It is important to note that as well as in Western hospitals (emergency caesarean sections (MRCS) as a site of conflict in obstetrics because birthing people are seeking access to a treatment ‘without any anticipated medical benefit’ while I agree with the conclusions of their paper ‘that there is a need to reform the approach to MRCS counselling to ensure that the structural vulnerability of pregnant people making birth decisions is addressed—I disagree with the framing of MRCS as having ‘no anticipated medical benefit’. I argue that MRCS is often inappropriately presented as unduly risky, without supporting empirical evidence, and that MRCS is most often sought by birthing people on the basis of a clinical need. I argue that there needs to be open conversation and frank willingness to acknowledge the values that are currently underpinning the presentation of MRCS as ‘clinically unnecessary’; specifically there needs to be more discussion of where and why the benefits of MRCS that are recognised by individual birthing people are not recognised by clinicians. This is important to ensure access to MRCS for birthing people that need it.

In their paper, ‘How to reach trustworthy decisions for caesarean sections on maternal request: a call for beneficial power’ Eide and Bærøe present maternal request caesarean sections (MRCS) as a site of conflict in obstetrics. They explain that in MRCS birthing people are making a request for a healthcare intervention ‘without any anticipated medical benefit’ and that since obstetricians have a ‘right to act in accordance with their professional integrity and make adequate medical decisions in line with their specialist knowledge and clinical judgement’, they may wish to refuse to provide the intervention and there occurs a potential conflict. Their paper considers how this conflict should be managed by a proposed framework of ‘ethically justified decision-making’ that centres on the exercise of beneficial power.

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

I broadly agree with the reforms the authors suggest to ensure the counselling about modes of birth process promotes trust: including the promotion of information exchange, that counselling is specific to the individual, and avoids authoritative technical terms, and is undertaken with the express objective that people feel no pressure to conform to vaginal delivery, among others. However, first and foremost, the framing of MRCS as a ‘site of potential conflict’ must be addressed to avoid reforms being superficial.

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

REALITIES OF MRCS

Eide and Børøe’s conception of the MRCS as a possible site of conflict between the autonomous claims of health professionals (related to integrity) and birthing people’s preferences begins with the discussion of the dangers of caesarean for birthing people. The authors acknowledge that ‘There are no available evidence from randomised control trials comparing outcomes of vaginal versus caesarean delivery for low-risk women lacking obstetric indication’. However, they continue, ‘Still, CS is in general associated with increased risk for short-term and long-term health complications for both mother and child’. Even if we do not take these assumptions to be central to the arguments the authors make about power imbalances in the relationship between professionals and birthing people (though one assumes that this must play a key role since doctors as professionals are able to gate-keep what treatment is recognised as clinically appropriate in a given context), my response is still significant in pointing out the error in these assumptions about the claimed ‘increased risk’ of MRCS. The pervasive mischaracterisation of MRCS in debate about how requests are managed is a problem in itself that it is important to correct.

While the authors have acknowledged it, they commit a non sequitur in concluding that because caesareans (note they neglect to say—emergency caesareans) are associated with increased risks, MRCS must carry increased risks—without

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FRAMING THE REQUEST

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

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

Relatedly, the second criterion proposed explains that dialogue ‘must be carried out without any agenda of pressuring the woman to opt for vaginal delivery’, but where MRCS is routinely characterised as clinically unnecessary, it is difficult for professionals to avoid importing implicit biases about what constitutes clinical need into the counselling they provide. As one final example, the fourth criterion the

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Eide and Bærøe also commit an additional non sequitur in discussion of rising caesarean rates by implying this is associated with an increase in requests - despite the studies they cite in no way commenting on the incidence of MRCS (only reporting that caesareans are increasing in incidence). There are good reasons to believe that it is not MRCS behind the rise (Romanis 2020).
authors suggest considers the importance of counselling being attentive to individual needs (by avoiding authoritative and inaccessible jargon), considering the individual, and ensuring that the probability of complications is communicated with the certainty of evidence. Unless the misconceptions about the evidence surrounding MRCS and the values brought to decision-making in obstetrics about what constitutes clinical need are openly challenged and scrutinised (and individual practitioners are encouraged to be transparent), it is difficult to see how such reform can be brought into practice. All of the suggestions made by Eide and Bærøe are indeed crucial in ensuring more patient-centred care, but to accomplish this, we need to begin by dismantling ideas about what constitutes clinical need in birth choices and of conflict between professional integrity and birthing people’s preferences in MRCS.

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