CESAREAN SECTION ON DEMAND - A DISCUSSED REQUEST OF MOTHERS IN THE LIGHT OF MEDICAL AND LEGAL JUSTIFICATIONS

CISÁRSKY REZ NA ŽIADOSŤ - DISKUTOVANÁ ŽIADOSŤ MATIEK VO SVETLE MEDICÍNSKEHO A PRÁVNEHO ODÔVODNENIA

Erik Dosedla[1], Petra Gašparová[2], Zuzana Ballová[3], Andrea Erdősová[4]

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ABSTRACT

This study investigates the ethical and legal considerations associated with Cesarean Section on Demand (CSD), focusing on the principles of patient autonomy and informed consent within obstetrics. As elective cesarean sections become more prevalent, this research analyzes the consequences of allowing patients to choose their mode of childbirth, contrasting this with medical necessity and potential conflicts arising from healthcare professionals' commitment to do no harm.

ABSTRAKT

Táto štúdia skúma etické a právne úvahy spojené s cisárskym rezom na žiadosť (CSD), so zameraním na princípy autonómie pacienta a informovaného súhlasu v oblasti pôrodníctva. Keďže sa elektívne cisárske rezy stávajú čoraz bežnejšími, tento výskum analyzuje dôsledky umožnenia pacientom vybrať si spôsob pôrodu, kontrastujúc to s medicínskou nutnosťou a potenciálnymi konfliktmi vyplývajúcimi zo záväzku zdravotníckych pracovníkov nerobiť škodu.

I. INTRODUCTION

The shift towards patient-centered care has transformed obstetric practice, spotlighting CSD as a polarizing topic. This shift prompts vital discussions regarding the scope of patient autonomy, the responsibilities of healthcare providers, and the legal parameters that frame informed consent in healthcare settings. This research conducts a qualitative review of pertinent literature, legal statutes, and ethical standards concerning obstetric care, autonomy, and informed consent. It also examines case studies and decisions by the European Court of Human Rights to understand the equilibrium between patient rights and ethical considerations in medicine. The study reveals a nuanced interaction between the rights to informed consent and the ethical imperative of doing good. Although prioritizing patient autonomy is critical, the lack of medical justification for elective cesarean sections poses ethical and professional challenges

[1] doc., MUDr., PhD., MBA, Univerzita Pavla Jozefa Šafárika v Košiciach, Lekárska fakulta, Slovenská republika
Pavol Jozef Šafárik University in Košice, Faculty of Medicine, Slovak Republic.
[2] MUDr., Univerzita Pavla Jozefa Šafárika v Košiciach, Lekárska fakulta,Slovenská republika
Pavol Jozef Šafárik University in Košice, Faculty of Medicine, Slovak Republic.
[3] MUDr. Univerzita Pavla Jozefa Šafárika v Košiciach, Lekárska fakulta,Slovenská republika
Pavol Jozef Šafárik University in Košice, Faculty of Medicine, Slovak Republic.
[4] doc., JUDr., PhD., Paneurópska vysoká škola v Bratislave, Fakulta práva, *Slovenská republika*
Pan-European University in Bratislava, Faculty of Law, Slovak Republic.

for healthcare providers, caught between honoring patient preferences and the principle of avoiding harm.

II. INFORMED CONSENT IN SURGICAL PRACTICE: A PARTNERSHIP APPROACH

1. Informed consent as a patient's right

The paradigm of patient engagement in healthcare has evolved, emphasizing the significance of informed consent as a fundamental right. This shift diminishes the traditional passivity of patients, fostering a shared responsibility between healthcare professionals and patients, where the latter's autonomy in decision-making is paramount. According to § 6 of Act no. 576/2004 Z. z. o zdravotnej starostlivosti v platnom znení (hereinafter referred to as "ZoZS"), healthcare providers are obligated to comprehensively inform patients or their designated representatives about the intent, nature, potential outcomes, and risks associated with medical interventions, including the ramifications of opting out of proposed treatments.[5] This collaborative approach not only respects the patient's autonomy but also reinforces the principle of bodily integrity, allowing individuals to make informed decisions about their health, as supported by both national and international legal frameworks. Everyone has the right to health protection, as guaranteed by Art. 40 of Act no. 460/1992 Coll. The Constitution of the Slovak Republic (hereinafter referred to as the "Constitution").

Informed consent is i. a. in surgical practice considered to be a shared decision that is the result of a surgeon-patient partnership. The doctor provides information about the diagnosis, prognosis and treatment options, risks and benefits, and also gives recommendations for subsequent treatment. The patient expresses his set of wishes, opinions, values and goals according to the interpreted recommendations. And both then agree on what is to be done. This is the result of the erudition of the health professional and the will of the patient whose procedure is involved. This cooperative approach is exemplified in the landmark case of Canterbury v. Spence[6]

2. The Case law in history of the Informed Consent

Particularly in American jurisprudence, there is a paradigmatic case that addresses issues of informed consent mainly in the context of the medical malpractise (tort law).

Schloendorff v. Society of New York Hospitals is a 1914 New York Court of Appeals decision frequently cited as the foundational case establishing a patient's common-law right to bodily autonomy. The patient agreed to undergo either anesthesia for examination of the tumor but she did not agree to its removal. The surgeon determined that the tumor was malignant and removed it. "She brought a lawsuit claiming not that the surgery wasn't indicated, but that she never would have consented to the procedure because of the inherent risks and she didn't give permission."But Judge Benjamin Cardozo's assertion that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" was mere dicta. In affirming a directed verdict for the hospital where the plaintiff's uterus was removed without her consent, Cardozo deemed a nurse's awareness of the patient's objection to surgery insufficient to put the hospital on notice that an independent-contractor surgeon was planning a non-consensual hysterectomy.

