delivery. These findings have been supported by the information generated by my study through the interviewees encountering requests for caesarean deliveries. The reasons that women presented have already been covered in the previous chapter.

There are questions to ask in response to this; have a small minority of women always had a preference for a caesarean delivery? Why does it seem like a growing number of women would prefer surgical intervention over a vaginal delivery? Interviewee 10 felt that the influence of television and the media had created a fear-based culture surrounding birth, causing women to choose against having a vaginal delivery. This interviewee spoke about many of the ideas about birth that women held that had been based on misinformation, often spending first encounters with women and their

there was no need. They would want equal opportunity to discuss the perceived benefits of the procedure, and the perceived harms of having a vaginal delivery.

partners dispelling some of the myths. They felt that by offering a caesarean section in the first instance as a response to a fear of childbirth generated by mistruths validated the perception that there was something to be afraid of.

It is very feasible that a woman, as a result of her own experiences and the information available, could have developed a preference for a caesarean section. It should be recognized that a woman's preferences and choices about mode of delivery are informed not only by medical information, but also by her social and cultural context (Torres & De Vries, 2009). However, if this preference for a surgical intervention has been developed due to false ideas conveyed by media, television or negative birth stories, is a woman truly exercising autonomy due to well-informed ideas to influence her preference? Does this preference for a caesarean section accurately reflect evidence?

Apart from the influence of television and the media, some midwives were concerned by the message it may be sending if CDMR were performed. They showed concern that if a request was driven from a place of fear for a vaginal delivery, the performance of a caesarean section in response to this fear could be seen as legitimizing her request and showing that vaginal deliveries are something to be fearful of. The worry here is that it may deem vaginal deliveries as something to be avoided, encouraging more women to opt for a caesarean section for similar concerns. Interviewees who acknowledged that there was nothing unnatural about being fearful about an unknown event emphasized that there were many ways of dealing with particular issues that she may have, not just surgically intervening.

Although interviewees hypothesized that lay media and television shows could be leading to requests for caesarean sections, the question of whether the influence of these factors is actually driving this trend is debatable. A study conducted by Munro et al. looked at how birth stories influenced primiparous women who chose caesarean deliveries for non-medical reasons (Munro, Kornelsen, & Hutton, 2009). They found that these women had based their decision on social influences from their peers, as well as acquired medical knowledge. Their decisions had frequently not been based

on fear of a vaginal delivery due to hearing “horror stories” from women in their social interactions, but rather they had made their decisions after hearing positive stories of caesarean births.

“Do they really know what they’re asking for?”

A group of participants questioned whether the women who request caesarean deliveries fully understand the implications of their choice. They spoke about these women not fully understanding the increased risk of certain outcomes, particularly around limiting their future reproductive capacity. Midwives also tended to focus on the compromised state that these women be in after major abdominal surgery, while they cared for their new baby¹⁸. This group felt that if they truly understood these factors that they may make a different decision.

It would be nearly impossible to say whether women who request caesarean deliveries do understand the implications of their choice, and whether they would change their minds if they had a better understanding of what they were asking for. The closest we can get to answering these questions is by looking at available evidence on individuals in a particularly well-informed cohort still voicing a preference for CDMR- evidence which does exist.

This evidence is in the form of studies that gauge which mode of delivery is preferred by obstetricians in various countries. The studies involved sending surveys to a group of obstetricians and asking which mode of delivery they would preferentially choose for themselves (if they are female) or their spouse (if they were male). The first of these studies was Al-mufti’s study which occurred in 1997. As has already been mentioned in a previous chapter, it found that 31% of female respondents would choose an elective caesarean if given the choice (Al-Mufti et al., 1997). In 2001 a very similar survey was sent to obstetricians in New Zealand and Australia. This study found that 11% of the obstetricians who responded would choose an elective caesarean even if there was no clinical indication to intervene surgically (Land et al., 2001). The

¹⁸ This is understandable as midwives would have more contact with women as they recover from caesarean sections in the postnatal period.

reasons that they gave for their preference was fear of incontinence and perineal damage, fearing damage to their child through the trauma, as well as avoiding labour (Land et al., 2001). This mirrors many of the reasons that other women in the population have given the participants in my study. Although a much larger proportion of the obstetricians surveyed would still choose a vaginal delivery over CDMR it nevertheless illustrates that there is a minority among this well-informed group who would choose to have a caesarean section, and this is seemingly reflected in the general population too (Paterson-Brown & Fisk, 1997).

A critique of this argument is that these obstetricians, although more likely to be informed than the average woman in the population, might perceive the risk differently because of their professional perspective. Obstetricians may underestimate the risks of caesarean section because they will be very familiar with the procedure, it being a near daily occurrence for them (Monari et al., 2008). Of the participants in my study, obstetricians were more likely to talk about negative outcomes from vaginal delivery, potentially because their work is orientated around pathologies during birth, and because of the complications from traumatic deliveries that they would see in the gynaecological aspect of their work.

The group of obstetricians who showed a preference for a caesarean delivery in the survey clearly felt that the inherent risks associated with surgery were outweighed by the benefit of avoiding potential adverse outcomes of a vaginal delivery (Al-Mufti et al., 1997). Although I have stated that they may be more inclined to make this choice than the average population, the choice that they have made reflects their priorities based on their exposure to information and lived experience. This is the same way that a woman in the population would shape her ideas and preference for mode of delivery. It is therefore possible that a woman would have a preference for CDMR, and not just because she didn't understand what she was asking for.

Does having choice equate to autonomy?

A pregnant woman is offered a multitude of options with regard to the birth, and has the right to choose between them based on what she feels best aligns with her values

and is in the best interests of her and her child. For example, she can choose whether she wants a homebirth or a hospital birth or whether to have an epidural or not. With each of these decisions it is highly likely that one option will be associated with greater risk, but the riskier option may have benefits that are highly valued by the woman, leading her to make this choice (Torres & De Vries, 2009). Despite no existing evidence to promote one mode of delivery over the other, the ability to decide between two feasible options has conventionally not been extended to choosing a mode of delivery. The question is, if such an extension were made, and options could be outlined so that a woman could make her choice, would it increase a woman's autonomy?

