Maternal Choice in the UK Should Be Promoted Despite the Current Era of Financial Austerity

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Article history
Received: 2 October 2012
Accepted: 5 November 2012
Available online: 20 November 2012

Provenance and Peer Review
Unsolicited and editorial review

Keywords
Caesarian Section
Maternal Choice
Ethics
Delivery

With the ‘Nicholson challenge’ to cut costs by £20 billion over four years defining the current financial climate of the NHS,1 spiralling healthcare costs must be contained. Part of the reason for these increases is that the most modern interventions are often demanded by patients, even when the incremental health benefits are far outweighed by their cost. Maternity care is a major success of western medicine, and widespread maternal choice of location and type of treatment is increasingly expected in the developed world, and approved in recent NICE guidance.2 Though desirable to many, rarely in medicine is such a choice available where patients may demand that which is not clinically indicated, and for it to be provided free of charge.

In considering the ethical, economic, and empirical evidence for this debate, the four principles of medical ethics provide a useful framework: non-maleficence and beneficence (empirical evidence of risk and benefit), justice (economics), and autonomy (tantamount to maternal choice). Does increasing maternal autonomy provide benefits that outweigh any risks of harm to mothers and/or economic losses, and thus is current guidance justifiable?

For E. Edison

Increasing autonomy for patients is one of the foundations of a modern healthcare service, and should be promoted to ensure equitable access to quality services. Free and open maternal choice over both location and type of delivery can provide real benefits to the individual mother, whilst remaining sustainable and ensuring value for wider healthcare spending.

Location of Delivery

The case for promoting maternal choice with regards to location of delivery is clear. The current default position is to give birth in hospital in a consultant-led unit. Yet, despite the ability to choose location, only 5% of women give birth in a midwife-led unit, and 3% at home.2 For most low risk mothers, perinatal outcomes are generally the same regardless of location, with the exception of first-time mothers who experience a small but significantly increased risk of complications from a home birth.2 Many women do not realise that there are safe alternatives to hospital-led delivery, yet non-obstetric units are associated with lower odds of unwanted interventions, and a higher likelihood of achieving a ‘normal birth’ and establishing breast feeding.3 The economic argument for promoting maternal choice is undeniable. Delivery in a midwife-led unit saves £130 compared to a hospital consultant-led unit, whilst delivery at home saves £310.3 Increasing the uptake of delivery outside hospitals would potentially save millions of pounds. This dovetails with a wider long-term strategy to increase value in the NHS by moving care out of hospitals and into the community, streamlining high quality hospital resources for those who really need them.4

Promoting maternal choice would benefit mothers by allowing them to give birth in whichever environment they are most comfortable. This is closer to the ideal of patient-centred care, and a move away from the sometimes unnecessary medicalisation of delivery. This is not to say that medicalisation of childbirth is inappropriate, but to say that women should decide what level of medical intervention they would like. Clearly, initiatives to actively promote maternal choice would promote justice, beneficence, and autonomy.

Method of Delivery

The case for promoting maternal choice for method of delivery is less obvious. Autonomy is fundamental to medical ethics, and should be promoted provided it can be shown that beneficence, non-maleficence, and justice are not compromised, and that there is equipoise with regard to these factors. A commonly cited reason for denying caesarean section (CS) is that, as a surgical intervention, it carries risks; therefore, it cannot be justified if the mother can safely deliver vaginally. This appears to be on a spectrum with the viewpoint often conveyed in the lay press that CS is ‘unnatural’, often emotively expressed such as this statement from Louisa Foxcroft in The Guardian newspaper:5 “Rendering the caesarean a lifestyle choice smacks of cosmetic surgery and an example of the gynophobia in our society.”

Rhetoric aside, the evidence demonstrates that both vaginal
and CS delivery have complications, albeit different ones. For example, CS is associated with around one extra day in hospital on average, and a higher rate of neonatal intensive care unit admission, whilst vaginal delivery is associated with higher rates of post-partum bleeding, perineal injury, and pain. In fact, maternal choice CS complication rates may well be overestimated; many CSs included in these studies were indicated for some medical issue. The National Institute for Health and Clinical Excellence (NICE) has concluded that the risk profiles are similar, and it is impossible to argue for either method of delivery in favour of non-maleficence. Therefore, only autonomy is debatable. The guidelines have now changed such that maternal choice is a valid indication for CS, given an appropriate level of counselling and explanation. Evidence comparing the psychological effects of the mode of delivery is also conflicting. In fact, it appears that psychological wellbeing relates to the woman’s sense of control, rather than the mode of delivery itself. Thus, NICE predicts that, if properly implemented, maternal choice will not greatly increase uptake of CSs. Many CS requests are due to unfounded fears, and NICE guidelines state that proper counselling should be given before a CS request is accepted.

Economic calculations also suggest that there is insufficient cause to restrict maternal choice, although further work is needed. In the short-term, CSs are £700 more expensive due to the costs of active intervention. However, CS avoids the common spectrum of long-term perineal damage including urinary incontinence and vaginal prolapse. Calculations by NICE suggest that adjusting for these long-term costs, vaginal delivery may in fact be more expensive in the long-term. Further work is needed, as data used for this adjustment were based on an American study, with the limitations of using a different population in a more intervention-heavy health economy.