Every human being of adult years and sound mind has a fright to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent

[5] See also HUMENÍK, I., KOVÁČ P. et al. *Zákon o zdravotnej starostlivosti. Komentár*. 2nd edition. Bratislava: C. H. Beck, 2023, ISBN 978-80-8232-027-8, pp. 189-265.

[6] Jerry W. CANTERBURY, Appellant, v. William Thornton SPENCE and the Washington HospitalCenter, a body corporate, Appellees. No. 22099. United States Court of Appeals, District of Columbia Circuit. Argued Dec. 18, 1969. Decided May 19, 1972. Rehearing Denied July 20, 1972., available online: https://h2o.law.harvard.edu/cases/250&gt.

commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.

"That case led to the codification across many states of the laws of informed consent, saying that even if the procedure is indicated and done properly and a known risk develops, patients have a right to not subject themselves to those known risks," Kolbert says. "Being subjected to risks that a reasonably prudent person wouldn't subject themselves to becomes a compensable event."[7]

Another case of fundamental importance originated when the Plaintiff accused the Defendant of negligence in performing a laminectomy and failing to inform him of the associated risks. Despite knowing the 1% risk of paralysis from laminectomies, the physician chose not to disclose this to the patient, fearing it might deter him from undergoing beneficial treatment.[8] Post-surgery, the patient suffered paralysis after falling from his hospital bed, though it was unclear whether the fall or the surgery was to blame. The court ruled that physicians must disclose all relevant information about proposed treatments, establishing the principle that the patient's will is paramount, encapsulated by the maxim "Non salus, sed voluntas aegroti suprema lex."[9]

3. Autonomy of the patient's decision-making processes

The concept of a patient's decision-making autonomy is a multifaceted one, encapsulating an individual's capacity to govern their own life, act based on personal values and beliefs, and make independent choices. This principle forms a cornerstone in medical ethics, highlighting the importance of allowing patients the freedom and right to shape their own health-related decisions and life paths. In the healthcare context, patient autonomy is manifested through the process of shared decision-making, where healthcare professionals and patients collaborate to identify the most suitable treatment option that aligns with the patient's individual needs, values, and objectives.

It is crucial for healthcare providers to respect patient autonomy by furnishing all pertinent information regarding available treatment options, including their risks and benefits.[10]

This enables patients to make informed and considered decisions that resonate with their own values and life goals. Additionally, healthcare professionals should support patients in the decision-making process, providing the necessary guidance and assistance when patients face uncertainties or challenges in making choices.

In practice, this means healthcare providers should actively listen to patients, inquire about their preferences, concerns, and expectations, while also elucidating the potential consequences of various treatment pathways. The aim is to create an environment where patients feel adequately informed and supported, enabling them to make decisions that best suit their individual needs and lifestyle. This ensures that patient autonomy is not only acknowledged but also actively fostered within the healthcare setting.[11]

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7 FADEN, RUTH, BEACHAMP, TOM L. (1986). *A history and theory of informed consent*. New York: Oxford University Press. P. 123. ISBN 0195036867.

8 MURRAY B. Informed consent: what must a physician disclose to a patient? Virtual Mentor. 2012 Jul 1;14(7):563-6. doi: 10.1001/virtualmentor.2012.14.7.hlaw1-1207.

9 VARKEY B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30(1):17-28. doi: 10.1159/000509119.

10 Council of Europe. Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164). 1997. [online]. https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=164 Accessed 11 Mar 2024.

11 UBEL PA, SCHERR KA, FAGERLIN A. Autonomy: What's Shared Decision Making Have to Do With It? Am J Bioeth. 2018 Feb;18(2):W11-W12. doi: 10.1080/15265161.2017.1409844.

Since the publication of "The Principles of Biomedical Ethics" in 1977 by Beauchamp and Childress, and through its various editions, the principle of autonomy has been recognized as a cornerstone of medical ethics, alongside beneficence, non-maleficence, and justice. The prevailing view in the literature adopts a "liberal individualistic concept of autonomy," suggesting that patients should ideally possess complete decision-making authority, acting intentionally, with understanding, and free from both external and internal controlling influences.[12]

However, an excessively individualistic interpretation of patient autonomy is not universally endorsed within bioethics. Such an extreme stance is inherently problematic, as it could undermine the medical profession's autonomy and prioritize patient choice based on potentially flawed assumptions over the expertise of healthcare professionals. This could lead to a practice of medicine that is devoid of underlying values. Bioethics literature supports the idea that medical ethics must be contextualized within relationships and communities. There is a belief that if patient autonomy were the sole criterion for decision-making, it would reduce the patient-doctor relationship to a mere client-technician interaction.[13]

In maternity care, women are often faced with numerous decisions, making person-centered care and informed consent crucial. These principles contribute to a greater sense of autonomy and control for pregnant women during labor and birth, and are associated with more positive outcomes, both psychologically and physically. Yet, reports indicate that informed consent for procedures during labor and birth is frequently lacking, even in situations where women's explicit refusals are ignored. Such practices not only breach ethical and legal standards but can also negatively impact the birthing process, women's experiences of labor and birth, and ultimately, the quality and safety of care.[14]

III. THE LEGAL CONTEXT OF THE PATIENT'S RIGHT TO INFORMED CONSENT/INFORMED CHOICE.

The legal context of a patient's right to informed consent or informed choice is crucial in the medical field, ensuring that patients are fully aware of and agree to any medical procedures or treatments they undergo. The concept is deeply rooted in ethical principles and is enshrined in various laws and conventions to safeguard patients' autonomy and rights.

