REQUESTED CAESAREAN FOR NON-MEDICAL REASONS DUE TO POST-PARTUM STERILIZATION FOR FREE

CÉSARIENNE SOUHAITÉE POUR DES RAISONS NON-MÉDICALES À CAUSE D'UNE STÉRILISATION POST-PARTUM GRATUITE

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ABSTRACT

Should a gynecologist respectively an obstetrician operate on a healthy woman as part of a Caesarean with a supposedly healthy child in order to accommodate her request for sterilization – a procedure that can easily be performed at a future date or that can alternatively be replaced by other forms of contraceptives? Up to what extent is such action ethical? Why do women desire sterilization in this context? Which role do factors related to the German health care system and its economic bias play in the women's decision making process? Processes that do not only have repercussions in but reach beyond Germany. This article will shed light on the changing attitudes towards modes of delivery and hence developments such as the concomitant sterilization in the context of Caesareans as well as on corresponding principle-oriented approaches in medical ethics.

KEYWORDS

Childbirth, Caesarean, post-partum sterilization, counseling, medical ethics.

RÉSUMÉ

Un gynécologue ou un obtétricien devrait-il opérer une femme en bonne santé au cours d'une césarienne avec un enfant supposé en bonne santé afin d'accéder à sa demande de stérilisation – une procédure qui peut être facilement réalisée à une date ultérieure ou qui peut être remplacée par d'autres formes de contraception ? A quel point est une telle action éthique? Pourquoi les femmes désirent-elles une stérilisation dans ce contexte ? Quel rôle est joué par des facteurs liés au système de santé allemand et à son biais économique dans le processus de prise de décision de ces femmes ? Ce processus a des répercussions non seulement en Allemagne mais bien au-delà. Cet article éclairera les attitudes changeantes envers les modes d'accouchement et par conséquent des développements tels que la stérilisation concomitante lors d'une césarienne ainsi que les approches correspondantes basées sur des principes en éthique médicale.

MOTS-CLÉS

Accouchement, Césarienne, stérilisation post-partum, conseil, éthique médicale.

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INTRODUCTION

The request of pregnant women to have a Caesarean delivery for non-medical reasons and therefore free access to post-partum sterilization in Germany can be considered the culmination in terms of the transitioning process from a paternalistic to a nowadays autonomous model. The German Association for Gynecology and Obstetrics distinguishes between the indicated Caesarean and the Caesarean by request, the latter missing a discernible medical reason. Hereafter, a Caesarean by request (also called "Caesarean by virtue of agreement" or "Caesarean by accommodation") remains conceptually only the case when no medical indication is evident.(1) In times of bodily and mental enhancement(2) on the one, economic pressure on the other side – the patient seems to determine the modus operandi. The autonomous physician can back out of a treatment if the latter is not indicated, if the medical practice is against his or her conscience and if the treatment is not associated with appropriate standards of medical care. Influencing factors (e.g. economically) can however not be excluded. This "lifestyle respectively convenience medicine" more and more turns patients into customers; the physicians performing according to the latter's demands. It is hardly surprising that physicians increasingly face the situation of providing their services that bear little relation to illness or health in order to better serve the patient's needs as well as their own scheduling.(3) Many Caesareans would indeed mean an economic gain for the clinic or the private practice. It is otherwise unrewarding to be brought into bad repute because Caesareans are only performed due to higher gains. There is still the danger of numerically losing births since pregnant women would search for alternative ways where their requirements are being met. Physicians interfere with their moral convictions and their vocational ethos as well as with financial interests of their clinic or their private practice due to these competitive developments.(4) In Germany, it is usually a matter of healthy multiparas who could deliver *per vias naturales* without any problems. The request empirically concerns the matter of receiving sterilization for free when performing the Caesarean since the costs for sterilization outside of gestation ought to be paid by oneself analogous to the application of contraceptives. This regulation arises from the solidary social security that rests upon the German health system. Some women speculate on the absorption of costs if they carry out the sterilization within the scope of a medically not indicated Caesarean.(5) According to § 24b of the social security code five (Sozialgesetzbuch V – SGB V), the assured person has a right to receive benefits when the sterilization is necessary because of illness. Some women who completed their family planning decide in favor of sterilization after Caesarean or pregnancy termination. Caution is advised here since women may regret their decision later on. This does not apply so often in women who had no external pressure of time.(6)
How should the request of many pregnant women for a Caesarean without any medical indication combined with a subsequent sterilization be answered? Are gynecologists respectively obstetricians willing to accommodate this request?

