

Caesarean section between doctrine to heresis. Medicoethical and deontological view of caesarology: an opinion

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Increasing the incidence of caesarean section is not in line with professional and deontological guidelines. Elective cesarean section prevents primordial prevention of chronic cardiovascular, gastrointestinal, immunological, endocrinological morbidity by peripartur programming. Elective non-medical indicated caesarean section is not a procedure that respects deontological, clinical ethics, scientific and professional principles. It is like an unacceptable surgery outside the scope of medical ethics. Clientelism in high-risk clinical obstetric medicine is not a professional and deontologically correct category: a physician should not be a provider on request of healthy pregnant women with the potential to have a medically incorrect procedure and complications associated with it and to put a healthy pregnant/maternity and child status in the patient's status. The financial, social, political and cultural components must not outweigh good clinical practice and the moral principles of medicine.

Keywords

Caesarean section; Elective caesarean section; Non-medical indicated caesarean section; Medical ethics; Clinical ethics; Deontology

1. Introduction

Childbirth is a natural, biological, and primarily anthropologically defined process. Caesarean section (CS) had been performed centuries before it was legally recognized by the Roman emperors Numa Pompilius and Justinian and by their legal codes for the purpose of saving lives of unborn babies of moribund or mothers who had just died. Obstetrics is a high-risk profession, and a risk control is a fundamental postulate of practicing the medical profession and reducing litigations and deontological problems. CS has remained a clinically justified procedure as a life-saving surgical procedure for mother and/or baby but recently it has become a fashionable procedure as a consequence of various non-medical indications [1–5]. Over the last two decades the increase in CS has also resulted in defensive obstetrics beyond the scope

of good clinical practice, which has also been accompanied by an increasing number of obstetric litigations. Monitoring the implementation of CS is considered to be a part of quality control of some gynecological and obstetric wards and clinics, which has in return disturbed the paradoxical, professional and deontologically unacceptable benefits of enormous growth of elective primary medically indicated CS (ECS) and non-medically indicated CS (NMICS). Primary ECS is associated with significant morbidity in early infants, infancy, childhood, and adulthood due to the modulation of physiological factors, most notably the maternal and infant microbiome. Prior CS is a significant risk factor for severe obstetric urgencies such as uterine rupture, previal placentation, invasive morbid malplacentation with all following complications on the health and life of the mother and the unborn baby. Indeed, the increased incidence of CS, in particular ECS, has contributed to the epidemic of these obstetric complications and has become heresy of the 21st century medicine while obstetrics is transformed into risk-adopted obstetrics [5–9].

This review will outline the significant deontological and clinical ethical dilemmas of epidemic and endemy of elective caesarean section in 21st century.

2. Deontological view

The basic philosophy of medical ethics is to help with its knowledge and skills to preserve health and prevent diseases, which is required by the part of the Hippocratic Oath: "Under pressure I will not allow my medical knowledge to be used contrary to the laws of humanity." A doctor is an expert with his full awareness and consciousness, ethics and consistency in performing his profession. He is a medical authority and a person of trust, therefore, dishonesty and incompetence cannot be considered as professionalism. Clinical professionalism should not allow conflicts of interest between the mother

and the unborn child capable for life, for no person's benefit or detriment. It is unacceptable to create a patient from a healthy person, and thus to perform non-medically indicated surgery with a high percentage possibility of the creation of potential patients in future life. Furthermore, inviting and persuading for unnecessary surgery while giving anti-scientific and professional falsehoods of any interest is a violation of professional deontology. Professional societies of doctors and midwives must not allow the public opinion to claim that giving birth with ECS, especially NMICS, is safer than vaginal delivery [2, 4, 10, 11].

Fear of anesthesia and surgery is a normal reaction and perception of danger, even though it is not clear how the psychologically and anthropologically defined normal reaction of fear of anesthesia and cesarean surgery is absent with NMICS procedure. Furthermore, where did anxiety and fear of mutilation and pain with persistent pregnancy fear and pregnancy outcomes disappear? With NMICS and the consequences of repeated CS there is no consistent clause defined in the medical law known as concern for personal and child's health. However, parents, by their ignorance and actions, directly influence on the right to health and development of their children, which is unacceptable in terms of medical, ethical and professional clauses.