According to the definition provided in § 6 par. 4 of ZoZS informed consent is a clear agreement to receive health care, which must be preceded by proper instruction as per the stipulations of the Act. This definition emphasizes the necessity of providing patients with all relevant information about the proposed health care, allowing them to make an educated decision. The Act acknowledges the possibility of patients refusing to be informed; however, consent in such cases is still considered valid unless the law dictates otherwise.[15]

What cannot be omitted, is the so-called the emergency health care, which is defined as health care that is provided to a person in the event of a sudden change in health status, which immediately threatens his life or one of his basic vital functions, or there are other circumstances in which the absence of timely intervention may endanger life or the patient's health. The provision of the § 2 par. 3 ZoZS then continues with specific circumstances, among which is mentioned i. a. delivery of the child, examination, diagnosis, treatment, etc. Therefore, part of

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[12] Ibid.

[13] STIRRAT GM, R GILL. Autonomy in medical ethics after O'Neill. J Med Ethics. 2005 Mar;31(3):127-30. doi: 10.1136/jme.2004.008292.

[14] van der PIJL MSG, ESSINK MK, van der LINDEN T et al. Consent and refusal of procedures during labour and birth: a survey among 11 418 women in the Netherlands. BMJ Qual Saf. 2023 May 22:bmjqs-2022-015538. doi: 10.1136/bmjqs-2022-015538.

[15] see also HUMENÍK, I. - KOVÁČ, P. et al. 2023. *Zákon o zdravotnej starostlivosti. Komentár.* 2nd edition. Bratislava: C. H. Beck, 2003, ISBN 978-80-8232-027-8.

the urgent health care, which the law mentions in this provision, is an operative delivery. A part of the obligations of the health care system is the set of the health care actions for the newborn. The consequence of this is a legal situation where there is no need to obtain informed consent, because in the event of a premature birth and the life of the mother or fetus is at risk, we presume the informed consent according to § 6 par. 9 letter a) ZoZS. A prerequisite for this procedure is always the fact that informed consent cannot be obtained because of the lack of time and concurrently can be assumed.[16]

Further emphasizing the importance of informed consent, Article 5 of the Convention on Biomedicine (the Oviedo Convention) states that any health intervention can only proceed with the informed consent of the individual concerned. This entails that the individual must be adequately informed about the purpose, nature, consequences, and risks associated with the intervention.[17] This provision highlights the patient's autonomy, allowing them to revoke consent at any point.[18] The legal requirements for informed consent involve ensuring that patients are fully educated about their medical treatment options, including the benefits, risks, and alternatives. This process empowers patients, allowing them to make decisions that align with their values and preferences. The legal framework aims to protect patients, ensuring that medical interventions are conducted with respect for their autonomy and informed agreement.

In summary, the legal context surrounding informed consent involves clear legislative and ethical guidelines that mandate the provision of comprehensive information to patients before any health-related intervention. This ensures that patients' autonomy is respected and that they are active participants in decisions regarding their health care.[19]

The Article 5 of Oviedo Convention therefore addresses the general requirement for informed consent in medical interventions, noting that explicit informed consent is not always necessary for routine procedures as long as the patient is adequately informed. The nature of the intervention dictates the form of consent required, highlighting that implicit consent might suffice in certain contexts, provided that the patient is well-informed about the intervention.[20]

There is no dispute that the Oviedo Convention is an international treaty, which even has application priority over legal regulation.[21] From the point of view of legal force, it is then necessary to distinguish whether the given rights are derived from the hard law or from the soft law, the source of which can be various recommendations, guidelines, opinions or other forms of sources of law, which can, on the other hand, have a strong authoritative meaning and act as determining criteria for the consensual procedure of gynecologists and obstetricians.[22]

At this point we cannot omit, that there works the largest global federation for Gynecology and Obstetrics- so called FIGO, whose work among others serves as a respected guideline for making a Vaginal and Casearean delivery. According to this document, professionally responsible decision making with patients is based primarily on the ethical principles of

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16 Ibid.: p. 28 and related.

17 ERDOSOVÁ, A. -KOVÁČ, P. *Právo na informácie o zdravotnom stave vo vybraných otázkach aplikačnej praxe*. In: Bulletin slovenskej advokácie. ISSN 1335-1079.- Vol. 26, No.. 10 (2020), p. 14.

18 BOHDAN J. Informace o zdravotním stavu, poučení a souhlas pacienta. Zdravotnictví a právo. 2003;9: 8–18.

19 The Convention on the Protection of Human Rights and Human Dignity in Connection with the Application of Biology and Medicine (Convention on Human Rights and Biomedicine or also the so-called "Oviedo Convention").

20 Biomedicine and human rights, The Oviedo Convention and its additional protocols. Council of Europe Publishing. 2009; 26-27.

21 Article 7 of the Constitution of the Slovak Republic: International treaties on human rights and fundamental freedoms, International treaties for the execution of which no law is necessary, and international treaties that directly establish the rights or obligations of natural persons or legal entities and which have been ratified and promulgated in the manner established by law take precedence over laws.

