

## Editorials

### “But Doctor, I’d Prefer To Have A Cesarean Section”: When Public Policy Conflicts With Patient Preference

A trial of labor after a previous low transverse Cesarean section in women without ongoing contraindications appears to be safe for most women.<sup>1-6</sup> Nevertheless, in many areas of the country, obstetricians have had difficulty violating Craigin’s dictum of “once a Cesarean section, always a Cesarean section.”<sup>7</sup> The case series reported by Miller, et al.<sup>8</sup> in this issue of the *Journal* confirms this safety in a community hospital setting where the maternity care providers were appropriately trained family physicians. From 1988 to 1992, 56 of 98 women (57 percent) who had undergone a previous low transverse Cesarean section and who were eligible for a trial of labor agreed to a subsequent trial of labor. Forty-three of these women (77 percent) gave birth vaginally. This success rate agrees closely with that reported elsewhere in the literature.<sup>3</sup> This study provides important information for many family physicians around the country who have had their obstetric privileges limited to women who have not had a Cesarean section. Few studies, however, have dealt with two critical issues that could place women and their maternity care providers in conflict — patient preferences and the comparative costs of care for these two delivery methods.

#### Women’s Preferences for a Birthing Method

In the study of Miller, et al.<sup>8</sup> 87 of 98 women were eligible for a trial of labor, yet only 56 (64 percent) agreed to participate. The remaining one-third elected to have a repeat Cesarean section. This finding is consistent with the published literature. The reasons underlying women’s preferences for a trial of labor or elective repeat Cesarean section appear to be diverse, and they change during pregnancy.

Socioeconomic and ethnic factors; the advice of the physician; opinions of spouse, friend, or family member; previous birth experience; and so on, do not appear to influence women’s preferences for one method rather than another in a consistent manner. Women desiring a vaginal birth are influenced by the shorter recovery time associated with this method and a desire to experience the birth process. Factors influencing the decision for a repeat Cesarean section include convenience (desire to schedule the delivery to accommodate child care or employment, avoidance of labor pain, or reluctance to attempt labor without a support person), the woman’s perceived likelihood of being incapable of having a vaginal birth, and her desire for a postpartum tubal ligation.<sup>9</sup>

Women’s perceptions of the birth experience change during pregnancy and after delivery. Abitbol, et al.<sup>10</sup> found that 40 percent of women eligible for a trial of labor preferred an elective repeat Cesarean section early in pregnancy. After delivery, 7 percent of this group wished they had undergone a trial of labor, and nearly one-third of women who experienced a vaginal birth after a Cesarean section regretted the trial of labor. Seventy-five percent of those experiencing an unsuccessful trial of labor were angry that they had unexpectedly encountered such a painful labor and difficult delivery.

In a postpartum assessment of low-risk first- or second-time mothers, Kahn, et al.<sup>11</sup> reported that before their recent delivery, 14 percent preferred a Cesarean section delivery and 72 percent preferred a vaginal delivery. Twenty-three percent of those actually receiving a Cesarean section preferred this method before delivery. Considering their recent delivery experience, 24 percent thought that a Cesarean section would have been (or was) best for them.

Some studies suggest that a sizable proportion of women change their decision to undergo a trial of labor during labor in response to pain and other factors independent of obstetric risk. Joseph, et al.<sup>12</sup> found that among 131 “good”

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candidates for a trial of labor, 65 percent initially chose to attempt a vaginal delivery. Of these, 13 percent later changed their mind despite continued encouragement by their obstetrician, primarily because of "convenience." An additional one-third were discouraged from their choice by their obstetrician as their pregnancies progressed. Five women (11 percent) initially preferring repeat Cesarean section changed their decision during labor and experienced a vaginal birth.

### **Financial Costs of Elective Repeat Cesarean Section with Trial of Labor and Vaginal Birth after Cesarean Section**

Financial costs (as measured by hospital charges) of a Cesarean section delivery are nearly 2.4 times greater than for vaginal births. This difference is due almost entirely to the longer length of hospital stay for women giving birth by Cesarean section. Published financial costs have traditionally not included indirect or opportunity costs — the costs attributed to how time might otherwise be used. The opportunity cost to the physician supporting a trial of labor might be a loss of income from providing other kinds of care during the time the labor was supervised. To the woman, this cost might be a loss of caregiving to other family members or a loss of wages due to an uncertain date of delivery.