EPIDEMIOLOGY

The Caesarean-rate in Germany from 1991 (15,3%) to 2012 (31,7%) has more than doubled; less than 10% out of the 31,7% of the newborns in Germany in 2012 that were delivered by Caesarean presented a medical indication(7) – a development that needs to be taken into account in terms of a possible automatism.(8) Macfarlane *et al.* state increasing evidence from surveys and other research that decisions about the mode of delivery depend heavily on alterations within the health care system not only in Europe – this is primarily connected to the different organizational patterns and methods of payment in health care practices.(9) Parallels to Germany can easily be drawn as this paper elucidates.

(1) Deutsche Gesellschaft für Gynäkologie und Geburtshilfe e.V., DGGG, Absolute und relative Indikationen zur Sectio caesarea AWMF 015/054 (S1) - currently undergoing revision.

(2) B. Schöne-Seifert, D. Talbot, eds., Enhancement. Die ethische Debatte, Paderborn, Mentis, 2009.

(3) M. I. Evans, D. A. Richardson, J. S. Sholl, B. A. Johnson, Cesarean Section. Assessment of the Convenience Factor, in *Journal of Reproductive Medicine*, 1984, 29, p. 670-676.

(4) Bundesärztekammer, p. A2000.

(5) http://www.sterilisierung.com/sterilisierung-frau.htm, 16.1.2017.

(6) Bundeszentrale für gesundheitliche Aufklärung – BZgA, http://www.familienplanung.de/verhuetung/verhuetungsmethoden/sterilisation/frau/, 16.1.2017.

(7) I. Mylonas, K. Friese, p. 490.

(8) For more data and information see the news release of the Federal Office of Statistics dated September 26th 2014 (Statistisches Bundesamt. Pressemitteilung vom 26. September 2014 – 341/14: Anteil der Kaiserschnittentbindungen 2013 nahezu unverändert bei 31,8 Prozent).

(9) A. J. Macfarlane *et al.*, p. 7.

Sterilization within the scope of a Caesarean is basically applicable. Maass and Weigel collect the following advantages and disadvantages: In terms of advantages, a high level of certainty; a high level of women's satisfaction and an additional operative procedure that can be spared, can be listed. Disadvantages are connected to the potentially life-threatening illnesses and developments of the infant that cannot be foreseen at the time of birth; due to the involution as a result of pregnancy, there is furthermore lower certainty compared to a separate operative procedure and the desire to have a child with a new partner could emerge.(10) Moreover, about 10-20% of sterilized patients regret their decision; about 6% of sterilized women undertake an operative refertilization or decide upon in vitro fertilization (IVF) and embryo transfer. Chances to get pregnant after IVF and after refertilization by applying different techniques of sterilization are as follows: clip-sterilization: 80-90%, surgical methods: 45-70%, electrocoagulation: 25-80% and IVF (per cycle): 20-25%. The cumulative 10-year-likelihood of sterilization failure amounts to 2,48% and the cumulative 10-year-likelihood of tubal pregnancy (tubal coagulation under the age of 30) concerns 32 out of 1000 interventions.(11) The developing tendencies towards "hospitalization, medicalization and mechanization in childbirth"(12) have a significant effect on epidemiological data.

RISK PROFILES

Whether the mode of delivery is a Caesarean or a vaginal/spontaneous birth – each option is connected to a certain degree of risks and long-term complications.(13) If a Caesarean is performed only due to the request of a woman and without any medical indication, this risk profile no longer refers to a procedure with healing attempt. This results in the fact that medical procedures are performed although a treatment is not necessary and all the disadvantages that are closely connected to nearly every iatric action can hardly be balanced by means of a therapeutically benefit.(14) For the physician this means a contradiction in terms of the principle that a medical procedure is for the benefit of the patient – hence to do no harm to the patient (concept of nonmaleficence).(15)
The statement of the Central Ethical Committee (Zentrale Ethikkommission, ZEKO) with the German Medical Association (Bundesärztekammer, BÄK) in terms of medical treatment for non-medical reasons refers to the fact that the imperative of risk minimization and –prevention in the case of a medically not indicated procedure is of paramount importance since there is no compensation for treatment risks as long as there is no healthwise benefit as could be found in procedures that are meant to cure healthwise impairments.(16) The indication for Caesarean is for some time now rarely connected to an emergency procedure since generous and preventive indications are desired more and more in the field of obstetrics.(17) A serious emergency would indeed justify certain risks, "risks that nonemergency situations do not justify".(18)

THE CONCEPT OF BENEFICENCE AND NONMALEFICENCE

There should be no question to favor the vaginal/spontaneous delivery when there is no urgent medical reason to do otherwise – this is underlined by the concept of beneficence.(19) The patient's beneficence should considerably prevail within the scope of unsubscripted measures. Mylonas and Friese arrive at a similar conclusion in their overview: Due to an increase of maternal and neonatal individual risks (intra- and postoperative), the Caesarean should only be performed at considerable advantages. This mode of delivery is therefore not to be rated as equal alternative to the vaginal delivery and should hence be assessed critically.(20) It is not uncommon in some cases – the requested Caesarean without medical indication due to a post-partum sterilization for free representing such a case – that the fundamental and well-known aphorism *primum non nocere* (the Latin expression

(10) N. Maass, M. T. Weigel, p. 362f.