Conclusion

In a publicly funded system, patient autonomy and economics are often pulling in opposite directions. However, it appears that promoting maternal choice may have economic, as well as ethical, benefits. More work is needed to establish definitively what the long-term cost implications of the method of delivery in the UK are, but the implications for choice of location are clearer. For many women, delivery outside of hospital has not been considered as a realistic option before. Here we see that increasing choice, based on evidence that it is safe to do so, may in fact save money and help us move towards a more sustainable NHS.

Against S. Oxley

Free maternal choice in an age of austerity can only be justified when there is a corresponding balance of clinical benefit, non-maleficence and fair use of resources. Within the National Health Service, it is neither desirable nor affordable to offer normal mothers such rights to demand access to services that serve no clinical benefit, yet increase the burden of harm and cost. Controlling access would streamline services and maximise value, bringing maternity in line with other services where interventions are evidence-based, and allocated on clinical need.

Location of Delivery

Most women deliver in a consultant-led hospital environment. Yet, as has been shown above, this is significantly more expensive than midwife-led services and offers few, if any, benefits to low risk mothers. Rather than respond by encouraging more women to deliver in the community, we should actively limit consultant services to those with a legitimate medical need. It is no longer economically justifiable to offer complete autonomy over delivery services in the face of a need to maximise the use of resources. The time has come for a shift towards the midwife-led maternity unit (MU) as the default location, with elevation to an obstetric unit (OU) only on the referral of a professional during the antenatal or perinatal period.

Provided there are well established pathways to cover transfers between units, birth outside an OU is a fully integrated part of the maternity system. By having a presumption of delivery in MU, we would see significant cost savings and possibly an increase in desired outcomes. As care that was traditionally hospital-based moves out into the community, such approaches will be more and more acceptable in maternity.

This ‘limitation of location’ category would not preclude a woman from choosing her preferred maternity unit, as she might choose any other service, but she would not be suitable for transfer to an OU in the absence of a referral. This would be in keeping with the discipline of other services across the NHS, where primary care acts as a gatekeeper to consultant care.

Method of Delivery

Maternal and Foetal Outcomes

The first principle of a doctor should be non-maleficence; the duty to do no harm. Where there is evidence of increased harm from CS without satisfactory benefits, the clinician has a duty to take the safest option.

Much of the evidence base for the NICE guidance concerning the risks vs. benefits of CS are based on ‘very low’ or ‘low’ quality evidence; additionally a recent Cochrane study concluded that no evidence from randomised controlled trials was sufficient to assess the risks vs. benefits of CS without a medical indication. This raises doubts over the security of choosing CS to overcome any perceived complications of vaginal delivery. Nevertheless, CS does appear to introduce active harms both to the mother and the newborn, being associated with prolonged hospital stay, increased likelihood of hysterectomy caused by postpartum haemorrhage, and cardiac arrest in mothers. Babies have a higher chance of
Neonatal Intensive Care Unit admission, and a lower chance of successfully establishing breast feeding.

Harm from active intervention by obstetricians is of greater significance than possibly equivocal but ‘natural’ unwanted consequences from normal birth, which are passively tolerated. There is, therefore, a higher burden on those who wish to make the case for CS to demonstrate its benefits, particularly with no medical indication.

Aside from the issue of the current pregnancy, the risks to a future pregnancy need to be fully considered: much of the current guidance relates to first time mothers. Significantly, there is an increased risk of placenta praevia and accreta, with associated increased risks for the foetus, which is of particular concern for women planning larger families.

**Autonomy and Convenience**

The debate over maternal choice CS often involves autonomy and women’s rights, but not all see the addition of a riskier alternative as empowerment. Does the availability of maternal choice CS put pressure on women to undergo surgery to match a young, nulliparous ideal, rather than celebrating a materno-centric view of pregnancy? Autonomy is the right to make an informed decision, and give voluntary consent without undue pressure. This includes negative rights of a competent person to refuse treatment, which is stronger than the patients, whom it does not always empower.

**Financial**

Additionally, maternal choice CS is not financially justifiable. As CS is estimated to cost £700 more than vaginal delivery, even after discounting costs of emergency cases, it is estimated that a 1% reduction in the CS rate would save £4.9 million. This sum would pay for many midwives, and discount the potential costs of increased time for adequate counselling. Many other lifestyle treatments are restricted on the NHS, such as cosmetic surgery and IVF, and very rarely is a decision to operate based on convenience or the avoidance of anxiety, without corresponding evidence of medical benefit.

**Conclusion**

In the modern age, the most technologically advanced treatment is often confused with the highest standard of care. However, this does not apply to the natural process of childbirth, where healthy women do not benefit from an over-medicalised approach. Indeed, medicalisation may benefit the interventionists more than those it claims to serve. For pregnant women, the highest standard of care may be medical treatment when necessary, but the support of natural pregnancy for the low risk majority. The NHS should focus on optimising outcomes for patients, and operate based on clinical need.

**Ethical approval**

No ethical approval required for this editorial.

**Conflict of interest**

No conflicts of interest have been declared by the author.

**Author contribution**

SGO: Drafting and critical revision

EE: Drafting and critical revision

**Funding**

No funding source declared by the author.

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