A critique of the idea that increasing delivery options increases a woman's autonomy is that it cannot be assumed that an increase in the number of available choices increases a woman's capacity to make decisions in line with her needs and values (Kukla et al., 2009). Healthcare consumers may make incorrect judgments about what is best for them, just as doctors can, through being misinformed or failing to give adequate weighting to relevant facts (Savulescu, 1995). Therefore increasing choice does not necessarily enhance the exercise of rationality or ability to make decisions which have positive implications for ourselves, which are required to make an autonomous decision.¹⁹

¹⁹ This argument is based on the assumption that the healthcare provider would assume the role of fact provider in such a case, rather than being involved in a guidance capacity in the woman's decision.

Distributive Justice:

Economic Uncertainty and healthcare resource allocation

There have been numerous calls for a detailed economic analysis of CDMR to avoid basing clinical practice upon incorrect generalizations (Druzin & El-Sayed, 2006). As already discussed in chapter one, while economic analyses have been attempted by health economists, these have been plagued by numerous limitations and as a result have been unable to reach sound conclusions regarding cost-comparisons (D'Souza, 2013; Petrou & Khan, 2013).

Usually decisions about whether certain treatment options should exist are based on economic viability and proven clinical effectiveness of the intervention (Terry, 2004). It would be difficult to definitively say whether CDMR should be permissible on these grounds alone due to the limitations in knowledge of outcomes and the lack of an economic analysis. It has long been surmised that the overall costs of caesarean sections are higher compared with vaginal deliveries (Druzin & El-Sayed, 2006) and most participants I interviewed did believe that elective caesarean sections would inevitably be more expensive than a vaginal delivery as well. It is entirely feasible, based on what was said in the interviews, that requests for the procedure with no clinical indication would be rejected because of the “unnecessary expenditure of healthcare dollar”. However, it is not clear that caesarean deliveries are always more expensive than vaginal deliveries. There is literature that challenges this claim (Druzin & El-Sayed, 2006), and this view is supported by data collected in this study as three of the twelve interviewees thought that the costs of an elective caesarean had been overstated.

The literature and interviewees that challenged whether CDMR would be as cost effective as vaginal deliveries suggest that an elective caesarean would be cheaper overall because there are complications that are a result of vaginal deliveries which would require ongoing healthcare costs. They argue that the complications which stem from having a vaginal delivery would be as costly, if not more expensive, to deal with than those which have stemmed from an elective caesarean (L. H. Harris, 2001).

There are also certain complications that would stem from a vaginal delivery resulting in an emergency caesarean where it would have been less costly to provide an elective caesarean section in the first place (Macario, El-Sayed, & Druzin, 2004).

A point made by an obstetrician in my study was that it is such a small group of women who currently request caesarean sections that it would have a very small economic impact. It would be interesting to explore whether this is a factor that would make CDMR seem more economically viable, and therefore more acceptable to obstetricians and midwives.

It is beyond the scope of this work to comment on whether elective caesarean sections for non-obstetric reasons are always more expensive than vaginal deliveries. However, if pregnant women are being denied the option to have a caesarean delivery for non-obstetric reasons due to economic reasoning, then this reasoning should be supported by a comprehensive and conclusive economic analysis. It is not enough to base these decisions on assumptions. However, until such time where it is possible to accurately gauge the cost of CDMR compared to vaginal delivery, we must work within the realms of economic uncertainty. There is therefore an ethical argument to be considered: is it ethical to provide or withhold an intervention where economic uncertainty exists?

Availability in the public system

There was variation in opinion regarding whether a woman could currently access caesarean sections for non-obstetric reasons as a fully funded procedure in the public healthcare system. This could be due to the fact that there is no clearly documented statement or national guideline on CDMR for all practitioners to refer to regarding how to handle the requests in the public domain. This ambiguity could lead to some women having their request being handled differently depending on which practitioners they encounter, or where in the country they live. It was argued by most interviewees that there are simply not enough resources in the current infrastructure to support maternal demand for caesarean sections, and therefore it is not justifiable to provide CDMR in the public system.

Accessibility; a filtered cohort

One concern a participant had was that before an obstetrician had the opportunity to decide whether CDMR was appropriate in a given case that she may have already been “filtered out” by the system because of the views of the person she saw first;

How do people get past their LMC’s or GPs... to make that request?

There are some people who would want to who don’t even get past the first hurdle. Because it’s not done, it’s not acceptable. And so it is a particular kind of person that does ask, they have particular reasons. So ...they’re already filtered.

Interviewee 6

In the lay literature it seems that there are a lot of rumours regarding their availability amongst the healthcare consumers. This is substantiated by popular media where some women believe that they will be pushed to have a vaginal delivery, others have been told that they are only available in the private system, and some believe that they are available on request in the public system. Some women spoke of being told that they were not available at all by healthcare professionals, both in the public or the private domain.

Inconsistencies in the way that the first point of contact handles requests generate a lot of confusion and decrease the capacity for equity of access to CDMR. This may not be a system that is fair and just to all women who want to request a caesarean for non-obstetric reasons.

The lack of clarity about availability comes from the fact that it is not explicitly stated anywhere whether women can or cannot have a caesarean deliveries performed on request in the public system. The only way to avoid advice on availability differing from practitioner to practitioner is a clearly documented stance on CDMR, and a clear course of action for women who make these requests. It must also be established

within the statement whose job it is to determine which requests are appropriate, and which are not.²⁰

Although this would be beyond the scope of this project, it would be interesting to explore whether there was a difference in the populations who do end up making requests for a caesarean section for a non-obstetric reason, and those who would prefer one but either do not voice their concerns, or who are filtered out.

