



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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## Committee on Ethics

*This Committee Opinion was developed by the Committee on Ethics of the American College of Obstetricians and Gynecologists as a service to its members and other practicing clinicians. Although this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.*

## Elective Surgery and Patient Choice

**ABSTRACT:** Acknowledgment of the importance of patient autonomy and increased patient access to information, such as information on the Internet, has prompted more patient-generated requests for surgical interventions not traditionally recommended. Depending on the context, acceding to a request for a surgical option that is not traditionally recommended can be ethical. Decisions about acceding to patient requests for nontraditional surgical interventions should be based on strong support for patients' informed preferences and values; understood in the context of an interpretive conversation; and consistent with considerations of safety, cost-effectiveness, and attention to effects on the health care system of expanded choice. Physicians should make sure that their counseling about specific risks and benefits is based on current evidence. After the physician has provided information and careful counseling, the patient and physician will often reach a mutually acceptable decision. If the patient and physician cannot reach an agreement, then referral or second opinion may be appropriate.

Acknowledgment of the importance of patient autonomy and increased patient access to information, such as information on the Internet, has prompted more patient-generated requests for surgical interventions not traditionally recommended. Such requests are sometimes based on misunderstandings of risks or benefits or on concerns that can be readily addressed within traditional guidelines. But, they also can issue from knowledgeable understanding of the risks and benefits of relevant options and personal assessments that simply differ from the preferences and priorities that are assumed in medical guidelines and practice.

These issues raise important questions about whether and when it may be appropriate to accede to patients' specific preferences and priorities. Is it ethically acceptable to perform a risk-reducing oophorectomy for a 30-year-old patient with no family history of ovarian cancer if the patient's anxiety is strong and overwhelming? Is it ethically appropriate to perform a cesarean delivery on maternal request at term in an otherwise uncomplicated pregnancy (1, 2)?

The purpose of this Committee Opinion is to provide an ethical framework to guide physicians' responses to patient requests for surgical treatment that is not tra-

ditionally recommended. In using the examples of risk-reducing salpingo-oophorectomy and cesarean delivery on maternal request, the Committee on Ethics of the American College of Obstetricians and Gynecologists (the College) does not mean to comment on the clinical appropriateness of or medical evidence regarding these interventions, a topic beyond the purview of the Committee on Ethics that is addressed by the College's Committee on Practice Bulletins—Gynecology and the Committee on Obstetric Practice, respectively (3, 4). The Committee on Ethics also addresses other special considerations involving patient choice in obstetric decision making in Committee Opinion Number 321, *Maternal Decision Making, Ethics, and the Law* (5).

In summary, the Committee on Ethics recommends the following:

- When patients request surgical interventions that are not traditionally recommended, physicians should make sure that their counseling about specific risks and benefits is based on current evidence.
- Determining an appropriate course of treatment for individual patients requesting a surgical intervention that is not traditionally recommended requires

particularly careful communication. The goal should be decisions reached in partnership between patient and physician.

- Depending on the context, acceding to a request for a surgical option that is not traditionally recommended can be ethical. Decisions should be based on strong support for patients' informed preferences and values; understood in the context of an interpretive conversation; and consistent with considerations of safety, cost-effectiveness, and attention to effects on the health care system of expanded choice.

## **Ethical Principles Relevant to Expanding Patient Choice**

A recent ethical framework distinguishes four factors that are relevant to the responsible inclusion of patient preference in guidelines and physician care (6): 1) patient autonomy, 2) avoiding harm, 3) cost-effectiveness, and 4) effects on the health care system of increasing choice.

### **Patient Autonomy**

The importance of uncovering and incorporating, where possible, patients' own priorities and values in their medical care is widely endorsed, especially when the preferences are informed and deeply held. Patients can vary greatly in the values, preferences, and priorities they bring to a given medical situation. In particular, patients can vary considerably in how they weigh specific medical risks and benefits; a physician's risk-benefit analysis may not be the same as an individual patient's. Furthermore, nonmedical considerations are often of first-order importance to patients. This may be particularly true in obstetrics. Issues of process in birth, or securing a psychological sense of safety, matter deeply to some patients (6–8). Some of the most important issues to patients are found in personal, cultural, and narrative concerns that are not well captured in traditional medical guidelines.

It also is widely acknowledged that patients' requests for interventions may not always be appropriate or feasible to satisfy. Considerations of safety, cost-effectiveness, and effects on the broader health care system of expanding patient choice are all relevant to determining when it is appropriate to accede to patient requests. Although patients have strong autonomy interests in having access to expanded choice, these interests do not merit the same level of protection as rights to refuse treatment.