(11) N. Maass, M. T. Weigel, p. 362f.

(12) K. Haucke, N. Dippong, p. 44.

(13) Find in-depth examinations on risks profiles in N. Maass, M. T. Weigel; I. Mylonas, K. Friese and M. Langer, Der Kaiserschnitt – vielleicht der Geburtsmodus des 21. Jahrhunderts, in *Gynäkologe*, 2013, 46, p. 715-721 among others.

(14) K. Haucke, N. Dippong, p. 45.

(15) T. L. Beauchamp, J. F. Childress, p. 149-196.

(16) Bundesärztekammer, p. A2002.

(17) R. Uphoff, p. 287.

(18) T. L. Beauchamp, J. F. Childress, p. 153.

(19) T. L. Beauchamp, J. F. Childress, p. 197-239.

(20) I. Mylonas, K. Friese, p. 494.

for "above all, do no harm, or first, do no harm"(21)) overrides the concept of beneficence, "even if the best utilitarian outcome would be obtained [in terms of the patient] by acting beneficently".(22) This is particularly necessary to consider since the autonomy of the patient does not only frame a right of defense against unwanted treatments but also frames the basis for a right to claim.(23) Conflicts between beneficence and the patient's autonomy are often mirrored "in paternalistic refusals to accept a patient's wishes (…)".(24) This form of refusal is also called *passive paternalism* by Beauchamp and Childress.

IMPORTANCE OF APPROPRIATE COUNSELING

Particularly strict standards should apply when a medical indication and hence a justification for an operative proceeding – is missing.(25) Interventions that invalidate the physical integrity primarily belong to experienced iatric hands that act according to the best of their knowledge and belief. A requirement to perform such action is not only a comprehensive medical information *lege artis* but also a previously given permission.(26) The medical-ethical counseling needs to take place within a suitable scope. That is to say, the pregnant woman needs to understand that the Caesarean without precise medical indication is clinically worse and riskier compared to a vaginal delivery. Although the patient's will appears to play an ever greater role within the medical decision making of gynecologists and obstetricians – their self-perception should encounter the women's autonomy.(27) In the end it should be the professional who has "superior training, knowledge, and insight and […] thus [holds] an authoritative position to determine the patient's best interest".(28)

As part of the counseling it is important to clarify needs and wishes of the pregnant woman in a personal meeting. Thorough and comprehensible information not only need to address options that are available for the women but also desired and undesired results as well as their chance of occurrence.(29) Alternatives and their respective outcomes also need to be taken into account. This applies to the counseling in terms of the sterilization as well – an appropriate scope is significant: durability of the procedure, limited reversibility, alternative methods, possibility of failure, possibility of an extrauterine/ectopic pregnancy and additional necessity of condoms as protection against sexually transmitted diseases.(30)

As a non-indicated medical procedure, the requested Caesarean indisputably constitutes the fact of bodily injury as long as the pregnant woman did not conceive her request in free self-determination as well as self-responsibility after a regular counseling.(31) According to articles 630e, 630f paragraph 2 of the German Civil Code (Bürgerliches Gesetzbuch – BGB), every physician is obliged in due time to orally inform his patient, respectively legal representatives, about progression, alternatives and risks of planned medical procedures and to document this. According to Section 630e (2): The information must 1. be provided orally by the treating party or by a person who has the requisite training to carry out the measure; additionally, documents may also be referred to which the patient receives in text form; 2. be provided in good time so that the patient can take his/her decision on consent in a well-considered manner; 3. be understandable for the patient. The patient shall be provided with duplicates of documents which he/she has signed in connection with the information or consent. According to Section 630f (2): The treating party is obliged to record all measures in the medical records which are relevant in medical terms for the current and future treatment and its results, in particular the establishment of the medical history, diagnoses, examinations, results of examinations, findings, therapies and their effects, procedures and their impact, consent and information. Physicians' letters are to be included in the medical records.

THE ECONOMIC BACKDROP

The sterilization performed as secondary procedure after an elective Caesarean is – hypothetically – the result of an economic decision making process led by

(21) C. M. Smith, p. 371.