22 Examples of soft law include recommendations, guidelines, codes of conduct, non-binding resolutions, and standards. In contrast, hard law refers to legally binding instruments, which in international law typically take the form of treaties.

beneficence and respect for autonomy. The physician has the beneficence-based obligation to identify and present the medically reasonable alternatives for the clinical management of the patient's condition. The obstetrician-gynecologist should then explain the evidence base for the recommendation that was made and repeat the recommendation. The patient should be asked to reconsider, especially if her stated reasons support the obstetrician-gynecologist's recommendation. If, after these efforts to inform the patient's request have been completed and she is therefore able to make an informed and voluntary request, it is ethically permissible to implement her request.[23]

European Charter of Patients' Rights (2002): This charter, adopted in Brussels, outlines the fundamental rights of patients within healthcare settings. It emphasizes the patient's right to access all pertinent information to actively participate in decisions regarding their health. This includes details about proposed treatments or surgeries, associated risks, side effects, alternative methods, and the importance of providing this information in a timely manner (at least 24 hours in advance) to facilitate patient involvement in selecting therapeutic options.[24]

Charter of Patient Rights (Slovak Republic, 2001): Adopted by the Slovak government, this charter reiterates the rights of patients to be fully informed about their treatment options, including risks and alternatives, to enable active participation in their healthcare decisions. It underscores the necessity of integrating patient values and preferences into the decision-making process to ensure optimal outcomes.[25]

These documents collectively underscore a shift towards patient-centered care, where informed consent goes beyond a mere formality to becoming a fundamental aspect of ethical medical practice. They advocate for the empowerment of patients through information and education, ensuring that individuals are not passive recipients of healthcare but active partners in their treatment journey, capable of making informed choices that reflect their preferences and values.[26]

IV. THE PATIENT'S WISH AS AN IMMANENT PART OF THE BIRTH PLAN

1. Importance of Informed Consent and Prior Instruction

Informed consent is not only vital for ensuring a cooperating patient and respect for her autonomous will, but also serves as a protective measure for health professionals in legal disputes. They must demonstrate that the patient was properly instructed, especially regarding risky procedures or significant facts that would influence the patient's consent.

2. Legal Precedents in the Czech and Slovak Republics

- ***Supreme Court of the Czech Republic (Decision No. 25 Cdo 1381/2013):*** The medical facility's responsibility arises if the patient proves that, had they been fully informed, they would have likely made a different decision regarding undergoing a procedure.
- ***Supreme Court of the Slovak Republic (Resolution No. 6Cdo/914/2015)***: Consent is considered invalid, and the action of the medical facility illegal, if the patient was not sufficiently informed about essential facts crucial for their decision to undergo a procedure.

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23 FIGO (International Federation of Gynecology and Obstetrics). the global voice for women's *FIGO Ethics and Professionalism Guideline: Decision Making about Vaginal and Caesarean Delivery* . published June 29, 020, available on the official webside: healthhttps://www.figo.org/decision-making-about-vaginal-and-caesarean-delivery.

24 ACTIVE CITIZENSHIP NETWORK, Združenie za aktívne presadzovanie občianskych práv EURÓPSKA CHARTA PRÁV PACIENTOV. Presented on November 15, 2002 in Brusel. [online]. http://www.aopp.sk/storage/app/media/stanovy/Europska_charta_prav_pacientov.pdf Accessed 28 Feb 2024.

25 Práva pacientov v Charte práv pacienta v SR. 2017. [online]. https://www.slovensko.sk/sk/zivotne-situacie/zivotna-situacia/_prava-pacientov/#pravapacientovzakotvene Accessed 28 Feb 2024.

26 KRIST AH, TONG ST, AYCOCK RA et al. Engaging Patients in Decision-Making and Behavior Change to Promote Prevention. Stud Health Technol Inform. 2017:240:284-302.

The consent is inadequate if the patient demonstrates that they would have decided differently had they known these facts.

- ***District Court of Prešov, (file no. 25 C/41/2013, judgment of September 28, 2020):*** In addition to expertise, healthcare workers must also comply with the method of provision, which is not only a condition of expertise, but also a condition of respect for the personal rights of the patient. For this reason, the action of the defendant was evaluated as a *non lege artis procedure.* (Due instruction of the patient in obtaining informed consent is an inseparable prerequisite of the lege artis procedure)
- ***Regional Court in Hradec Králové, (file no. 26 Co 317/2017-133, judgment of December 12, 2017):*** The Court of Appeal came to the conclusion of the *lege artis* procedure, because the plaintiff was informed about the risks of the operation and even though he was not informed about increased risk as a result of previous surgical interventions in the same place, there is no causal connection between the breach of duty and the occurrence of damage, because the plaintiff himself stated that he would undergo the procedure despite all the instructions. (Due instruction of the patient on the increased risks of surgery)

Application to Childbirth and Postpartum Care: Comprehensive information and consultation regarding the birth wish, including options like caesarean section on demand, are essential between the health professional and the patient. This ensures the patient is fully aware and consenting to the procedures and care they will receive.

Shift in Patient's Role in Decision-Making: Historically, women had limited decision-making options during childbirth. This is changing with the emphasis on informed consent and greater integration of the patient in the decision-making process, aligning with the concept of "patient medicine."

These points emphasize the critical nature of informed consent and patient involvement in decision-making, particularly in the sensitive and significant area of childbirth and postpartum care.[27]

3. Cesarean section in obstetric practice

In recent years, we have increasingly encountered, as it were, a new "trend" in births - caesarean section (CS). This surgical procedure involves delivering a newborn through an incision in the mother's abdomen and is usually performed when vaginal delivery would put the mother or child at risk.