Postcode Lottery

There was speculation by interviewees that a woman's request could be handled differently depending on where in the country she lives. If where someone lives changes the care or range of treatment options that exist, this may be seen to be a "postcode lottery". These differences in availability of a service can be attributed to economic constraints and the way that decisions are made at a local level, even where there is an over-riding national healthcare provider (Terry, 2004). This potential lottery could be a result of the structure of the New Zealand healthcare system, which divides the country's healthcare service into twenty separate entities known as District Health Boards (DHBs). Although there are national health targets and policies, the DHB system allows each area to adapt its approach to each healthcare target depending on the perceived individual needs of the area's population (Ashton, 2005). In this way, practice could be entirely different depending on how appropriate the requests are perceived to be, and subsequently handled, from DHB to DHB. The concern is that taxpayer money could be spent differently depending on where a woman lives, which brings about considerable questions surrounding distributive justice. It can be argued that in a situation where a postcode lottery exists, health equity is not being achieved (J. Harris, 1999).

There are clearly limitations on what our healthcare system can provide, and it cannot cater to everyone's desires and preferences. However, whether it is decided that

²⁰ Other related ethical questions would be whether all women should be informed that they had an options regarding mode of delivery. In the case where it was decided that they should be available in the public system, the next question would be whether CDMR should be proactively discussed with pregnant women.

CDMR can justifiably happen in the public system or not, an appropriate response to CDMR must be unanimous across the country if public funding is being used.

CDMR in the private system

Even interviewees who did not agree with CDMR in principle thought that it would be more acceptable if it were performed in the private healthcare system. Although in this case there would be less involvement of taxpayer-funded expenditure, there are still considerations concerning distributive justice that need to be taken into account.

If a woman's request for a caesarean section is acceded to, for each subsequent pregnancy she will be regarded as having a medical indication for a caesarean section. Therefore, if she wasn't able to have a caesarean section in the public sector for her first child, so instead obtained one privately; she would be able to go through the public system a second time due to the increased medical risks associated with the second delivery. In Dunedin, women have the option to have a VBAC using public resources following a prior caesarean section. The implied future commitment of public resources, regardless of the first caesarean section being performed in the private system, must be considered.

Harms and Benefits

The interviewees referred to risks and benefits during the interviews. For this reason, I will refer to risks and benefits, but take this to include the ideas of beneficence and non-maleficence. Many interviewees felt that the risk of providing a caesarean delivery instead of a vaginal delivery was not the primary reason that they would not accede to a request. Interviewees were more commonly concerned with whether a CDMR conferred any additional benefit over a vaginal delivery and therefore whether it was justified to use finite health resources to perform the procedure.

Limited evidence

As previously stated there have been no randomized control trials (RCTs) comparing the outcomes of planned caesarean sections to vaginal deliveries (Hannah, 2004; NIH, 2006). Numerous interviewees spoke about incomplete evidence being a major concern when it came to CDMR, and the fact that it made it difficult to judge what action would be inferring the greatest benefit with the least risk of harm.

In the face of uncertain evidence deciding whether it would be in the best interests of the mother and child to accede to a woman's request for a caesarean section is an even more complicated decision. A previously published paper by one of the leading researchers in the TERM breech trial discussed whether CDMR was a reasonable choice for some women (Hannah, 2004). After a thorough discussion of the known risks and benefits of either mode of delivery, they considered that if a woman still perceives it to be in the best interests of her and her child to have a caesarean delivery, that the overall health and wellbeing of the mother will be promoted by acceding to her request. An ACOG committee opinion put this view into a position statement when they concluded that "if the physician believes that caesarean delivery promotes the overall health and welfare of the woman and her foetus more than vaginal birth, he or she is ethically justified in performing a caesarean delivery"²¹ (ACOG Committee

²¹ Other papers which have supported this view have emphasized the importance of the woman and the doctor both playing significant roles in the decision making process. This has been previously discussed in the autonomy subsection.

on Ethics, 2007). It is important to note that in these cases, it is entirely at the doctor's discretion whether they believe it will promote the woman's welfare.

Despite previous literature and committee statements suggesting that providing a CDMR would promote a woman's welfare in some circumstances, and therefore be ethically justifiable, such a view is not shared by all. One interviewee considered that because there is no empirical evidence showing clear benefit, doctors who practice Evidence Based Medicine should not provide caesarean sections on demand. It is questionable whether such empirical evidence will ever be available. The feasibility of conducting a RCT to compare the outcomes of caesarean deliveries and vaginal deliveries is very difficult. There are obvious ethical concerns with conducting an RCT, and concerns surrounding generalizability would need to be carefully worked through when decisions were being made about inclusion and exclusion criteria. The feasibility of such an RCT has been discussed in existing literature, but discussions focus on the need to do one rather than the details about how it would be feasible (McCourt, Bick, & Weaver, 2004). Empirical evidence generated by a RCT would mean that the maternity care provider and the woman would be able to quantify any risk or benefit of a caesarean section compared to a vaginal delivery, and this would significantly change the circumstances of asking for and providing a CDMR. Other evidence that would significantly change the ethical considerations of CDMR would be that from a full economic analysis, as already discussed.

Although an RCT may not be a feasible option currently, observational studies could be ethically conducted. This would mean that better evidence could be generated, which would be invaluable to maternity providers and women.²² In the future it is highly likely that evidence will be available on CDMR that will allow an objective comparison of the outcomes associated with a CDMR verses a vaginal delivery. This evidence may be generated by longitudinal studies rather than an RCT.

²² A historical cohort study would not be able to be completed currently due to the data not being reliable enough (inaccurate patient records) and small numbers.

The value of risk

It is important to realize that even when outcomes can be statistically quantified and compared that there will still be a subjective element to risk. This is due to the fact that risk is value laden, and therefore the risk of any given outcome will not be absolute and fixed because it requires normative weighting by an individual.

An illustrative example of this is in Kukla et al.'s paper; *Finding Autonomy in Birth*, which outlines a situation in which someone is choosing between two medically viable treatment options (Kukla et al., 2009). One of the options has a 50% risk of the patient having a headache the following day, whereas the other carries 3% chance of death. This paper argues that because of our values and preferences, we would say that the second option is riskier even though the outcome is less common. However, we cannot come to that conclusion without a normative weighting telling us that death is a worse outcome than a headache.

However, there are much more complex examples that could be spoken about with regard to CDMR. Individuals differ in their priorities, preferences, and values and it would be difficult to gauge the relative badness of two outcomes without considering the influence of these factors in context (Kukla et al., 2009). For example, it is known that caesarean sections are partially protective in women developing pelvic floor dysfunction later in life, particularly for urinary incontinence (Gyhagen, Bullarbo, Nielsen, & Milsom, 2013). For a woman who works alone in a private office, moderate urinary incontinence may be a manageable nuisance and would not necessarily prevent her from doing her job. However, if a professional dancer were to become moderately incontinent it may be a debilitating incapacity for them, and potentially mark the end of their career²³ (Kukla et al., 2009). These two women would almost certainly quantify the risk of a vaginal birth differently due to urinary incontinence having different implications for either of them²⁴.

²³ This would potentially have implications for her mental wellbeing as well as her physical wellbeing which may increase the weight of her request

²⁴ Some people may argue that if a woman were to request a caesarean delivery for this reason that there would be an obstetric reason to act. This is especially the case because there is moderately strong evidence showing that a caesarean delivery is partially protective against a woman becoming incontinent.

Statistics alone cannot show how risky one mode of delivery is over the other; the women's values and perceptions play an important role in quantifying the risk in the first place (Kukla et al., 2009). These examples reiterate the importance of doctors and midwives seeing lives and diseases in context, and tailoring the appropriate course of action to individual patients (de Costa, 2000). I think it also provides insight into how these requests should be handled when a woman brings up the possibility of having a caesarean section for non-obstetric reasons. The starting point should not be to assume that the patient's priorities mirror "the norm" or the maternity provider's values. An assumption should be made that there are probably entirely legitimate reasons for why the woman feels the way that they do about having a CDMR, and a starting point for the consultation would be establishing the reasons behind their request. Maternity providers must also have an awareness of their own values, preferences and biases as these things will almost inevitably affect the way they counsel women about their options, and whether they ultimately accede to a woman's request.

No guarantees

Even if a woman's request is not acceded to because it is not believed to be acting in her and her child's best interests, there is no guarantee that this decision will lead to a good clinical outcome. There are adverse outcomes associated with a complicated vaginal delivery that could be avoided through providing the requested elective caesarean, especially if she would prefer to have a caesarean section in the first place.

The fact that there is no guarantee of a good outcome has been recognized as an important factor in women who voice a preference for caesarean deliveries. Interestingly, one of the leading reasons reported in previous studies for women requesting a CDMR is increased predictability of outcome (Al-Mufti et al., 1997; Land et al., 2001). In fact, in the studies that showed that a significant proportion of female obstetricians would choose an elective caesarean section for themselves, this was the most common reason for their choice (Al-Mufti et al., 1997; Land et al., 2001). The fact that some obstetricians would choose it for themselves has been used in the argument

for CDMR to be a reasonable request for other women to choose a CDMR for similar reasons (Paterson-Brown & Fisk, 1997). It raises an important question; if a woman does request a caesarean delivery in a low-risk pregnancy, can her request be acceded to the grounds of avoiding a traumatic vaginal delivery or a failed trial of labour?²⁵

Some interviewees argued that risk surrounding a vaginal birth was just a fact of life, and because there was still a high chance of a vaginal delivery being successful that surgical intervention would be unwarranted on the grounds of “certainty of outcome”. Others argued that because there is the capacity for something to go wrong in either mode of delivery, and that the woman and her family are the ones that will live with the long-term implications of that, they should feel empowered to make the best choice possible for them even if that choice is to have a caesarean delivery in a pregnancy which is considered to be low-risk medically. This implies that if their decision is to have a caesarean delivery despite it being a low-risk pregnancy, then this is still a reasonable choice because certainty of outcome cannot be given in either case.

The “gamble of labour” would still exist at an individual level even if there was clear experimental evidence generated by a randomized control trial showing the outcomes associated with CDMR compared to a vaginal delivery. Some interviewees spoke about the aspiration to develop tools or algorithms to work out a woman’s chances of having a successful delivery, and if her risk of requiring an emergency caesarean section was high enough then at that point being able to offer an elective caesarean section increase the chances of a good outcome. Currently there is not enough information to be able to do generate such algorithms.

Despite the fact that there is still no such tool that exists for a woman’s overall chance of a successful outcome from a vaginal delivery, a recently published paper suggests a scoring system known as UR-CHOICE to predict a woman’s chances of developing

²⁵ There was concern raised by some interviewees that caesarean sections were perceived to be a safer option due to the fact that they increase the chance of a good outcome. The emphasized that this may not necessarily be the case.

pelvic floor dysfunction later in life (D. Wilson, Dornan, Milsom, & Freeman, 2014). Depending on a woman's individual risk factors, she may generate a low, medium or high UR-CHOICE score, which would correspond to the same level of risk in developing pelvic floor dysfunction. In response to this score, women may be reassured by a low score or advised of action that she may take in response to her increased risk. If a woman has a high UR-CHOICE score, this does not necessarily mean that she should have an elective caesarean delivery as there are alternative ways of managing this risk, but it would support a request for a CDMR because of the increased capacity for harm from a vaginal delivery and increase the capacity for a woman to make an informed choice.

