

Clinical Cases

Responding to a Request for Early Delivery

An elective cesarean section before a fetus is full-term involves various risk factors and should not be done for convenience or emotional reasons.

Commentary by Wendy Savage, FRCOG, and Mary B. Mahowald, PhD

Learning Objective Understand the physician's role in guiding patients who may be requesting procedures that are not medically advisable.

Recognize how non-medical factors can play part in a patient's health care decisions.

Maggie Olsen is 6-months pregnant with her third child and first son when she and her husband, Dave, receive news that his unit is being sent overseas. Dave, a Marine pilot, is not sure how long he will have to stay or how dangerous this mission will be. Maggie understands that the separation is part of being married to a military man but worries about her husband and the possibility of his getting hurt or even killed. Maggie and Dave have planned to name the little boy after his father, and the couple would really like Dave to be able hold his first son before he leaves.

At her next appointment with her obstetrician, Maggie brings all of this up with her doctor, Dr. Anita Beal. With her first daughter, Stephanie, Maggie had difficult and long labor and, when Stephanie's heart rate started to fall, Dr. Beal decided on a cesarean. Stephanie was a healthy baby and has been a healthy child, but she weighed just 5 lbs 10 oz at birth. Maggie had her second daughter, Christine, by cesarean as well; the baby weighed 6 lbs 3 oz. Maggie is scheduled to have this baby by cesarean on June 12, which puts her right at 39 weeks. Maggie asks Dr. Beal if it would be okay to reschedule the surgery for May 30 since her husband has to report on June 1.

Although Dr. Beal understands Maggie's desire for her husband to meet his son she worries about the possibility of complications if the baby is born too soon. Dr. Beal notes that Maggie's two daughters were on the light side and thinks this baby might really need those last two weeks in utero for weight gain. Dr. Beal explains the risks of moving back the delivery date to Maggie and her husband. The couple talks about it and decides they would still like to have the baby before the first of June.

Commentary 1

by Wendy Savage, FRCOG

My first piece of advice to this couple would be for Dave to approach his commanding officer and ask if he could have some compassionate leave so he could be with his wife for the birth at term. Usually units do not travel to their destination by the swiftest route and it might be possible for him to go later by a scheduled airline and still be available when he is needed. I would be happy to write a letter to support him being present at the birth since this is a special time during which couples cement their relationship--and service personnel are known to have a higher than average rate of marriage breakdown.

Although Maggie's first child was small and required a cesarean section (CS) presumably for fetal distress after a long labor, the size would be due to some degree of intra-uterine growth retardation (now sometimes called intra-uterine growth restriction-IUGR). Maggie's second daughter was also on the small side but the case offers nothing to suggest that the CS was necessary. Since all seems to be going well in this pregnancy I would argue that Maggie should be

offered a trial of labor to see if she could deliver normally this time around. The chances of this being successful are good, 60 to 80 percent in most studies.

Since Maggie is now only 6 months pregnant, one could do an ultrasound at about 32 weeks to see if the baby's growth is normal and, if so, then investigate with ultrasound at 36 weeks or earlier if clinically indicated. If there was any evidence that growth was beginning to tail off I would offer induction of labor at 37 weeks. Leaving a growth retarded baby in utero so it can gain some weight is not a sensible thing to do because the baby will use up its reserves of glycogen and possibly switch the blood supply to the upper body thus reducing the renal output and the liquor volume. I would explain that, whilst there was not an absolute guarantee that Maggie would deliver vaginally, this was the most likely outcome, and I would hope that the baby would have enough reserves to get through labor without becoming distressed.

I would explain to Dave and Maggie that going through labor offers the baby some health benefits such as the effect it has on the baby's ability to breathe spontaneously and prepare for the extra-uterine environment. Babies born by elective CS may have transient breathing difficulties and require admission to the special care baby unit, and those born too early may even develop respiratory distress syndrome (RDS) which occasionally can be fatal. It is hard to put a figure on this because most of these data are old, but at 37 weeks it may be as high as 1 in 1000.

As the doctor for both the woman and the baby at this time, I must decide whether my role is purely an advisory one in informing the couple about the increased risk to the baby if delivered at 37 rather than 39 weeks.

Do I then leave the decision to them?

Epidemiologically the risk of stillbirth is lowest at 40 weeks and the overall perinatal mortality falls to its lowest at 40 weeks. Even if the risk of a baby dying at 37 weeks is only 1 in 1000, is it the doctor's role to prevent the couple from taking this risk after having put it to them? Or is it up to the couple to decide for themselves? Who is the advocate for the baby?