CS is associate with complication including bleeding, postoperative infectious complications, embolization, and anesthesia complications; however, with a well-prepared elective cesarean section, the risks associated with birth are very similar to those of a vaginal birth.[28] Additionally, CS is associated with a higher risk of abnormally invasive placenta and ectopic pregnancy in the cesarean scar in subsequent pregnancies.[29]

The rising rate of CS in obstetric practice can be attributed to several factors, both medical and non-medical:

Medical Indications: There are legitimate medical reasons for opting for a CS, such as complications during pregnancy, the health of the mother or the fetus, or previous surgeries that may affect vaginal birth.

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[27] LIPPKE S, WIENERT J, KELLER FM et al. Communication and patient safety in gynecology and obstetrics - study protocol of an intervention study. BMC Health Serv Res. 2019 Nov 28;19(1):908. doi: 10.1186/s12913-019-4579-y.

[28] GREGORY KD, JACKSON S, KORST L et al. Cesarean versus vaginal delivery: whose risks? Whose benefits? Am J Perinatol. 2012 Jan; 29(1): 7-18. doi: 10.1055/s-0031-1285829; Latham SR, Norwitz ER. Ethics and "cesarean delivery on maternal demand". Semin Perinatol. 2009 Dec; 33(6): 405-9. doi: 10.1053/j.semperi.2009.07.009.

[29] KLAR M, MICHELS KB. Cesarean section and placental disorders in subsequent pregnancies--a meta-analysis. J Perinat Med. 2014 Sep;42(5):571-83. doi: 10.1515/jpm-2013-0199.; Cheng XL, Cao XY, Wang XQ et al. Diagnosing early scar pregnancy in the lower uterine segment after cesarean section by intracavitary ultrasound. World J Clin Cases. 2022 Jan 14;10(2):547-553. doi: 10.12998/wjcc.v10.i2.547.

Maternal Request without Direct Medical Indication: Some women request CS due to fear of childbirth, anxiety, stress, negative past experiences, or even for cultural reasons. These personal reasons contribute to the rising trend.[30]

Increasing Maternal Age: Older mothers often face more complications during pregnancy, leading to a higher likelihood of opting for CS.

Advances in Medical Technology: Improvements in anesthesia and surgical techniques have made CS a safer option, encouraging both doctors and patients to consider it more readily.

Fear of Medical Malpractice: In some cases, healthcare providers may prefer CS as it can be perceived as reducing the risk of complications compared to vaginal delivery, which could lead to lawsuits in case of adverse outcomes.

Influence of Assisted Reproduction: Women who conceive through assisted reproduction methods might be more inclined towards CS due to the perceived risks associated with vaginal birth after such treatments.

Economic Factors: In some cases, economic considerations can influence the decision for a CS, as it is often a more expensive procedure than vaginal birth.

Payment of Health Care by the Patient: According to § 8 of Act no. 577/ 2004 Coll. on the basis of public health insurance, health care that is not indicated for health reasons is not covered. Here we come across a rather complicated area, where on the one hand there is a medically obvious indication on the side of the fetus and then a medical indication on the side of the pregnant woman. The sphere of distinguishing medical indication and elective caesarean section without medical indication is sometimes rather difficult in practice. In the absence of a medical indication, opinions prevail that the caesarean section as such should be paid for by the patient herself and not from public health insurance sources, similar to the case of aesthetic surgery. Cesarean sections at the request of patients are, however, more complicated due to the fact that, in the case of her ellective CS, the issue of benefits is not solely the case for mother, but the fetus as well.

Lack of Uniform Guidelines: The World Health Organization (WHO) initially suggested that a 10% CS rate was ideal, but this rate has been deemed too low and unattainable in most countries. Current medical evidence does not confirm that CS is explicitly less beneficial or more difficult for postpartum adaptation for the mother and child.[31] C-sections should only be performed when medically necessary. However, every effort should be made to provide caesarean sections to those women who absolutely need it, rather than trying to achieve a specific frequency (10-15%) according to the World Health Organization.[32]

Uneven Global Availability: The availability of CS varies significantly across the world. In developed countries, emergency CS is almost commonplace, while in many developing countries, access is limited even when necessary to save lives.

Patient Autonomy vs. Medical Ethics: The increase in CS on demand reflects a conflict between women's right to self-determination and the medical profession's duty to prioritize patient beneficence. Doctors must balance respecting a patient's choice with the medical preference for natural childbirth when clinically appropriate.

Informed Consent: Any acceptance of a woman's request for CS requires specific informed consent, which includes information about possible complications and the absence of a strict clinical indication for the procedure.

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[30] TADEVOSYAN M, GHAZARYAN A, HARUTYUNYAN A et al. Factors contributing to rapidly increasing rates of cesarean section in Armenia: a partially mixed concurrent quantitative-qualitative equal status study. BMC Pregnancy Childbirth. 2019 Jan 3;19(1):2. doi: 10.1186/s12884-018-2158-6.

[31] WHO Statement on Caesarean Section Rates, Q&A. 2021. [online]. https://www.who.int/news-room/questions-and-answers/item/who-statement-on-caesarean-section-rates-frequently-asked-questions Accessed 11 Mar 2024.

[32] DOSEDLA E, BALLOVÁ Z, TURCSÁNYIOVÁ Z egt al. Je nutná zmena prístupu k vedeniu pôrodu na základe zmeny reprodukčného správania tehotných? Actual Gyn. 2022;14:6-11.

Increasing rate of cesarean sections is multifaceted, influenced by both medical and non-medical factors, ranging from individual preferences and fears to advancements in medical technology and changing societal norms.[33]

It's evident that the approach to maternal requests for cesarean sections without clinical indications involves a balance between respecting patient autonomy and ensuring informed decision-making. The key points regarding the handling of elective cesarean requests can be summarized as follows:

Informed Decision Making: Medical professionals, including doctors and midwives, aim to provide women with comprehensive information, not to dissuade them from choosing a C-section but to ensure they make an informed decision. This includes discussing the risks and benefits of both C-sections and vaginal births, aiming for a positive birth experience.[34]

Ethical Considerations: The American Society of Obstetricians and Gynecologists considers a C-section without clinical indications to be ethically justifiable. However, there's a recommendation for a second opinion, as suggested by the National Institute for Clinical Excellence (NICE) in the UK, to confirm the woman's request.[35]

Legal Framework and Guidelines: Legal arrangements and guidelines, such as those from NICE, legitimize cesarean sections on request. These guidelines emphasize the importance of supporting the patient's will and their ability to make an informed decision. They recommend discussing the reasons for the C-section request, including addressing any childbirth-related anxieties by referring the patient to a perinatal mental health expert if necessary.[36]

Patient Autonomy vs. Medical Advice: If a patient insists on a C-section after counseling and being offered specialist support, hospitals are advised to ensure the procedure can be performed upon request. However, individual obstetricians may refuse to perform the surgery if it goes against their professional judgment. In such cases, patients should be referred to another obstetrician willing to perform the operation.

Respecting Autonomy: In reality we often face the automatic denial when talking about elective caesarean in the absence of any clinical indications. We suggest that the reasons for restricting elective CS in the absence of any clinical indications in literature are not sufficient to counter the presumption in favor of respecting these autonomous decisions.[37]

We highlight the importance of balancing respect for the patient's autonomy and self-determination with the physician's expertise and responsibility to make decisions based on medical science and guidelines. It emphasizes that while patient autonomy is crucial, the gynecologist must maintain their independence and authority in decision-making.[38] This stance ensures that the doctor does not merely acquiesce to patient demands that may not align with medical best practices. Instead, the gynecologist should provide informed advice based on their experience and the current state of medical knowledge, aiming to protect the health of both the mother and the newborn. This approach fosters a partnership between the patient and the physician, wherein patient autonomy is respected, but medical expertise guides the final decisions.[39]

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[33] ACOG. American College of Obstetricians and Gynecologists. Cesarean delivery on maternal request. Committee Opinion No. 761. Obstet Gynecol 2019; 133: e73–7. doi: 10.1097/AOG.0000000000003006.

[34] SORRENTINO F, GRECO F, PALIERI T et al. Caesarean Section on Maternal Request-Ethical and Juridic Issues: A Narrative Review. Medicina (Kaunas). 2022 Sep 10; 58(9):1 255. doi: 10.3390/medicina58091255.

[35] MUULA AS. Ethical and practical consideration of women choosing cesarean section deliveries without "medical indication" in developing countries. Croat Med J. 2007 Feb; 48(1): 94-102.

[36] NICE. National Institute for Health and Clinical Excellence. Caesarean birth [NG192]. [online]. https://www.nice.org.uk/guidance/ng192/resources/caesarean-birth-pdf-66142078788805. Accessed 8 Mar 2024.

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[39] Ibid.

V. BIOETHICAL CONSIDERATIONS ABOUT CAESAREAN SECTION ON DEMAND.

We have accepted that the patient is entitled to aesthetic surgery provided that he provides informed consent. The bioethical considerations discussion surrounding caesarean section on demand, emphasizing that the decision-making process should not solely focus on whether women should be allowed to choose their mode of childbirth. Instead, it suggests that the value of women's autonomy in childbirth decisions should be considered a given. The discussion then shifts towards how guidance, practices, and social conditions can best promote and protect women's involvement in a safe and positive birth process.[40]

Cesarean section on demand is defined as a primary cesarean section performed at the request of the mother to avoid vaginal delivery, without any recognized medical or obstetric indication for the procedure. The document highlights that modern medicine recognizes the patient's right to actively participate in the selection of treatment procedures, including methods of childbirth.[41]

Furthermore, it addresses the risks associated with different modes of delivery. For instance, the risk of postpartum hemorrhage associated with uterine atony, which can increase with vaginal delivery (whether or not labor is induced), leading to complications such as placental retention and emergency caesarean section. The authors of this study refer about the practice-based knowledge and scientific findings that suggest these risks can be mitigated by a planned cesarean section.[42]

Some authors outlines the benefits of a planned cesarean section, including the prevention of risks associated with vaginal delivery, such as pelvic floor integrity, preservation of sexual functions, and avoidance of perinatal infections (e.g., herpes, hepatitis, HIV, human papillomavirus, and group B streptococcus). It suggests that a planned cesarean section between the 39th and 40th week of pregnancy can prevent in utero death and offers several other benefits, thereby highlighting the complex interplay of medical, ethical, and personal considerations in decisions regarding cesarean section on demand.[43]

Recent articles emphasizes the importance of individual responsibility in patient decision-making, particularly in the context of caesarean sections on demand (CSOD). It suggests a paradigm shift towards viewing consent not just as "informed consent" but as "informed choice," highlighting the necessity for patients to understand the implications of their choices fully. This approach accentuates decision-making competence and the readiness to accept the outcomes of one's decisions.[44]

Some authors also explores the legal implications of such decisions, indicating that the burden of proof in lawsuits might shift towards patients. They would need to prove that their decisions were not made freely or were influenced by incorrect or incomplete information from healthcare professionals. This shift underscores the significance of ensuring patients are well-informed and make decisions that are genuinely autonomous. Moreover, the text argues against state interference in personal health decisions, provided the individual's decision-making capacity is intact. This stance is rooted in the principle of respecting patient autonomy, emphasizing that adults should have the sovereignty to make choices about their health without

[40] Obstetrics and Gynecology Risk Research Group. KUKLA R, KUPPERMANN M, LITTLE M et al. Finding autonomy in birth. Bioethics. 2009 Jan;23(1):1-8. doi: 10.1111/j.1467-8519.2008.00677.x.

