MODE OF DELIVERY BASED ON PATIENT PREFERENCE 3.0

Background

Deciding when and how to incorporate patient preference regarding mode of delivery is challenging for both obstetric providers and policymakers. Although patient-choice advocates have called for more patient-responsive guidelines, concerns also have been raised, especially in the context of discussions on maternal request, about the dangers of unfettered patient-preference-driven clinical decisions.

The current approach is that more explicit incorporation of patient preference is called for in cases of prior caesarean section, twin delivery and breech presentation but that expanding this same approach to caesarean delivery purely on maternal request is more complicated and would therefore require more evidence- based data before definite recommendations can be presented (Little *et al.*, 2009).

Taking the above into consideration the following guidelines should be followed:

1. Do not offer elective caesarean section during discussions related to birthing plans for patients where no medical indication for a caesarean section exists
2. If a patient requests an elective caesarean in the absence of any clinical indication, the clinician should find out the reasons for the request and address the patient's concerns about labour and vaginal birth, as well as the availability, efficacy and safety of intrapartum pain management. The risks and benefits of planned vaginal and caesarean birth should be discussed over a series of visits, and should include conclusions from the best available evidence that a planned caesarean section is associated with:
    a. minimizing the risk of surgical complications associated with unplanned or emergency caesarean section, but also with
    b. increased risks of short-term neonatal respiratory problems,
    c. longer maternal hospital stay and recovery,
    d. an increased risk of abnormal placentation and need for gravid hysterectomy in future pregnancies, and
    e. increased risk of uterine rupture in future pregnancies if a trial of labour is attempted.
3. The following guidelines should be applied (ACOG Committee Opinion N0 761, 2019, reaffirmed 2020):
    a. It should not be performed before 39 completed weeks in the absence of other indications for early delivery

b. The woman should be informed that in the absence of maternal or fetal indications for caesarean delivery, a plan for vaginal delivery is safe and appropriate, and is recommended.
c. The reasons behind the patient's request need to be explored and risks and benefits discussed in detail. Given the high repeat caesarean delivery rate, patients should be specifically informed that the risks of placenta previa, placenta accreta spectrum, and gravid hysterectomy increase with each subsequent caesarean delivery.
d. If a patient's main motivation to elect a cesarean delivery is a fear of pain in childbirth, obstetrician–gynecologists and other obstetric care providers should discuss and offer the patient analgesia for labor, as well as prenatal childbirth education and emotional support in labor.

4. For patients with twin pregnancies, breech presentations or prior caesarean section, the option of vaginal delivery or caesarean section can be discussed, as long as the relevant risks of these two birthing options are discussed in detail to allow the patient to make an informed decision

References

1. Little, M. O. *et al.* (2009) 'Mode of delivery: Toward responsible inclusion of patient preferences', *Obstetrics and Gynecology*, 113(1), p. 230. doi: 10.1097/AOG.0b013e318193be74.
2. American College of Obstetricians and Gynaecologists 2019(reaffirmed 2020) Caesarean Delivery on Maternal Request. Committee Opinion No.761.

Authorship

These guidelines were drafted by a clinical team from Mediclinic and were reviewed by a panel of experts from SASOG and the BetterObs clinical team in 2020 and revised by the scientific Committee of BetterObs in 2023. All attempts were made to ensure that the guidance provided is clinically safe, locally relevant and in line with current global and South African best practise. Succinctness was considered more important than comprehensiveness.

All guidelines must be used in conjunction with clinical evaluation and judgement; care must be individualised when appropriate. The writing team, reviewers and SASOG do not accept accountability for any untoward clinical, financial or other outcome related to the use of these documents. Comments are welcome and will be used at the time of next review.

Released on date: 2023 09 15

Disclaimer: This document has been developed by interdisciplinary healthcare teams utilising the best available evidence and resources believed to be accurate and current at the time of release. They are intended to provide general advice and guidance on which to base clinical decisions. SASOG takes no responsibility for matters arising from changed circumstances or information that may have become available after issued. They must not be solely relied on or used as a substitute for assessing the individual needs of each patient.