According to existing works, the incidence of tocophobia is 6-10% in some countries where it is used as a reason for ECS and NMICS. Genital tract injuries are noted as the cause of tocophobia, and simple performing of CS as a surgery is an indisputable extensive iatrogenic injury, especially of the genital tract. On what basis is a medical diagnosis made: from its real existence, from a misinterpretation, the influence of the media, the subjective transfer of other women's experiences from their childbirth, public forums, or the financial and social background [4, 6, 12, 13]? Medical authorities interpret the width of the NMICS name as "cesarean section of desire", "cesarean section as agreed", cesarean section for "facilitated"/"easier" route, which explains the use of surgery to fulfill the wishes of the healthy pregnant women with no difference to aesthetic surgery. CS is not an aesthetic procedure, because according to the clauses of cosmetic surgery, a healthy person WANTS aesthetic correction for various reasons, and CS does not serve as the correction of aesthetic disorders or the desire for a better appearance. CS does not belong to the so-called, small surgical procedures, such as suture or incision of a skin abscess, but already belongs to the category of major surgery [1, 2, 6, 13, 14]. Twenty years ago, when the movement of performing of NMICS was launched, the world's gynecological and obstetric federations were pointing to the NMICS problem: it was considered ethically unacceptable with no maternal and neonatal benefit according to the 1999 International Federation of Gynecology and Obstetrics (FIGO) and ACOG recommendations from 2004 [15-17]. From 2004 until 2008, WHO conducted a study on maternal and fetal complications of CS in 24 countries which proved there is a significant increase of the risk

for mother and child associated with CS when compared to vaginal delivery [18].

The premise of bioethical principles represents exactly finding of the pragmatic solutions for numerous clinical problems present between a doctor and a patient, respecting the rights of the patient primarily to health and life, including available healthcare beyond the framework of fulfilling the wishes which are not based on a good clinical practice and can potentially impair health regardless of patients' autonomy, if indeed they are real patients. A patient is a layman who listens to a doctor in addressing his or her health problems. Moreover, it is necessary to distinguish the term healthy pregnant woman/puerpera from the sick pregnant woman/puerpera patient, ie patient (lat. *Patiens, suffering*), who requires medical help of any kind. A healthy pregnant woman does not require medical attention, but rather midwifery care over a normal pregnancy and the expected normal birth, and there are numerous studies that have indicated that midwives are associated with fewer assisted births and fewer peripartum injuries. Therefore, it is unacceptable to create an acute or chronic patient from a healthy pregnant woman, whether created by the client or the doctor who is performing the surgery [1, 6, 11, 13, 15, 19-22].

NMICS has become a public health, epidemiologic, perinatal, pediatric, juristic, and deontological problem worldwide as it burdens the healthcare system and is beyond the reach of good clinical practice with incontrovertible evidence of late-onset chronic disease and maternal obstetric complications associated with a high percentage of CS. Today, the NMICS epidemic is linked to the media and political influence of various associations that emphasize patient autonomy by not evaluating the basic assumptions of preserving health and life in general. It is a fact that there is extremely increased number of births with CS in private hospitals in regard to public hospitals [11]. It is ethically unacceptable to discriminate pregnant women and laboring mothers who have no financial means for elective NMICS: they have no ability to pay for CS in private hospitals or to have out-of-standard care, so they are ethically discriminated. However, they are spared of the surgery and its possible complications, in short and long term, as well as their newborns. Children born with ECS and NMICS have a disallowed right to health that is compromised by medical treatment and not guaranteed good health, so they might be primarily bioethical and medically discriminated [3, 6, 8, 11, 13].

3. Discussion

The profession of medicine is defined by law and numerous deontological regulations, it is based on doing the good for the benefit of the healthy and the sick people, and in relation to the historically defined, always actual Hippocratic clause "*Primum et super omnium: nihil nocere*". Nowadays, it is possible to witness heresy of the 21st century modern medicine.