Developing similar scores that would help predict the chances of certain adverse outcomes for either mode of delivery would be extremely valuable. Women who request CDMR cannot be reassured that the odds will be in their favour of every adverse outcome from a vaginal delivery, but these scoring systems allow the risk of certain outcomes to be quantified, and allow clinicians to counsel and then make decisions surrounding an appropriate mode of delivery accordingly. This is an improvement on having to say to a woman requesting a caesarean that there is no guarantee of a good outcome and no way of quantifying her chance of having the outcome of concern. It is important to state that the point of such scoring systems is not to increase the rate of caesarean sections, but rather to allow women and clinicians to make better-informed decisions about mode of delivery.

The fact that there is no guarantee of a good outcome strengthens the argument for women to be involved in decisions about mode of delivery and a clear care pathway to be developed to handle requests. No matter which LMC a woman is counselled by, or where in the country she lives, she should feel empowered to voice her concerns and preferred mode of delivery and understand the risks and implications associated with either mode. There must be the opportunity to convey to woman that neither mode of delivery is risk free, and that uncertainty of outcome exists with either mode

of delivery.²⁶ If after this process a well-informed woman still maintains that her preference would be to have a surgical birth because she feels it would be in the best interest of her and her child then it could be considered acting in her best interests to perform a caesarean section, as declining a request at this stage may have a significantly negative effect on her mental wellbeing.

Harm to maternal wellbeing

When a woman makes a request for a caesarean section, it is likely to be grounded on a desire for a better clinical outcome for both them and their child, and this belief will have stemmed from educating themselves in multiple ways, as well as social and cultural influences. Therefore, if the mother is unable to be adequately reassured that a vaginal delivery is likely to lead to a good clinical outcome then there is the capacity for harm to the mother's wellbeing if her request is not acceded to.²⁷ This quotation from an interview clearly illustrates this point:

I don't think in 99.9% of cases it would be maternal choice alone, I think there would be reasons behind it in terms of which way they were educated and had made a decision for good reason or they would just be terrified

Interviewee 7

One interviewee spoke about a case where they had initially declined a request for a caesarean delivery. Although this interviewee had thoroughly explained the reasons why a caesarean section would not be clinically necessary, the woman presented later in her pregnancy so significantly anxious that a caesarean section was then provided for mental health reasons. This interviewee argued that more harm was caused to the woman through declining the request than there was for the capacity for harm from performing a caesarean section. They felt the decision to not act had not only negatively affected the mother's mental state, but the fact that the mother was

²⁶ Although not the main point here, it is interesting that a caesarean section has obviously been perceived to be a safer option in many cases despite there being no guarantee that a caesarean section will lead to a good outcome either.

²⁷ The risk of harm to maternal wellbeing must be balanced against the potential physical harms through adverse outcomes of a vaginal or caesarean delivery.

significantly anxious may impact neonatal outcomes. There is an emerging body of evidence showing that depression and anxiety can negatively effect neonatal outcomes (Field et al., 2010).

Almost all interviewees said that in cases where mental health concerns exist that a CDMR may be reasonable.²⁸ However, there seemed to be very different thresholds between interviewees of the point at which anxiety relating to a vaginal birth becomes so significant that they believed it would be justifiable to accede to the request for CDMR. If the mother's anxiety was considered to be pathological by a maternity provider then they may argue that there is a medical reason to act, which would add to the weight of the woman's request significantly. However, other maternity care providers may interpret this anxiety as being a normal fear that most mothers have as they approach the birth, and therefore that their concerns do not warrant surgical intervention²⁹.

A significant proportion of interviewees spoke about the need to take a collaborative multidisciplinary approach in such cases and refer to the woman to a psychologist or counsellor as an alternative way to work through her anxiety, or to getting a psychologist's professional opinion the woman's mental state. There were varying opinions on whether these referrals to the psychiatrist or psychologist were currently occurring, with some interviewees speaking about being something that should be happening rather than something that is currently happening.

Previous papers have also spoken about the importance of taking a multidisciplinary approach in this situation, involving collaboration between psychologists and obstetricians³⁰. A paper by Saisto et al. argues that the capacity for psychological harm should recognized by the maternity care provider when women present with intense

²⁸ It is hard to define exactly what was meant by "mental health concerns" and whether this was the same between all interviewees

²⁹ This view was vocalized particularly by interviewees who were midwives. They also thought that it may change the maternity culture because acceding to requests on this basis seem to confirm that there is something to be fearful about and further increase the number of women that request a caesarean section

³⁰ These studies have not involved the collaboration of midwives, potentially because these studies have occurred in countries where the structure of the maternity care system is very different to New Zealand

anxiety about childbirth, and that psychologists needs to be implemented into their care pathway (Saisto, Salmela-Aro, Nurmi, Könönen, & Halmesmäki, 2001). The paper emphasized that the goal of psychotherapy should not be to coerce women into having vaginal deliveries, but to diminish the fear surrounding birth, and to empower them to make decision about the mode of delivery that is not fear based. The study claimed that such an intervention led to better clinical outcomes. Another study conducted in 2006 found that after one to fifteen hours of psychological counselling after requesting a caesarean delivery that 86% of the group opted to have a vaginal delivery and were satisfied with their choice (Nerum, Halvorsen, Sørli, & Øian, 2006).

The ability to refer to a psychologist and allow time for any psychotherapy to be effective relies on the woman raising her concerns early enough in her pregnancy. One interviewee spoke about a woman presenting to her in her 36th week of gestation so significantly distressed that she may not be able to have a caesarean delivery after “shopping around” for an obstetrician who would perform one. This obstetrician felt that the level of distress had clearly caused harm to maternal wellbeing, and that by the time she had had her request acceded to that there was significant concern for her mental health, and therefore a medical reason to act. It is unknown whether efforts to refer this woman had been made earlier in her pregnancy, and whether this would have led to a better outcome without causing such harm.