### **Avoiding Harm**

Nonmaleficence instructs health care professionals to minimize harm. Consideration of risk limits a health care professional's obligation to accede to requests for medical intervention; if risks are too high relative to the benefits accrued, those risks serve as a barrier to the permissibility of performing the intervention. Summary judgments of what is "safe" and "unsafe" are more properly understood as a series of probabilities and ranges of severity of untoward outcomes and processes. Risk should be under-

stood as a function of likelihood and severity of outcome and can be setting specific and physician specific.

### **Cost-effectiveness**

Consideration of cost-effectiveness limits a physician's obligation to accede to requests for surgical interventions. If an intervention offers little or no incremental benefit but uses substantially more resources than an alternative, then physicians may reasonably decline a request for the first.

Questions have been raised about whether traditional cost-effectiveness measures adequately capture personal factors, including process-oriented ones that are often of as much importance to patients as discrete medical outcomes (6). For instance, mode of delivery is an area in which women may have preferences that are deeply important to them yet that are poorly captured in traditional recommendations focusing on discrete medical outcomes. For interventions that are known to intersect with such personal considerations, the relevance of cost-effectiveness assessments should be made in conjunction with an understanding of what matters most to the patient.

Furthermore, accurate assessment of medical costs can be difficult to achieve. Concerns have been raised that expanding access to cesarean deliveries will raise costs, with clinicians citing the higher cost of cesarean delivery over vaginal delivery (9). Determination of the true cost comparison is complicated, however, by the need to account for the probability of conversion from a vaginal delivery to an emergent cesarean delivery, which is more costly than a planned cesarean delivery.

### **Effects of Expanding Choice on the Health Care System**

Changing patterns of patient preference can have strong indirect effects on the options available to other patients. If demand for a given procedure increases sufficiently, it can decrease the availability of other more traditional options by decreasing the training and experience health care providers then have with traditional options or through downstream shifts in staffing patterns.

The potential for such effects may be among the most significant concerns for increasing access to elective cesarean delivery. As the cesarean delivery rate has increased, so too have concerns that labor and delivery wards orient more to high-intervention births, with a resultant decrease in proficiency with or staffing to support low-intervention births. The experiences in certain Latin American countries, where high rates of cesarean delivery have limited meaningful access to low-intervention or vaginal birth, are a case in point (10). Concerns have been raised that allowing cesarean delivery on maternal request will amplify those trends. This issue is especially important given that for many women, a vaginal delivery is meaningful in its own right and not simply as a function of other risks and benefits.

How the choices of some can affect opportunities for others raises important questions of justice. As with other issues of justice, what this might mean for an individual physician who provides care for an individual patient is complex. Physicians must balance their advocacy obligations to individual patients with their stewardship role for community resources. This balance, which is always difficult in medicine, is influenced, among other things, by how important the intervention is to the patient, upon full understanding of its risks and implications, and by how high the incremental cost to the health care system is to acceding to the request.

## Supporting Informed and Meaningful Decisions

When individual patients request surgical intervention that is not traditionally recommended, determining an appropriate course of treatment requires particularly careful communication. The goal should be decisions reached in partnership between patient and physician.

In years past, a paternalistic physician–patient model of medical counseling was advocated, in which physicians present only information on risks and benefits of a procedure that they think will lead the patient to make the “right”—that is, physician-supported—decision regarding health care (11). This model, problematic for many reasons, is especially inappropriate in contexts in which patients are known to have a significant range of values, preferences, and priorities about the intervention being considered.

Instead, an interpretive model of medical counseling is critical. The interpretive model of medical counseling outlines the role of the physician as helping the patient clarify and integrate her priorities, preferences, and values into the decision-making process while acting as an information source regarding the technical aspects of any given medical procedure (11, 12). Alliance, communication, and support are emphasized, along with *clinical empathy*, defined not as the attempt to feel what the patient feels, but as the ability to be attuned to and follow up on the patient’s emotional signals (13, 14).

When implementing this model, physicians must be careful to help the patient clarify her values while not imposing their own values on the patient. For instance, obstetricians should be cautioned against reliance on their own personal opinion as to what is normative for a “good birth,” recognizing that women vary—from woman to woman and, sometimes, from one pregnancy to the next in the same woman—on the criteria of a good birth (15). At the same time, physicians should understand the importance of helping patients to frame and integrate medical issues into the context of their values and lives, remembering that physicians’ professional judgments generally are of considerable value to patients. Especially in complex decisions, patients prefer the physician role of a caring partner and medical expert in the decision-making process as opposed to a simple pur-

veyor of information (16–18). In addition, when patients request surgical interventions that are not traditionally recommended, physicians should provide counseling about specific risks and benefits based on current evidence. The physician should review the evidence with the patient, acknowledge where evidence is limited, and help to frame considerations to facilitate patient exploration.