[41] ACOG. American College of Obstetricians and Gynecologists. Cesarean delivery on maternal request. Committee Opinion No. 394. Obstet Gynecol. 2007 Dec;110(6):1501. doi: 10.1097/01.AOG.0000291577.01569.4c.

[42] DUPERRON L. Should patients be entitled to cesarean section on demand? YES. Can Fam Physician. 2011 Nov; 57(11): 1246–1248.

[43] Ibid.

[44] ARULKUMARAN S. Health and Human Rights. Singapore Med J. 2017 Jan; 58(1): 4–13. doi: 10.11622/smedj.2017003.

undue interference, as long as they are capable of understanding the consequences of these decisions.[45]

This perspective aligns with bioethical principles that prioritize respect for autonomy, informed choice, and individual responsibility, suggesting a more nuanced approach to patient care and decision-making in gynecological practice.[46]

There is a significant decision-making practice of the European Court of Human Rights, within which we come to two paradigmatic decisions. In the judgment in the case **Jehovah's Witnesses v. Russia**, the ECtHR stated that "an operation - although life-saving - carried out despite the consent of an autonomous adult patient represents an interference with the individual's personal autonomy and his right to self-determination (respect for the patient's physical and psychological integrity) and as such is contrary to Art. 8 ECHR."[47]

Furthermore, the European Court of Human Rights (ECtHR) clarified in the **Glass v. UK** case that consent should have two main qualities: it must be explicitly given and directly related to the specific medical procedure in question.[48]

In the final analysis of the **Evans v. UK** case, the necessity of securing voluntary and informed consent is emphasized, aligning with the duty to honor individual rights and dignity. This principle holds significant weight for both the government and medical practitioners, as a clear and comprehensible consent process not only fulfills ethical obligations but also shields the state from allegations of infringing upon the right to private life.[49]

In the **Ternovszky v. Hungary (32)** case, the European Court of Human Rights affirmed that "the right to respect for private life encompasses the right to select the circumstances under which to give birth." It is evident that there's a growing acknowledgment of the importance of patient autonomy and human rights within the healthcare industry. This shift has led to the understanding that to move away from traditional paternalistic approaches, the desires of women requesting a caesarean section ought to be respected and facilitated.[50]

There is no known legal case specifically concerning a woman's demand for a cesarean delivery. Yet, considering the right to determine the conditions of childbirth as a component of private and intimate life under Article 8 of the Human Rights Convention, this right extends to the method of childbirth chosen by a woman.

Judge Van Dijk articulated it as follows: "Although the Convention does not explicitly and individually enshrine the right to self-determination, it underpins various rights it enumerates, especially the right to liberty as per Article 5 and the right to respect for private life as per Article 8. Moreover, self-determination is a crucial aspect of 'inherent dignity,' which, as stated in the preamble of the Universal Declaration of Human Rights, forms the foundation for freedom, justice, and peace globally."[51]

In paragraph 61 of the judgment (as referenced), the Court distinguishes between "self-determination" and "personal autonomy," noting their close connection yet distinct meanings. The ECtHR clarified that "the freedom to direct one's own life according to one's preferences may encompass the freedom to engage in acts that might be viewed as physically or morally hazardous or detrimental to the individual involved."[52]

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45 STIRRAT GM, R GILL. Autonomy in medical ethics after O'Neill. J Med Ethics. 2005 Mar;31(3):127-30.

46 The Constitutional Court of SR, finding from January 2, 2017, File Ref. I. ÚS 2078/16, point 28.

47 Jehovah's Witnesses of Moscow and others v. Russia, app. no. 302/02, Judgment of June 10, 2010.

48 Glass v. United Kingdom, app. no 61827/00, Judgment of March 9, 2004.

49 Evans v. United Kingdom, app. no. 6339/05, Judgment of April 10, 2007.

50 FEINMANN J. How to limit caesareans on demand--too NICE to push? Lancet. 2002 Mar 2;359(9308):774..

51 Sheffield and Horsham v. United Kingdom, app. no. 22985/93, Judgment of July 30, 1998 and see the dissenting opinion of the judge Van Dijk, par. 5.

52 KOFFEMAN, N. R. (2010). (The right to) personal autonomy in the case law of the European Court of Human Rights (nota opgesteld ten behoeve van de Staatscommissie Grondwet). Leiden: Leiden University. Retrieved from https://hdl.handle.net/1887/15890.

The principle of personal autonomy is intrinsically linked to Article 3 of the European Convention on Human Rights (ECHR), safeguarding an individual's physical and mental well-being against torture and inhumane or degrading treatment. This provision, perhaps more so than others within the Convention, is rooted deeply in the values of human dignity and freedom. In conjunction with Article 8, Article 3 upholds the comprehensive protection of an individual's mental and physical integrity.[53]

In real-world scenarios, it's often challenging for a healthcare provider to prove that comprehensive and accurate information was provided to the patient. This difficulty arises especially when information regarding specific risks is omitted. Under such circumstances, the responsibility shifts to the patient to prove whether the omission constituted a significant or minor error. This determination plays a crucial role in evaluating the legality of the healthcare provider's actions.[54]

