INDUCTION OF LABOR
AND CESAREAN
SECTIONS

AN ETHICAL ISSUE

By: Kathryn Herr, Maria Burkett,
Sofia Perez-Espinosa, Hannah Kertes
OBJECTIVES

• Describe a c-section, its' indications, and classifications
• Describe an induction
• Identify the ethical issues in the decision-making process of diagnosing a failed induction and proceeding with a c-section
• Understand the relevance to the nursing profession
WHAT IS A C-SECTION?

• A surgical procedure where an incision is made through the abdominal wall and uterus to deliver a fetus.
• One in three neonates in the U.S. are delivered via c-section.
• Studies suggest that many are elective for convenience.
• (Durham & Chapman, 2019)

WHAT IS AN INDUCTION?

Majority of women go into labor naturally at full term (between 37-42 weeks).

An induction is the intentional stimulation of uterine contractions to start labor, for vaginal delivery.

- Induction using oxytocin: stimulates contractions and ripens the cervix
- Amniotomy: artificially rupturing membranes, using an amni hook to rupture amniotic sac
- Ripen cervix: softening, thinning, and dilating of the tissue (mechanically with balloon catheter, pharmacologically with Cervidil or misoprostol)
- Stripping of membranes: separating membranes away from the uterus during a vaginal exam by the provider

(Durham & Chapman, 2019)

A study in Pennsylvania found that 35.9% of women who were induced ended up having a c-section, compared to only 18.9% of women in spontaneous labor (Kjerulff et al., 2017).
QUESTION FOR THE AUDIENCE

How long do you feel it is ethically appropriate for a physician to wait after a labor induction, before performing a c-section?
INDUCTIONS (CONTINUED)

• The body takes about 15 hours to enter the active phase of labor after oxytocin administration and/or rupture of membranes (Grobman et al., 2018).

• Criteria for an induction: risks to fetus/mother, gestational age (> 39 weeks), fetal maturity, and must be able to perform an emergency c-section

• Indications: preeclampsia, chorioamnionitis (intraamniotic infection), rupture of membranes, gestational hypertension, post-term pregnancy, fetal compromise/demise

• Contraindications: malpresentation of the fetus, umbilical cord prolapse (cord is compressed, reducing blood supply to fetus), previous c-section with vertical incision, active herpes infection

• (Durham & Chapman, 2019)
## Indications for a C-Section

- Previous c-section or uterine surgery
- Labor arrest or failed induction
- Abnormalities of the placenta (e.g., placenta previa, where the placenta covers the cervix opening)
- Cephalopelvic disproportion (when the pelvic shape does not allow for fetal passage during birth)
- Preexisting health factors (e.g., preeclampsia, cardiac disease)
- Malpresentation of the fetus (breeched)
- Multiple gestation
- Category II or III fetal heart rate pattern (non-reassuring fetal heart rates)
- Maternal request

(Durham & Chapman, 2019)
CESAREAN BIRTH CLASSIFICATIONS

- Scheduled: decided before labor onset
  - e.g., previous c-section, malpresentation, maternal request, maternal/fetal conditions causing risk
- Nonurgent: labor has started, but infant/mother is not in imminent danger
  - e.g., failure to progress (cervix stops dilatating) or failure to descend
- Urgent: rapid delivery needed
  - e.g., malpresentation (diagnosed after labor starts), placenta previa with mild bleeding
- Emergent: immediate delivery needed
  - e.g., prolapsed umbilical cord, or ruptured uterus

(Durham & Chapman, 2019)
ISSUES IN PERFORMING C-SECTIONS

While c-sections are a great option, there are risks associated that can be prevented with a vaginal birth:

- Postpartum infection (incision site or endometritis)
- Hemorrhage
- Deep vein thrombosis (DVT)
- Pulmonary embolism
- Trauma to bladder or bowel
- Side effects to anesthesia medications (respiratory depression, maternal hypotension)
- Maternal death
- Fetal injury
- Low APGAR scores
- Fetal respiratory distress
- (Durham & Chapman, 2019)
THE ETHICAL ISSUE OF DECISION MAKING AND C-SECTIONS

• One study concluded that one-third of physicians from their study were willing to perform a c-section, even though not medically indicated. It was stated that providers significantly influence the delivery mode. There was also an issue with providers respecting the patient's autonomy (Rivo et al., 2018).

• The risk of malpractice: overlooking best practices and appropriate care for the mother and baby

• Decreased autonomy: a patient should have a part in decisions unless it is a medical emergency

• The fetus needs to be fully developed, so a c-section needs to be medically indicated for it to be safe and ethical.
Method

- We created a Google Forms survey containing 6 questions and posted it to a nationwide labor and delivery online group.
- The survey was open for responses for five days.
- There was 475 nurses that responded to the survey.
- The states with the highest responses were Texas, Pennsylvania, and Ohio.
What state do you work in?