All of these factors take time—with complex issues, time ideally spent over multiple visits—to allow the patient to process the information and implications that are most salient to her. Time is a scarce commodity; the realities of current clinical practice often place severe restrictions on it. Still, it is worth underscoring that a recent study found that time spent with the patient was a critical factor in supporting consent—indeed, the only thing that correlated with improved decisional capacity was time with the patient (19).

Presented with a request for a surgical intervention that is not traditionally recommended, the physician must start with assessment of the current data regarding the relative medical benefits and risks of the approach and its alternative(s). For instance, because of the potential for lung complications, the College Committee Opinion Number 559, *Cesarean Delivery on Maternal Request*, states that cesarean delivery on maternal request should not be performed before 39 weeks of gestation; because of the increased risk of placenta previa, placenta accreta, and gravid hysterectomy with each additional cesarean delivery, the College does not recommend cesarean delivery on maternal request for women desiring several children (4).

The physician should explore the patient’s concerns and the factors that matter most to her, in the context of a supportive and open conversation, and offer appropriate education and counseling as needed. Such exploration may lead the patient to reconsider the request. For instance, a 30-year-old requesting risk-reducing salpingo-oophorectomy based on fear of cancer may rethink the request after being counseled on the functions of ovaries and the implications of their removal: that it would remove the option of having a child with her own egg; that it would diminish vaginal lubrication and pliability; or that estrogen is critical to bone density. Similarly, if a patient requests elective cesarean delivery because she is afraid of pain during labor (20), providing her with information about procedures available for effective pain relief during labor may lead her to change her mind about wanting surgery (21).

Alternatively, conversation may confirm the woman’s initial request. Consider a woman who is finished with childbearing and whose family has already been devastated by a sister’s death from genetically linked ovarian cancer. Although the woman herself is not a genetic carrier, she may decide that she is willing to move up the date of menopause and take recommended medications for the reassurance that she would not die and leave her own small children because of ovarian cancer. Similarly, a woman might strongly prefer a scheduled cesarean

delivery if she strongly disvalues a one-in-four chance of having an exhausting trial of labor followed by a cesarean delivery and finds herself facing delivery at a hospital with a high rate of conversion from vaginal delivery to cesarean delivery (22).

If, after careful counseling, the physician believes that the surgical option is best for this individual woman and her life circumstances, then it is ethically permissible to perform the surgery. If constraints on insurance or hospital regulations preclude acceding to the request, the physician can maintain alliance with the patient by expressing respect for her perspective and request as understandable and reasonable and communicate regret that it cannot be met.

If the physician believes, based on evidence, that performing the surgery would be detrimental to the overall health and welfare of the woman, he or she should not perform the surgery. In these circumstances, physicians do not have an ethical obligation to refer the patient to a willing health care provider, but they may wish to offer a referral for a second opinion with the thought that another, likely concordant, opinion may be useful for the patient.

For cesarean delivery on maternal request in particular, all obstetricians are encouraged to examine whether there are practice-based or facility-based changes that can remove some of the concerns that may contribute to a preference for planned cesarean delivery. Physicians should ensure adequate pain management, effective and supportive communication, and a strong commitment to training in low-intervention births. The College continues to support vaginal delivery as the primary mode of delivery in the absence of medical indications for cesarean delivery. Performing cesarean delivery on maternal request should be limited to cases in which the physician judges that it is sufficiently safe, given the specifics of the woman's pregnancy and setting, and has had the opportunity for thorough and thoughtful conversation with the patient.

## Summary

Decisions about acceding to patient requests for surgical interventions that are not traditionally recommended should be based on strong support for patients' informed preferences and values; understood in the context of an interpretive conversation; and consistent with considerations of avoiding harm, cost-effectiveness, and effects on the health care system of expanded choice. When patients request a nontraditional surgical intervention, conversations and recommendations must begin with the physician having a good understanding of the scientific evidence for and against the requested procedure. Physicians should be sure that the safety concerns that limit acceding to patient requests are evidence-based and not merely a reflection of a physician's traditional approach. The physician should use the opportunity that this kind of request presents to explore the factors

specific to the woman in the context of her own life narrative. Health care professionals also should understand that medical risk and benefit, although of obvious and first-order importance, do not exhaust all fully reasonable factors that may be important to the patient. Listening to patients, helping to frame what they might be thinking, and including process as well as outcome are key obligations. Depending on the context, acceding to a request for a surgical option that is not traditionally recommended can be ethical.

After the physician has provided information and careful counseling, the patient and physician will often reach a mutually acceptable decision. If the patient and physician cannot reach an agreement, then referral or second opinion may be appropriate.

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