Therefore, unnecessary surgery as iatrogenic injury vi-

olates the rules of good clinical practice and thus becomes forensically and deontologically consequent. CS has become the most commonly performed obstetric surgery, thus surpassing all known obstetric surgery so far, including an episiotomy and assisted vaginal delivery whose skills gradually disappear from some delivery rooms and are not justified in replacing them with performing CS [1, 2, 6, 11]. CS is not an anthropologically defined category, it is not a biological mode of birth or natural childbirth, nor is it an aesthetic procedure or a surgery without short-term and long-term risk (risk-free procedures). ECS prevents primordial prevention of chronic cardiovascular, gastrointestinal, respiratory, immunological and endocrinological morbidity, which is outside the postulates of preventive medicine. ECS, especially NMICS potentially deprives a child of the right to health, that is, by peripartal programming a chronic patient is created in 20-30% of cases.

NMICS is not a procedure that respects deontological, scientific and professional principles. It is like an unacceptable surgery outside the scope of medical ethics. The financial, social, political and cultural components must not outweigh good clinical practice and the moral principles of medicine. The interpersonal relationship between the doctor and the pregnant woman/laboring mother is a basic prerequisite for resolving bioethical dilemmas, and thus preventing the potential criminalization of an intervention such as CS that should not be classified under other rights, such as the right to abortion. Although there are works supporting the reasons for tocophobia and NMICS dating twenty years ago, in the studies they conducted they find no objective reason other than personal, psychosomatic factors and emotional and social reasons [14, 16]. Recent work has also shown that women who gave birth by CS or in relation to vaginal delivery had more severe symptoms of somatization, obsessive compulsive disorder, anxiety, especially depression [19–22]. Clientelism in high-risk clinical obstetric medicine is not a professional and deontologically correct category: a physician should not be a provider on request of healthy pregnant women with the potential to have a medically incorrect procedure and complications associated with it and to put a healthy pregnant/maternity and child status in the patient's status.

Medical and legal experts of organized forensics in obstetrics and medical ethics emphasize exaggerated pluralism and liberalism in decisions to end NMICS pregnancies that, in the event of potential complications and adverse outcomes (maternal or child death, permanent disability), have significant legislative and public repercussions, regardless of informed consent coverage, such as the recently reported case of maternal death from intracranial hemorrhage as a complication of spinal anesthesia in ECS indicated due to tocophobia [15]. Patient autonomy implies that the provision of a health service that has no justification in the patient's valid consent has the character of injury to the patient's body and personality (physical and mental integrity), which is interpreted, in civil

law, as a violation of personality rights and non-pecuniary damage, while medical and legal authorities interpret that the injury to the body is itself an indication of unlawfulness, including medical treatment performed on the body of a patient [9, 23–25].

Therefore, a logical sequence of a good antenatal preparation for pregnant women and mutual trust is the key to solving problems, including obstetricians, midwives, psychologists, and psychiatrists in the cases of possible tocophobia. It remains for us that the method of enlightened absolutism should introduce reeducations of extra-hospital and hospital obstetricians in reducing the epidemic of unnecessary CS before the tendency to grow into a pandemic scale of the ECS clinical problem from obstetric and deontological views beyond the scope of pro-clientism and pro-populist aggression, which is recommended by non-medical interventions in the prevention of ECS [24–26].

There is no scientific evidence that the fetal and female somatograms have been changed for the last twenty years, especially in pelvimetry, and which will require a change in obstetric practice that has occurred in many countries. It is unclear how conscious populism, which holds firmly in the position of keeping the uterus as an organ, opposing hippocratism as an interpreter of the uterus as a cause of hysteria, on the other hand, for fear of childbirth, precisely supports laparohysterotomy as a significantly invasive procedure in general or regional anesthesia. Moreover, obstetrics shows a transformation of gynecologists and obstetricians who recently performed *a priori* hysterectomy due to obstetric hemorrhage, to gynecologist and obstetricians, undergoing all professional guidelines, who nowadays perform all conservative preservation procedures for uterine preservation. The above mentioned may be a revitalization of neo-hippocratism.

Author contributions

DH contributed to the collection of data and writing the manuscript.

AČ, MP, DD and AC contributed to analysis of the data and writing the manuscript.

All authors approved the final version of the manuscript.

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Conflict of interest

The authors have no conflicts of interest.

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