It seems presumptuous to say that the doctor cares more about the baby than the couple does. But clearly in a highly emotionally charged situation such as this, the doctor has the ability, and I would contend the duty, to act rationally since she is not as emotionally involved as the parents are. Experience has shown me that if something goes wrong during a birth, couples often cannot cope with their own guilt. They blame themselves excessively and sometimes their doctor or midwife, and the grieving process is prolonged and may be unresolved after years.

Whilst it would be ideal for Dave to be present at the birth of his son, and I do not underestimate the emotional bond that this could create, his absence would not damage his son or his wife in any serious or lasting way. If the child were to die of RDS, it would be hard for Dave or Maggie not to blame themselves, and this could lead to lasting regret and damage to their marriage. One of the most important lessons for a physician is to learn is "*primum non nocere*." first do no harm. I would try to explain my viewpoint to the couple, that as an autonomous professional I cannot ethically do what I do not think is in the best interests of the child, the mother, and the whole family. However, if they do not wish to accept my advice, they have a right to seek a second opinion about the timing of the birth. Naturally I would be sad to see this happen, having looked after Maggie during her first two pregnancies, but would quite understand should they wish to do this.

Wendy Savage, MD, is a retired obstetrician and gynecologist, honorary professor at Middlesex University and honorary senior lecturer at the Medical School of St Bartholomew's and the Royal London Hospitals at Queen Mary College, University of London.

Commentary 2

by Mary B. Mahowald, PhD

Any doctor who assists a woman in delivering her baby is morally, legally, and professionally bound to weigh the expected harms and benefits of the timing and choice of alternative modes of delivery to both the woman and her

expected child. Respect for her and her partner's wishes are also relevant to the doctor's calculation. However, when a patient asks for treatment that involves a health risk to her or to another, without countervailing medical benefit to either, no doctor is bound to give priority to her request. *Respect* for patient autonomy does not impose the obligation of conformity to a patient's request for treatment that is not medically indicated.

Two distinctions are particularly relevant to this case. The first is between treatment for health reasons and treatment for other-than-health reasons. Operative procedures such as cosmetic surgery are routinely performed for nonmedical reasons that may be frivolous in comparison with those that motivate Maggie and Dave, but only when the health risks associated with the intervention are relatively minimal. In the hands of an experienced practitioner, cesarean section at 37+ weeks gestation involves minimal risk to Maggie and her potential child. An infant born at this gestation falls within the threshold of a term pregnancy, and therefore, if the gestational age is correct, does not face the risks of prematurity. However, to insure that the risk is minimal, fetal lung maturity should be tested and fetal weight should be estimated, and both should be judged adequate to healthy survival after delivery on May 30. As long as the risks are small, and Maggie is fully aware of them, Dr. Beal may, but is not obliged, to perform the surgery on that date. Dave's wishes are morally relevant, but Maggie's consent is ethically indispensable because she, not he, will undergo the risks of surgical delivery.

The second important distinction is between the right to refuse treatment, regardless of whether it is medically recommended, and the right to obtain treatment that is not medically recommended. The latter is never as compelling as the former because practitioners may not justifiably be coerced to perform procedures that are professionally inappropriate or morally unacceptable to them. If Maggie were to refuse rather than request surgical delivery, even if cesarean section were considered necessary to preserve her life or that of her fetus, going ahead with it would legally be considered assault. Although some would argue that her refusal is overridable if the surgery is necessary to save or reduce disability in her potential child, this rationale is not generally supported by legal statutes or by medical organizations. However, Maggie is requesting rather than refusing treatment, and the treatment is not only medically unnecessary but entails some risk to her and to her fetus. If the treatment were medically beneficial to either, the physician would be legally, professionally, and morally bound to provide it with Maggie's consent. As it is not medically beneficial to either, Dr. Beal may refuse to perform the cesarean section on May 30. If she cannot in good conscience do so, she should transfer Maggie's care to a colleague for whom the early delivery does not pose a moral problem. Maggie and Dave should not object to this because the ethical principle of respect for autonomy applies to practitioners as well as patients and family members.

If Dr. Beal chooses to perform the surgery, her rationale should be based not only on respect for the couple's autonomy but also on the calculation that nonmedical benefits to them outweigh the health risks to Maggie and her soon-to-be-born son. Presumably, the principal nonmedical benefit to her and Dave is the comfort and joy of both being present to welcome their son into the world on his first day of life. The fact that this is a son rather than a daughter is, or ought to be, irrelevant to the calculation of benefit.

Mary Briody Mahowald, PhD, is Professor Emerita in the Department of Obstetrics and Gynecology and the MacLean Center for Clinical Medical Ethics at the University of Chicago, and currently Visiting Professor Emerita at Stanford University Center for Biomedical Ethics. Her recent books include *Women and Children in Health Care: An Unequal Majority* and *Genes, Women, Equality* both published by Oxford University Press.

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