(22) T. L. Beauchamp, J. F. Childress, p. 150.

(23) R. Uphoff, p. 288.

(24) T. L. Beauchamp, J. F. Childress, p. 197.

(25) C. S. von Kaisenberg *et al.*, p. 595.

(26) F. Steger, p. 8.

(27) R. Uphoff, p. 288.

(28) T. L. Beauchamp, J. F. Childress, p. 208.

(29) Bundesärztekammer, p. A2002.

(30) N. Maass, M. T. Weigel, p. 363.

(31) N. Maass, M. T. Weigel, p. 362.

factors like income of the person concerned, the extent of health insurance coverage/insurance status and the size of the hospital. In Germany, the circumstances are similar to the situation of American women as Garcia *et al.* describe it: "[I]ncreased restrictions associated with Medicaid coverage have led to a lack of alternative contraceptive choices among low-income women and thus sterilization related decision making should be viewed as constrained. [W]omen […] choose […] sterilization [as] the only long-term contraceptive option that does not require future costs or maintenance".(32) It is to be expected that many pregnant women in Germany would abandon the desired combination of Caesarean and sterilization, would the health insurance cover the costs for sterilization beyond the process of birth. Costs hereof amount to approximately 800 euro.(33) Costs for sterilization including anesthesia range depending on the procedure from 600 to 1000 euro. It is only within the realms of narrow confined requirements that the health insurance takes over the costs at this stage. This would be the case when medical or psychological reasons urgently recommend against a pregnancy and when the woman will not tolerate oral contraceptive or contraceptive coil.(34) A delivery *per vias naturales* would be an option again, if the sterilization would not have to take place within the context of a birth event. The women – no longer under pressure – would as a consequence have time to weigh the advantages and disadvantages of sterilization which could possibly lead to the consideration of alternative contraceptive methods as well.

RECOMMENDED COURSE OF ACTION

The framework of modern medicine certainly requires fundamental considerations in terms of physician's duties – a fortiori if concepts such as beneficence or nonmaleficence are at stake. The medical professions as well as society need to aim at a responsible handling when it comes to iatric procedures without any relation to illness. This is particularly a challenge in light of severe economic incentives when it comes to such procedures.(35) In this context, reference should be made to clinical studies and their ethical challenges for research. This refers to the physician who may be blinded by the economic gain as well as to the patient who only decides to undergo a Caesarean with concomitant sterilization to circumvent extra costs that are not covered by health insurance. Such lucrative considerations should however never interfere with ethical dimensions of medical practice since ethical goals have "too often […] commingled with protection of self-interest, privilege, and prerogative".(36) Physicians cannot be compelled to perform any medical procedures that are not indicated – they are – as a matter of principle – not bound to treat someone without any medical reason.(37) They can nonetheless follow the pregnant woman's request without fearing criminal or professional penalties if they adhere to the rules of appropriate and comprehensive counseling and recording since medical actions that do not attend to the treatment of diseases are equally subject to central requirements of the medical profession.(38) This article elucidates the medical-ethical tension between the mode of delivery and its forms of indication as well as the role of the appropriate counseling. The spectrum reaches from paternalism in the context of a more and more medicalized field of obstetrics to an understanding that approaches a "customer-service orientation"(39). It should also be kept in mind that "[s]ociodemographic differences by region may further play a role, because sterilization is more common in those with less education and greater parity".(40) Caesareans and post-partum sterilizations should – as a general rule – be only performed with the given precise medical indication. If fewer Caesareans for non-medical reasons are performed, the number of post-partum sterilizations will decline automatically. In order to have fair shared decision making processes and hence autonomous decisions made by pregnant women, a definite counseling-implementation within the patient-physician-relationship is absolutely essential. ■

(32) G. Garcia *et al.*, p. 635.

(33) http://www.sterilisierung.com/sterilisierung-frau.htm, 16.1.2017. Bundeszentrale für gesundheitliche Aufklärung – BzgA, http://www.familienplanung.de/verhuetung/verhuetungsmethoden/sterilisation/frau/, 16.1.2017.

(34) Bundeszentrale für gesundheitliche Aufklärung – BzgA, http://www.familienplanung.de/verhuetung/verhuetungsmethoden/sterilisation/frau/, 16.1.2017.

(35) Bundesärztekammer, p. A2000.

(36) E. D. Pellegrino, A. S. Relman, p. 984.

(37) Bundesärztekammer, p. A2002; T. L. Beauchamp, J. F. Childress, p. 220.

(38) Bundesärztekammer, p. A2001.

(39) R. Uphoff, p. 292.

(40) G. Garcia *et al.*, p. 6.

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