- This question was asked to analyze trends in responses between states.
- We received responses from 47 out of 50 states, including two responses from Canada.
- The three states that did not respond:
  - Idaho
  - New Hampshire
  - South Dakota
- Due to privacy and anonymity, the specific facility and location was not asked.
SURVEY QUESTION 2

Approximately how many unscheduled c-sections does your facility have in a week?

• 253 (53.26%) out of 475 participants said that their facility has 0-5 unscheduled c-sections a week
• Wide variety of responses ranging from 1 a month to 150 a week
• Many expressed that they didn’t know, or there were “too many”
• Limitations: it is unknown how big the facility is, or how many deliveries there are in a week. Unscheduled c-sections could include emergency situations, it is not specific to failed inductions.
• Suggestions: it would have been better to ask what percentage of all deliveries are unscheduled c-sections.
SURVEY QUESTION 3

Do you think a healthcare provider allows enough time for an induction to progress before calling a c-section? If no, why?

- 43% out of 475 nurses said yes, providers do wait an appropriate amount of time.
- 35% out of 475 nurses said no, providers do not wait an appropriate amount of time.
- 22% out of 475 nurses says it depends on the different providers at their hospital.

One study indicated that 14.8% of labor induction patients and 13.3% of cesarean section deliveries received pressure from a physician to perform the procedure (Jou et al., 2014).

https://commons.wikimedia.org/wiki/File:Anterior_wall_of_uterus.JPG
How long do your providers wait until they determine an induction has failed and proceed with a c-section?

- "5 pm"
- "2-4 hours"
- This question gave a wide variety of answers, making it hard to categorize and produce percentages, but there was major pattern of nurses stating it varied according to the provider.
- The answers to this question posed an ethical concern. Many providers do not determine a failed induction based on medical indication, but simply on the fact that they do not want to be inconvenienced.
SURVEY
QUESTION 5

In your nursing clinical judgement, when do you feel it is an appropriate amount of time for a health care provider to wait before calling a c-section?

• Majority of the responses expressed that this decision is case dependent and there is no clear-cut answer.

• Limitations: We did not factor into our question the time after the rupture of membranes or fetal and maternal tolerance.

One study suggests that a c-section should not be performed unless an oxytocin infusion has been running for ideally 18-24 hours (Berghella et al., 2020).
How do health care providers handle patient birth plans in regard to making the decision to proceed with a c-section?

- 39.6% out of 475 nurses said yes, they do respect the patient’s birth plan.
- 43.9% out of 475 nurses said no, they do not respect the patient’s birth plan.
- 16.5% out of 475 nurses said it depends on the provider.
- Nurses expressed their frustration with providers because many do not care about the patient’s wishes, and stated there was manipulation at play when the provider wanted the patient to go through with a C-section.
- Many nurses, however, replied that their providers try their best to adhere to the patient’s wishes as long as the mother and baby are tolerating the delivery.
- We found that nurse midwives handle birth plans with a more positive attitude than healthcare providers.
• ANA Code of Ethics:
  • Provision 2: the nurse has a commitment to the patient
  • Provision 3: the nurse advocates and protects the rights, health, and safety of patients

• Nursing practice
  • Nurses must advocate for their patient’s health and medical desires.
  • Nurses must educate patients to know the risks and benefits, so that patients are able to give informed consent to inductions or c-sections.
  • Nurses are expected to uphold the ethical principles (autonomy, nonmaleficence, beneficence, and veracity).

• Evolution
  • Between 1965 and 1987, the c-section rate in the United States rose from 4.5% to 25% of births. Today, almost one in three births are by c-section (Wolf, 2017).
  • Obstetricians avoided cesarean surgery in the nineteenth century because the maternal death rate after a c-section was so high and in order to conserve their good reputation, physicians avoided them.
  • There was a drastic increase in the number of malpractice suits brought against obstetricians for failing to operate if there was an indication of trouble in delivery.
QUESTION FOR THE AUDIENCE

Have you ever felt pressured by a health care professional about a medical decision?
In our study, some of the nurses expressed great disappointment in their providers at their hospitals with the ethical issue of having a c-section after induction when it is not yet medically indicated.

Our own study found:

- 35% of nurses feel that health care providers at their hospital do not allow enough time for a labor induction to progress naturally before making the decision to proceed with a c-section.
- 22% of nurses said it depends on the specific provider at their hospital.
- Many nurses feel that this is unethical because the doctor does not adhere to the patient’s wishes; they only care about fitting the delivery into their desired schedule.

This ethical issue needs to be further researched to discern how it impacts patients, which then can lead towards a solution.
REFERENCES


Photos:


