

Has NICE Guidelines increased Maternal Request for Elective Caesarean Sections?

Authors: Nadira Kasi, Jane Thomas, Hossein Hajizadeh, Ahmar Shah

ABSTRACT

Background: In 2021, The National Institute for Health and Care Excellence (NICE) updated its guidelines to emphasize maternal choice in mode of delivery. It was expected that this would result in an increase in elective caesarean sections (ELCS) performed exclusively for maternal request. **Objective:** To assess whether maternal request for ELCS increased following the introduction of the NICE guidelines, by comparing data from 2018 and 2024 at a single UK hospital. **Methods:** A retrospective review of birth records from 2018 and 2024 was conducted. We included ELCS cases for maternal request, without medical or obstetric indications and excluded caesareans done for clinical reasons. The proportion of maternal request ELCS was compared between the two years.

Results: Total caesarean rates rose from 26% (2018) to 44% (2024). However, maternal request ELCS slightly decreased from 11% to 10.9%. This suggests that while overall caesareans increased, maternal requests did not contribute to the rise.

Conclusion: Improved counselling and informed decision-making may have influenced this trend. Broader studies are needed to determine the national impact.

INTRODUCTION

Caesarean section on maternal request (MRCS) is a rising trend in modern obstetric care which raises ethical, clinical, and policy concerns. Initially, Caesarean sections (CS) were reserved for cases with clear medical indications but they are now more frequently requested by women without such indications. This shift in pattern may be driven by evolving perceptions of risk, an emphasis on patient autonomy, and wider sociocultural changes (D'Souza & Arulkumaran, 2013). NICE in the Guideline CG132 (2011), formally stated that women requesting a CS should receive counselling and be supported in their request. The 2021 update further reinforced this guidance, placing greater emphasis on maternal choice and shared decision-making (MASIC, 2022). Despite these policy developments, implementation across NHS Trusts remains inconsistent (MASIC, 2022). These challenges highlight ongoing concerns around informed consent and the battle between patient autonomy and professional judgement. This study investigates whether the 2021 NICE guidance has influenced the rate of MRCS at a single UK hospital. By comparing data from 2018 and 2024, we aim to understand how policy changes have been reflected in clinical practice and whether MRCS has become more common or if improved counselling has led to different outcomes.

DESIGN AND METHODOLOGY

This study was a retrospective cohort analysis conducted at a single UK maternity unit. The primary aim was to assess trends in maternal request caesarean sections before and after the publication of the 2021 NICE guidelines. We analysed the birth register data for 2018 (pre-guideline) and compared the data for the year 2024 (post-guideline). All births were reviewed, and elective caesarean sections were identified. Cases were included if the ELCS was carried out solely at the maternal request for reasons, such as fear of childbirth (tokophobia), anxiety, or personal preference. Exclusion criteria included breech or malpresentation, previous caesarean section, multiple pregnancies, placenta praevia or accrete etc. A comparative analysis was then conducted between 2018 and 2024 to determine whether there was a significant shift in maternal request rates, potentially associated with the implementation of the NICE guidelines. This study was conducted in Yeovil District Hospital, Somerset NHS Foundation Trust.

RESULTS

Between 2018 and 2024, the overall caesarean section rate at our study site rose significantly from 26% to 44%. However, MRCS as a proportion of total caesareans showed a slight decline from 11% to 10.9% during the same period. This finding is notable as it contrasts with expectations following the 2021 update of NICE guidelines, which reinforced support for maternal choice in delivery.

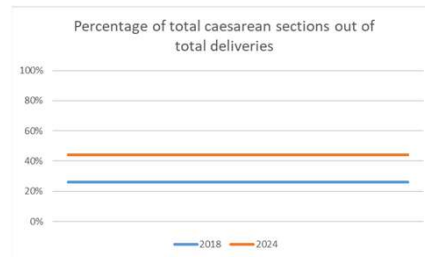


Fig.1 – Percentage of total Caesarean section out of total deliveries

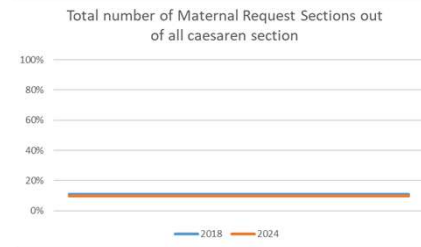


Fig 2. Total number of maternal request section out of all caesarean section

DISCUSSION

Although D'Souza and Arulkumaran (2013) anticipated that NICE guidelines would increase maternal request CS, data indicate the rise in CS overall is more attributable to factors like repeat caesareans, older maternal age, comorbidities, and risks of vaginal birth after CS. Interestingly, MRCS rates have slightly declined, possibly due to improved antenatal counselling and informed decision-making under the NICE policy. Enhanced communication may have reduced anxiety related requests (e.g tokophobia), empowering women to make more confident decisions without increasing MRCS rates.

Ethical and Legal Considerations

Respect for patient autonomy supports offering MRCS as a valid option (Brown & Mulligan, 2023). Following *Montgomery v Lanarkshire Health Board* (Romanis, 2022), healthcare providers are legally required to inform patients of all birth options, including elective CS. Yet, MASIC (2022) found that 75% of NHS Trusts lack written MRCS policies, resulting in limited access to legally supported care.

Psychosocial Motivations

MRCS is often driven by tokophobia—fear of childbirth due to prior trauma, anxiety, or depression (Sethi, Rajaratnam & Abdullah, 2023; Sorrentino et al., 2022). Women also cite long-term concerns like incontinence or organ prolapse (D'Souza & Arulkumaran, 2013), and prefer the predictability and perceived safety of CS. Cultural factors and advanced maternal age also contributing factors (Sorrentino et al., 2022).

Medical Considerations

Planned CS avoids emergency risks and may offer better outcomes (Brown & Mulligan, 2023; Romanis, 2022). However, CS increases future pregnancy risks (e.g., uterine rupture, abnormal placentation) and neonatal complications (Eide & Bævre, 2020). A personalized and informed approach is essential, especially for first-time mothers (Sethi, Rajaratnam & Abdullah, 2023).

Policy Implications

Despite NICE guidance (NG192, 2021), inconsistent MRCS support persists because limited perinatal mental health access and lack of national policy create disparities (MASIC, 2022) between mothers within the general population. Therefore, standardised national MRCS protocols and early, unbiased counselling are needed. Brown and Mulligan (2023) suggest that MRCS should be seen as a valid reproductive choice and not a deviation from clinical norms.

CONCLUSION

Maternal request Caesarean section has a complex relationship with ethics, law, clinical practice, finances and personal values. While not risk-free, it is a valid option when based on informed, autonomous choice. Patient-centred care requires consistent national guideline implementation, clinician training, and early, balanced counselling on all birth options. In this study, the 2021 NICE guidelines emphasizing maternal choice did not increase MRCS at our centre. Although overall CS rates rose, MRCS slightly declined—likely due to improved counselling and supporting women empowerment and their role in making an informed decision. The rise in total ELCS appears driven by clinical factors such as more repeat caesareans. As this is single-centre data, broader research is needed to assess national trends and NICE's overall impact.

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