From an ethical viewpoint, certain scenarios in medicine, such as non-consensual caesarean sections, highlight the tension between two core principles: beneficence and autonomy. This dilemma is emblematic of broader ethical debates in healthcare, where the preference is increasingly for prioritizing autonomy over beneficence under typical conditions. This means that it is widely accepted that competent individuals have the right to decline medical interventions, even those critical for their health or survival. This stance is not only supported within the realm of medical ethics but also reinforced by legal frameworks that eschew paternalistic approaches in favor of respecting patient autonomy.[55]

It is important to note that caesarean delivery, being a surgical procedure, inherently incurs higher costs than vaginal birth. This cost disparity becomes particularly significant not only in contexts where the healthcare system struggles to provide even emergency caesarean sections, but also in scenarios where the procedure is elective, conducted at the patient's behest. There is a prevailing view that public health insurance should not cover the expenses of surgeries that lack a medical necessity.*"*[56]

In Norway, a notable survey on the costs associated with Caesarean Delivery on Maternal Request (CDMR) revealed that up to 40% of gynecologists believe that women opting for a caesarean section for non-medical reasons should contribute to the financial cost of the operation.[57]

The importance of this request becomes evident as we aim to establish transparent and enforceable guidelines for conducting caesarean sections upon request.

VI. CONCLUSION

We conclude without providing a definitive answer to the question of the correctness of caesarean section on request due to the lack of randomized trials comparing vaginal and cesarean delivery. It emphasizes that a caesarean section on request cannot be deemed non lege artis or contrary to the principle of "primum non nocere" due to this absence of clear evidence. Article advocates for establishing clear conditions for performing a caesarean section on request, acknowledging that certain operations in medicine are performed without a medical indication, similar to plastic surgery operations. In the case of a caesarean section, autonomy is

[53] X. a Y. v. Netherland, app. no 8978/80, Judgment of March 26, 1985, par. 22; see also Costello-Roberts v. United Kingdom, app. no. 13134/87, Judgment of March 25, 1993, par. 36.

[54] DOLEŽAL T. The legal nature of informed consent and the consequences of improper disclosure in terms of civil law. Journal of Medical Law and Bioethics. 2019; 9: 55-72.

[55] PUGH J. Caesarean Sections, Autonomy and Consent. [online]. http://blog.practicalethics.ox.ac.uk/2013/12/caesarean-sections-autonomy-and-consent/. Accessed 3 Mar 2024.

[56] KOVÁČ, P. in DOSEDLA, E. a kol. *Moderný cisársky rez*, 1st. ed. Osveta, 2022, ISBN 9788080635077.

[57] SORRENTINO F, GRECO F, PALIERI T et al. Caesarean Section on Maternal Request-Ethical and Juridic Issues: A Narrative Review. Medicina (Kaunas). 2022 Sep 10; 58(9):1 255. doi: 10.3390/medicina58091255.

proportionally limited in relation to decision-making to protect not only the mother's health but also the newborn's.

It highlights the unpredictability of childbirth and the importance of trust between the patient and the doctor. It suggests that the foundation for a planned caesarean section should be part of a comprehensive birth plan that ensures the patient is fully informed. While the discussion often focuses on caesarean section at the mother's request, it should also consider the doctor's recommendation, with the patient deciding based on her autonomy.

The article mentions that data on the risks of caesarean section on request versus planned vaginal delivery are minimal and mostly based on indirect comparisons. It concludes by recommending programmed vaginal delivery as the appropriate and safe method in the absence of maternal or fetal indications for a caesarean section. However, if a caesarean section is chosen after thorough information on risks and benefits, it should be performed only after the 39th gestational week has concluded.

KEYWORDS
caesarean section – caesarean section on demand - choice of birth - maternal request - labor pain - prohibition of torture - informed consent - patient autonomy

KĽÚČOVÉ SLOVÁ
cisársky rez – cisársky rez na žiadosť - voľba pôrodu - žiadosť matky - pôrodná bolesť – zákaz mučenia - informovaný súhlas – autonómia pacienta

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KONTAKTNÉ ÚDAJE AUTOROV
doc. MUDr. Erik Dosedla, PhD., MBA
ORCID 0000-0001-8319-9008
Head of Dpt. Obstetrician and Gynecologist at UPJŠ LF and Hospotal AGEL in Košice-Šaca
Hospital AGEL Košice-Šaca a.s., Lúčna 57, 040 15 Košice-Šaca, Slovak republic
Phone: +421 55 7234 200
E-mail: erik.dosedla@nke.agel.sk

MUDr. Petra Gašparová
ORCID 0000-0002-6354-6911
Physician and lector at Dpt. Obstetrician and Gynecologist at UPJŠ LF and Hospotal AGEL in Košice-Šaca
Hospital AGEL Košice-Šaca a.s., Lúčna 57, 040 15 Košice-Šaca, Slovak republic
Phone: +421 55 7234 203
E-mail: petra.gasparova01@nke.agel.sk

MUDr. Zuzana Ballová
ORCID 0000-0002-0605-948X
Physician and lector at Dpt. Obstetrician and Gynecologist at UPJŠ LF and Hospotal AGEL in Košice-Šaca
Hospital AGEL Košice-Šaca a.s., Lúčna 57, 040 15 Košice-Šaca, Slovak republic
Phone: +421 55 7234 203
E-mail: zuzana.ballova@nke.agel.sk

doc. JUDr. Andrea Erdősová, PhD.
ORCID 0000-0002-5430-5788
Associate Professor
Pan-European University in Bratislava
Faculty of Law
Tomášikova 20, 821 02 Bratislava, Slovak republic
Phone: +421 2 4820 8817
E-mail: andrea.erdosova@paneurouni.com