Prophylactic Caesarean Sections

One interviewee raised the idea that CDMR could be viewed as being prophylactic; a way to prevent harm from adverse outcomes of a vaginal delivery. The idea of “prophylactic caesarean sections” has been referred to in previous literature (Feldman & Freiman, 1985; Paterson-Brown & Fisk, 1997). The interviewee who raised this idea felt that it was negligent to not acknowledge the real risks carried by a vaginal delivery and that there was medical justification to intervene with a caesarean section even if a conventional medical indication did not exist. This interviewee implied that it was justifiable to provide a CDMR on the grounds of added benefit and in the aversion of harm that may come from a complicated vaginal delivery. Using the term

“prophylactic” to describe CDMR would infer that there is some benefit to providing a caesarean section over a vaginal delivery to avoid an adverse outcome. However, some would argue that until this is proven through sound empirical evidence that CDMR was protective for certain outcomes that it could not be considered to be prophylactic. The other issue with viewing a caesarean section as prophylactic is that usually a treatment can be viewed as prophylactic for a certain outcome, and when I raised this idea in other interviews the only response given was “prophylactic for what?”

Recommendations and Limitations

Based on the perceptions of interviewees in this study there were a number of themes that emerged regarding the way that CDMR is handled currently, and ways that this could be improved. This chapter outlines some of the key issues around CDMR in New Zealand at present, and suggests some improvements to existing guidelines and policy.

Current Practice

At present there are no reliable figures on the rate of CDMR in New Zealand. As discussed in Chapter Three, it is difficult to determine the current rate and records may not be entirely accurate due to the following reasons. Firstly, interviewees felt that CDMR was not viewed as an acceptable sole reason to provide a caesarean section by managerial staff in the hospital, and for that reason would record the indication for performing the caesarean delivery as a secondary medical indication (for example, mental health reasons). Secondly, they felt that the software they used did not provide an opportunity to record a woman's request as the primary indication for the procedure while being able to acknowledge the other factors that led to the caesarean section being performed. It would be valuable to management, midwives, obstetricians and women to gauge how many caesareans are occurring on maternal request, and to be able to monitor trends.

Another issue that was raised during interviews was the inconsistency in care between cities and even between maternity providers in New Zealand for CDMR. It seems that because the decision rests at the discretion of each healthcare professional that there is a huge amount of variability in the way that cases are handled. For this reason I feel it would be of value to establish a national position statement on whether CDMR is acceptable in New Zealand, and secondly, whether it is ever appropriate to accede to requests in the public healthcare system. In order to establish a stance, key groups in the New Zealand maternity care system would need to be consulted. Guidelines developed would need to be based on the latest evidence available on maternal and

foetal outcomes and clearly state the ethical issues that would need to be considered.³¹

A number of interviewees spoke about the importance of taking a multidisciplinary approach for CDMR, but there were differences in opinion as to whether this happened in practice. Many agreed that the best care for patients would require collaboration between midwives, obstetricians, anaesthetists and members of the mental health team. All of these parties should be involved within a care pathway for the women who request caesarean deliveries in low-risk pregnancies.

Guidelines

I believe that New Zealand could benefit from developing a comprehensive care pathway for CDMR, much like the NICE guidelines of the United Kingdom. Although our maternity care systems are very different, there are elements from the NICE guidelines that could be incorporated into New Zealand guidelines. Although New Zealand may not reach a similar conclusion on whether CDMR is acceptable or not, the idea behind the NICE guidelines could be implemented. This idea is to establish a set national standard and approach to CDMR that incorporates a variety of healthcare professionals in order to offer the best support to women making such requests.

Any guidelines developed would need to outline a clear care pathway for when women request caesarean sections in low risk pregnancies. Within these guidelines it should be clear which members of the multidisciplinary team should be involved, where and when women should initially be referred, and whether this can occur within the public healthcare system. This process should not increase a woman's anxiety and should not encourage maternity providers to coerce women into the choice that they believe to be in their best interests.

As stated in chapter one, the guidelines most applicable to New Zealand are the RANZCOG guidelines. These guidelines acknowledge that there would be some

³¹ Despite the limitations in evidence NICE have been able to produce guidelines and care pathways

instances where CDMR would be appropriate, however they do not explore the circumstances or factors that would need to be considered in any depth (RANZCOG, 2013). Although they encourage maternity providers to exercise discretion and counsel each patient individually, there is no clear statement about whether a well-informed woman should have a CDMR or not, unlike other similar statements from other countries (NICE, 2011).

It is interesting that the current RANZCOG document on CDMR states that the guidelines are intended to be used by all maternity care providers and patients (RANZCOG, 2013). It is unclear whether these guidelines are being utilized by all parties. It is important that any document written concerning CDMR contains information relevant to any LMC in New Zealand, and not just obstetricians. This is because it is highly likely that a woman will enquire about the possibility of CDMR with a midwife first. New Zealand guidelines would need to clearly state the role of each healthcare professional within an appropriate care pathway when a woman makes a request for a caesarean delivery.

The NICE guidelines do not provide a list of specific reasons where a woman's request should be acceded- for example, stating that it would be acceptable to accede to a request due to moderate fear of childbirth. Although structuring guidelines in such a way may reduce variability in the way that CDMR is handled, it might not be commendable to create such guidelines. Stringent and transparent guidelines may lead to women misrepresenting their situations in order to fulfil certain criterion. Perhaps the best form of transparency for guidelines would be to make it clear that women have the right to request caesarean deliveries, and have their request explored with appropriate professionals, thereby being very patient orientated, responsive, and flexible.

It is important to emphasize that the aim of policy changes would not be to encourage women to choose caesarean sections over vaginal deliveries, but to ensure that women have balanced information available to them to make better-informed decisions surrounding modes of delivery.

Constructing a standardized approach to CDMR may be misinterpreted by some as an attempt to increase accessibility to CDMR, and this may raise some concerns. For example, there may be concern that such changes could increase the rate of caesarean sections. Although it may have an effect on the caesarean section rate, this would not be the primary aim of the changes. The focus would be on maternal choice, rather than increasing the caesarean delivery rate. Furthermore, making clearer guidelines would not be aim to change New Zealand maternity culture to such an extent where there would be a preference for a caesarean delivery.

Limitations

A difficulty in discussing allocation of healthcare funding, is that it is currently unclear how the monetary cost of an elective caesarean compares to a vaginal delivery. This is an especially significant limitation because according to interviewees, the cost of an elective caesarean greatly reduced the acceptability of performing caesarean deliveries for non-obstetric reasons. An important area for future research would be to complete a full economic analysis to compare the cost of an elective caesarean delivery to a vaginal delivery, including costs generated from certain long-term outcomes of both. As was previously discussed in chapter one, there have been numerous attempts at doing this, including NICE, but all results have been inconclusive due to the complex nature of sequelae from both modes of delivery.

Locality is a limitation that may reduce the generalizability of the data. There are a few factors that make the maternity care services in Dunedin different from other parts of the country. Firstly, Dunedin has a very limited number of private obstetricians. Although the perspectives of obstetricians who practice privately were included, they still practice in a city where intrapartum care is very rarely provided in the private system and this may affect their practicing patterns. For example, there is little competition for patients in the private sector. The second significant difference is that any caesarean section that private practitioners perform will occur in a public hospital due to the lack of a private hospital equipped to do this. Because of this, they may

have to consider resource constraints in a way that obstetricians who practice entirely in private hospitals would not have to. As stated earlier, there was a lot of speculation that caesareans performed for non-obstetric reasons would be more common in private obstetrics practice- although this does not seem to be the case in Dunedin. A larger study would have allowed the inclusion of obstetricians from multiple cities in New Zealand to explore this further, but this would have made the project too large to complete in the time I was given. I would recommend that similar studies be completed in different parts of the country.

The lack of accurate statistics on the number of caesarean deliveries performed for non-obstetric reasons was another limitation of the study. It is very ambiguous at the moment as to how many caesarean deliveries are performed for non-obstetric reasons. This was a factor that was beyond my control. Even if I had ascertained current figures the data would not capture the full number performed for non-obstetric reasons. I have already outlined the reasons as to why this would be the case in previous chapters. The reason this information would have been of value is because I would have been able to estimate how common this clinical scenario is, and therefore how large the group would be that would benefit from any changes to the system.

As well as the number of caesareans performed for non-obstetric reasons it would have been helpful to know how many requests had been made over a certain time period, how they were handled and the outcome of these requests.

Directions for further research

No data has been previously published on CDMR in New Zealand; therefore this explorative work forms a platform for further discussion on the topic. Because this was a small qualitative study, it would be valuable to gather the perceptions of a broader group of midwives and obstetricians from other parts of the country. This could be done through conducting a survey, using the information in this study to generate the questions.

A quantitative piece of research could gauge the rate of CDMR in New Zealand. This information may need to be gathered utilizing survey methodology because hospital data may not be entirely reliable, as previously explained.

A perspective that would have added further insight would have been healthcare consumers in the New Zealand maternity care system. This was beyond the scope of my project, but it would be an interesting to hear the perspectives of women who had had a caesarean delivery for a non-obstetric reason, or those who had requested one and had their request declined.

Ultimately, finding ways to generate information about outcomes between vaginal deliveries and CDMR. Although the feasibility of an RCT is still debatable, it may be possible to generate longitudinal studies regarding outcomes of interest.

Conclusion

Most interviewees could recall at least one case where a woman had requested a caesarean delivery for a non-obstetric reason in their time as a midwife or obstetrician. This is significant because no other studies have shown that CDMR occurs in New Zealand. There have also been no other studies that have gathered the perceptions of New Zealand maternity care providers on CDMR. The individuals that I interviewed felt that it would be ethically justifiable to provide a CDMR for some women, but not in all instances. Although all interviewees agreed that women's requests should be legitimized and explored, they also agreed that it was not ethically justifiable to accede to all requests. They often emphasized that there would be alternative ways of addressing anxieties surrounding childbirth, especially if their concerns were regarding pain.

It may be too early to simply argue for or against CDMR. The social and cultural pressures linked with birth, the lack of high quality evidence, and the economic uncertainty of CDMR all make the situation too complex to be able to do this. However, just because the situation is complicated and uncommon in New Zealand it does not provide an excuse to not handle these cases in a reasonable and fair way, in line with ethical principles. This is best summarized by quoting one of the interviewees, who after talking about the lack of quality evidence said:

But I guess that is not the point. The point is to ask...for this small subset of women in New Zealand, is it the right thing to be doing? Whatever it is that we are doing.

Interviewee 7

As explained in chapter 5, it would be valuable to address the ambiguity surrounding the availability of CDMR in New Zealand by establishing a stance on the procedure, and producing a position statement. If CDMR is acceptable in some circumstances then these women should have equal access to the procedure- no matter which maternity care provider she sees, or where in the country she lives. The goal of any approach taken, needs to allow the pregnant woman to make informed choices about

the mode of delivery that she believes would best promote her and her child's wellbeing.

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Appendices



D14/109

Academic Services
Manager, Academic Committees, Mr Gary Witte

26 March 2014

Professor J McMillan
Bioethics Centre
Dept. of Medical and Surgical Sciences
Dunedin School of Medicine

Dear Professor McMillan,

I am writing to confirm for you the status of your proposal entitled “**Caesarean delivery for non-medical reasons**”, which was originally received on 20th March, 2014. The Human Ethics Committee’s reference number for this proposal is **D14/109**.

The above application was Category B and had therefore been considered within the Department or School. The outcome was subsequently reviewed by the University of Otago Human Ethics Committee. The outcome of that consideration was that the proposal was approved.