In 1989 the average national hospital cost for a normal delivery was \$2,842.<sup>13</sup> Physician fees for a normal pregnancy and vaginal birth were an average of \$1,492. Cesarean section costs in 1989 were an average of \$7,186 (\$5,133 for hospital charges and \$2,053 for physician's fees). In 1990, the average hospital stay in the United States for Cesarean section was 4.4 days, and the average cost was \$8,530.<sup>14</sup> Controlling for the presence or absence of complications, the hospital lengths of stay for a Cesarean section in Oregon in 1991 and 1992 were on average 2.2 times greater than for a vaginal birth.<sup>15</sup>

### **Balancing Patient Preferences against the Costs of Delivery Method: Whose Choice?**

If one ignores financial costs, determinants of clinical decisions should include the "best" clinical outcomes obtained by the decision and the preferences of patients and providers. Many physicians might now believe that with the high success rate of trial of labor and the increased mor-

bidity associated with Cesarean section delivery, allowing women a choice of a repeat Cesarean section is unjustified.

If financial costs are included, this argument becomes even more compelling. Insured women pay a very small amount of the cost difference between Cesarean section and vaginal delivery, because charges for a vaginal delivery reach the out-of-pocket limit of a typical policy.<sup>16</sup> Greater cost-sharing by patients, advocated by Enthoven and Kronick,<sup>17</sup> might increase sensitivity to such differences in cost and might influence the decision toward trial of labor, which if it results in a vaginal birth, would be a lower cost delivery option.

Recent published recommendations suggest that payment for obstetric care should not be tied to the delivery method.<sup>18-20</sup> While third-party payers have traditionally paid much more for Cesarean sections than for vaginal deliveries, increasing numbers of private insurers and state Medicaid plans are paying the same amount or even more for vaginal births than for Cesarean section.<sup>21,22</sup> The effect of these new payment policies on physician practice and Cesarean section rates is not well known at this time.<sup>23-25</sup> There are, however, increasing anecdotal reports of shortened lengths of hospital stay for both vaginal delivery (12 to 36 hours after delivery) and Cesarean section (48 to 72 hours after surgery), which have been commonly attributed to the influence of managed care.

One expects that increasing and not-so-subtle pressure will be brought to bear on the one-third of women eligible for a trial of labor who opt for a repeat Cesarean section. Current practice policies toward these women range from informed consent and compliance with their wishes to a firm trial-of-labor-for-all position. Primiparous women who desire a primary Cesarean section birth without sufficient medical indication rarely find a receptive audience among maternity care providers. With current safety and cost data strongly supporting trial of labor, one does indeed have reason to wonder why the choice of a repeat Cesarean section is still an option for women in 1995.

The conflicts between patient preferences and public policy could be even more acute in the future. Who should make such decisions and what factors should be taken into account when they are made are at the crux of this issue. These con-

flicts are likely to have consequences for all maternity care providers and have an impact on the patient-provider relationship in ways that could challenge even the staunchest patient advocate — the family physician.

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## References

1. Flamm BL, Lim OW, Jones C, Fallon D, Newman LA, Mantis JK. Vaginal birth after cesarean section: results of a multicenter study. *Am J Obstet Gynecol* 1988; 158:1079-84.
2. Flamm BL, Newman LA, Thomas SJ, Fallon D, Yoshida MM. Vaginal birth after cesarean delivery: results of a 5-year multicenter collaborative study. *Obstet Gynecol* 1990; 76:750-4.
3. Flamm BL, Goings JR, Liu Y, Wolde-Tsadik G. Elective repeat cesarean delivery versus trial of labor: a prospective multicenter study. *Obstet Gynecol* 1994; 83:927-32.
4. Boucher M, Tahilramaney MP, Eglinton GS, Phelan JP. Maternal morbidity as related to trial of labor after previous cesarean delivery, a quantitative analysis. *J Reprod Med* 1984; 29:12-6.
5. Meehan FP, Magani IM. True rupture of the cesarean section scar (a 15 year review, 1972-1987). *Eur J Obstet Gynecol Reprod Biol* 1989; 30:129-35.
6. van Amerongen D. Vaginal birth after cesarean section. Experience in a community-based practice. *J Reprod Med* 1989; 34:531-4.
7. Craigin EB. Conservatism in obstetrics. *NY Med J* 1916; 104:1-3.
8. Miller ES, Partezana J, Montgomery R. Vaginal birth after Cesarean: a 5-year experience in a family practice residency program. *J Am Board Fam Pract* 1995; 8:357-60.
9. McClain CS. Why women choose trial of labor or repeat cesarean section. *J Fam Pract* 1985; 21:210-6.
10. Abitbol MM, Castillo I, Taylor UB, Rochester BL, Shmoys S, Monheit AG. Vaginal birth after cesarean section: the patient's point of view. *Am Fam Physician* 1993; 47:129-34.
11. Kahn K, Fiske M, DiMatteo R, Bradley M, Edwards C, Gifford D, et al. Mother's thoughts about cesarean as compared with vaginal deliveries and the effect of those thoughts on method of delivery. Abstract presented to the Association of Health Services Research Annual Meeting, San Diego, CA, 13 June 1994.
12. Joseph GF Jr, Stedman CM, Robichaux AG. Vaginal birth after cesarean section: the impact of patient resistance to a trial of labor. *Am J Obstet Gynecol* 1991; 164:1441-7.
13. Minor AF. The cost of maternity care and childbirth in the United States, 1989. Washington, DC: HIAA Research Bulletin (Pub No R1589), December 1989.
14. Charges for a cesarean section: United States, 1990. *Stat Bull Metrop Insur Co* 1992; 73(1):12-8.
15. Data from the Oregon Department of Human Resources. Portland: Office of Health Policy. Patient Discharge Database System.
16. Gold RB, Kenney AM, Singh S. Paying for maternity care in the United States. *Fam Plann Perspect* 1987; 19:190-206.
17. Enthoven A, Kronick R. A consumer choice health plan for the 1990s. Universal health insurance in a system designed to promote quality and economy. *N Engl J Med* 1989; 320:94-101.
18. Finkler MD, Wirtschafter DD. Why pay extra for cesarean-section deliveries? *Inquiry* 1993; 30:208-15.
19. Danforth DN. Cesarean section. *JAMA* 1985; 253:811-8.
20. Porreco RP, Klaus MH, Shearer E, Petitti D, Hohe P, Boylan PC. Commentaries: the cesarean section rate is 25 percent and rising. Why? What can be done about it? *Birth* 1989; 16:118-22.
21. Barclay L, Andre CA, Glover PA. Women's business: the challenge of childbirth. *Midwifery* 1989; 5:122-33.
22. Spellacy WN. Vaginal birth after cesarean: a reward/penalty system for national implementation. *Obstet Gynecol* 1991; 78:316-7.
23. Darby M. Reimbursement has small impact on c-section rates. In: Report on medical guidelines and outcomes research. Alexandria, VA: Capitol Publications, 1992:8-10.
24. Sims PD, Cabral D, Daley W, Alfano L. The incentive plan: an approach for modification of physician behavior. *Am J Public Health* 1984; 74:150-2.
25. Stafford RS. Alternative strategies for controlling rising cesarean section rates. *JAMA* 1990; 263:683-7.

## Relationship-centered Care: Beyond The Finishing School

Andrew D. Hunt, the first dean of the College of Human Medicine at Michigan State University and later the founding director of its Medical Humanities Program, used to decry the "finishing school" view of ethics and humanities in medicine — according to which students would first learn "real" medicine and then, as a sort of afterthought, would be given a course in ethics or humanities, as young ladies of an earlier era were sent to finishing school to learn how properly to hold a teacup. Hunt believed that ethics and

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