Reviewer’s report

**Title:** Cesarean delivery on maternal request: can the ethical problem be solved by the principalist approach?

**Version:** 2  **Date:** 29 October 2007

**Reviewer:** Carson Strong

**Reviewer's report:**

**General**

This is a well-researched article with a very helpful list of references that includes excellent reviews of empirical studies relevant to the issue.

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**Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)**

I believe that there are several areas of needed improvement that I would like to see addressed before I would consider the article to be publishable. These are as follows:

1. In the final paragraph (p. 12), the authors seem to be saying that although principlism has been criticized for containing within itself no basis for assigning priorities to conflicting principles, it does nevertheless provide a resolution of the issue of CDMR. First, it is not clear that this is actually what they are saying. There is a need to state this more clearly so that the reader will not be left wondering what their conclusion is. Secondly, if this is indeed what they are saying, then I do not believe that they have satisfactorily argued for this conclusion.

2. The very last sentence (p. 12) states, "Taking into account the model of shared decision making proposed by Whitney has allowed restricting the scope of application of the general principle of autonomy, so that a conclusion could be reached both at the level of the individual patient and of health policy setting." This is the first time that the authors have referred to "restricting the scope of application of the general principle of autonomy", and the earlier parts of the paper do not make it clear in what way that has been done or why it is justifiable to "restrict the scope of autonomy". Also, what is the "health policy" conclusion to which they refer? The fact that these things are not stated clearly leaves me wondering what are the main points the authors are trying to make.

3. On p. 11, the authors state, "...the obstetrician or anesthesiologist feeling that compliance with CDMR is at odds with appropriate clinical practice retains the right to refer the patient to a different doctor, provided that her care is not adversely affected." What if the available physicians are in agreement that CDMR is outside the standard of care and referral is therefore not feasible? In...
those circumstances, may the obstetrician refuse to perform the surgery? This goes to the issue of the integrity of the physician who is being asked to do something he/she considers to be outside the standard of care. And why is there no discussion in the paper concerning the importance of having these discussions in advance of term so that the patient may have an opportunity to obtain prenatal care from an obstetrician who accepts her opinion about CDMR? It seems to me that these are central issues that need to be addressed.

4. On p. 11 the authors state, "The degree of decisional latitude recognized to the patient should be directly related to the level of professional uncertainty, and is maximised when the choice hinges essentially on patient personal values and preferences." This statement and the subsequent discussion seem to imply that, because there is uncertainty concerning the risks and benefits of CDMR vs. trial of labor, the woman's wishes should be allowed to prevail. If this is what they mean, they should state it explicitly. Perhaps this is not what the authors mean, but if so, they should state their view more clearly.

5. When one makes an ethical argument, it is important to consider the main objections that could be given to one's argument and try to respond to them. I do not see the authors raising, much less responding to, any objections to their view. This is a serious shortcoming. The authors should try to identify the main objections to their view and respond to them.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
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Discretionary Revisions (which the author can choose to ignore)
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6. In regard to comment 5 above, there are at least two objections that the authors might consider. I am not convinced that these objections are entirely persuasive, but they seem to be the sorts of objections that should be considered at this stage of the debate. I suspect that these are the types of considerations many obstetricians have in mind when they think about this issue. One is based on the fact that we know the short-term balance of risks over benefits favors "vaginal delivery" over "planned cesarean section". Whether there is a significant risk of injury to the pelvic floor resulting from vaginal delivery requires long-term studies that have not been accomplished. Admittedly, data concerning "planned vaginal delivery" would be more to the point than data concerning "vaginal delivery", and data concerning "CDMR" would be more to the point than data concerning "planned cesarean section". However, we do not have good data concerning planned vaginal delivery vs. CDMR. So, it can be claimed that we should use the best data that we do have, which is data comparing planned cesarean with vaginal delivery. It might be asked, why should the known short-term risks of cesarean be trumped by the possibility that there might be long-term risks from vaginal delivery? These are the sorts of considerations that would support those who would prefer to refuse the woman's request because of
the higher short-term risks of cesarean compared to vaginal delivery. How would the authors respond to this?

7. A second objection that could be given is based on an understanding of what it takes to justify altering the standard of care. Before the debates over CDMR, it was clear that the standard of care was to recommend and carry out a trial of labor in the absence of indications for cesarean section. This standard of care is based on a substantial body of evidence concerning the short-term balance of risks and benefits of planned cesarean vs. vaginal delivery. The fact that there is such evidence gives at least some support to that standard of care and suggests that the burden of proof for altering the standard of care rests on those who would alter it. On this view, the standard of care should remain as it is until there is sufficient evidence to support changing it. How would the authors respond to this objection?

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.