Approval is for up to three years from the date the Head of Department signed off on your proposal which was the 24th March 2014. If this project has not been completed within three years of this date, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz



Health Research South

30/04/2014

Project ID 01013

Dr. Michael Stitely
Dept of Women's Health, DSM

Dear Michael

REF: Caesarian delivery for non-medical reasons

I am writing on behalf of Health Research South to confirm that the project mentioned above has been granted approval to proceed.

According to our records:

This project is due to commence on:	28/04/2014
It is due to be completed by:	31/12/2014

If you have any questions with regards to this process, please contact me quoting the project ID shown above.

Yours sincerely

Ruth Sharpe
CLINICAL RESEARCH ADVISOR

CC.: ELAINE CHISNALL, SOUTHERN DHB
EMILY DWIGHT, BIOETHICS, UoO

Health Research South
University of Otago, Dunedin School of Medicine and Southern District Health Board
PO Box 56, Dunedin 9054
Ruth Sharpe, Clinical Research Advisor, Ph: 03 470 9032 (Hosp 9032); Ruth.Sharpe@otago.ac.nz

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KĀI TAHU

Tuesday, 15 April 2014.

Professor John McMillan,
Bioethics Centre - Division of Health Sciences,
DUNEDIN.

Tēnā Koe Professor John McMillan,

Caesarean Deliveries for Non-medical Reasons

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 15 April 2014 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states "Ngāi Tahu acknowledges that the consultation process outline in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of importance to Māori health.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project. That is the questions on self-identified ethnicity and descent, these questions are contained in the latest census.

The Committee suggests dissemination of the research findings to Māori health organisations regarding this study.

We wish you every success in your research and The Committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 15 April 2014 to 2 October 2015.

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KĀI TAHU

Nāhaku noa, nā

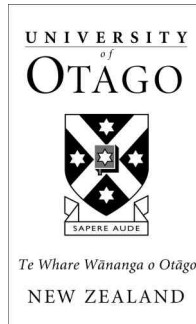


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The Ngāi Tahu Research Consultation Committee has membership from:

*Te Rūnanga o Ōtākou Incorporated
Kāiti Huirapa Rūnaka ki Puketeraki
Te Rūnanga o Moeraki*



Caesarean delivery for non-medical reasons

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This Bmedsc(Hons) project aims to explore the ethical implications of Caesarean delivery for non-obstetric reasons. In order to do this it is important to explore the reasons that women give when requesting Caesarean deliveries when they are not medical indicated. Finding this out will inform my plan to address the following ethical questions;

- 1) What weight should health care professionals give to requests for non-medical Caesarean delivery?
- 2) What is our current understanding of the relative risk and benefits of this mode of delivery compared with vaginal delivery and how should that be weighed against patient preferences?

This study is being completed as a BmedSc(Hons) project by Emily Dwight who is a Medical Student at Otago University.

Who is funding the project?

This study is being funded by the Bioethics Centre, Division of Health Sciences, Otago University, Dunedin, New Zealand.

What Type of Participants are being sought?

Obstetricians and midwives who have been working in the maternity care system in the Dunedin area for a significant period

We would be grateful if you could contribute up to an hour of your time for the study interview. The interview should only take 40minutes at most. We will provide you with a copy of the final report of the study once it is completed should you wish to have one.

What will Participants be Asked to Do?

If you agree to take part in this project, you will be asked to arrange with Emily Dwight a time when she can meet with you in a quiet place in your practice to conduct a recorded interview. The interview will take approximately 40minutes. This project involves an open-questioning technique. The general line of questioning includes questions about your experiences and views on Caesarean Delivery for non-medical reasons on maternal request. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops.

At the end of each interview you will be given an opportunity to comment on anything you feel that was not covered, but might add value to the project. At that point I may incorporate a question in future interviews. After interviewing all participants I will give all interviewees an opportunity to answer questions that they may not have been asked due to the fact they were only added in later interviews.

What Data or Information will be Collected and What Use will be Made of it?

The recorded interview will be transcribed into a written document that will be seen only by Emily Dwight and her supervisors. The only person who will have first hand access to the recordings is Emily, and before the supervisors have access to the information the information will be transcribed in such a way where all identifying features are removed. Emily will then conduct the analysis using the transcribed data. Copies will be kept on our computers, which are in Otago University. When the study is completed the data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for ten years, after which it will be destroyed.

The results of the project may be published but every attempt will be made to preserve your anonymity. We will not name any participants.

Can Participants Change their Mind and Withdraw from the Project?

If the line of questioning does develop in a way that makes you feel hesitant or uncomfortable you can decline to answer any particular question(s) and also withdraw from the project at any stage without any disadvantage to yourself of any kind. You may also decide not to take part in the project without any disadvantage to yourself of any kind.

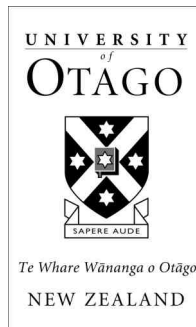
What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Emily Dwight and/or John McMillan
Bioethics Centre, Division of Health Sciences, University of Otago, PO Box 56,
Dunedin 5054, New Zealand
University Telephone Number 03-479-4135
Email Address: dwiem601@student.otago.ac.nz

Email Address: john.mcmillan@otago.ac.nz

This study has been approved by the Department stated above. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



Caesarean delivery for non-medical reasons

CONSENT FORM FOR

PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information (audiotapes) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least ten years;
4. This project involves an open-questioning technique. The general line of questioning includes questions about your experiences and views on Caesarean deliveries completed for non-medical reasons on maternal request. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way the interview develops. If the line of questioning develops in a way that makes me feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.
5. I understand that I will not be paid for my participation in the study but that I will receive a copy of the final report that is written for the Otago University if I wish.
7. The results of the project may be published, but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....
(Signature of participant)

.....
(Date)

