EDITORIAL

Please stop using the adjective “elective” to describe the important health services ObGyns provide

Calling a health intervention “elective” risks miscommunicating that it is unnecessary or should have a lower priority than “indicated” interventions. We can avoid this confusion if we discontinue the use of “elective” to describe ObGyn procedures.

Robert L. Barbieri, MD
Editor in Chief

During the April 2020 peak of patient admissions to our hospital caused by coronavirus disease 2019 (COVID-19), we severely limited the number of surgical procedures performed to conserve health system resources. During this stressful time, some administrators and physicians began categorizing operations for cancer as “elective” procedures that could be postponed for months. Personally, I think the use of elective to describe cancer surgery is not optimal, even during a pandemic. In reality, the surgeries for patients with cancer were being postponed to ensure that services were available for patients with severe and critical COVID-19 disease, not because the surgeries were “elective.” The health system leaders were making the rational decision to prioritize the needs of patients with COVID-19 infections over the needs of patients with cancer. However, they were using an inappropriate description of the rationale for postponing the surgery for patients with cancer—an intellectual short-cut.

This experience prompted me to explore all the medical interventions commonly described as elective. Surprisingly, among medical specialists, obstetricians excel in using the adjective elective to describe our important work. For example, in the medical record we commonly use terms such as “elective induction of labor,” “elective cesarean delivery” (CD) and “elective termination of pregnancy.” I believe it would advance our field if obstetricians stopped using the term elective to describe the important health services we provide.

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Stop using the term “elective induction of labor”

Ghartey and Macones recently advocated for all obstetricians to stop using the term elective when describing induction of labor.[1] The ARRIVE trial (A Randomized Trial of Induction vs Expectant Management)[2] demonstrated that, among nulliparous women at 39 weeks’ gestation, induction of labor resulted in a lower CD rate than expectant management (18.6% vs 22.2%, respectively; relative risk, 0.84; 95% confidence interval [CI], 0.76-0.93). These findings indicate that induction of labor is not elective because it provides a clear health benefit over the alternative of expectant management. Given current expert guidance, induction of labor prior to 39 weeks’ gestation must be based on an accepted medical indication and provide a health benefit; hence, these inductions are medically indicated. Similarly, since induction of labor at 39 weeks’ gestation also provides a clear health benefit it is also medically indicated and not “elective.” Ghartey and Macones conclude[1]:

> The words we choose to describe medical interventions matter. They send a message to patients, physicians, nurses, and hospital administrators. When the term “elective” is applied to a medical intervention, it implies that it is not really necessary. That is certainly not the case when it comes to 39-week nulliparous induction. The ARRIVE trial provides grade A (good and consistent) evidence that labor induction provided benefit with no harm to women and their infants. These inductions are not “elective.”

An alternative descriptor is “medically indicated” induction.

Stop using the term "elective cesarean delivery"

I recently searched PubMed for publications using the key words, "elective cesarean delivery," and more than 7,000 publications were identified by the National Library of Medicine. "Elective cesarean delivery" is clearly an important term used by obstetrical authorities. What do we mean by elective CD?

At 39 weeks' gestation, a low-risk nulliparous pregnant woman has a limited number of options:

1. induction of labor
2. expectant management awaiting the onset of labor
3. scheduled CD before the onset of labor.

For a low-risk pregnant woman at 39 weeks' gestation, the American College of Obstetricians and Gynecologists recommends vaginal delivery because it best balances the risks and benefits for the woman and newborn.[3] When a low-risk nulliparous pregnant woman asks a clinician about a scheduled CD, we are trained to thoroughly explore the reasons for the woman's request, including her intellectual, fact-based, concerns about labor and vaginal birth and her emotional reaction to the thought of a vaginal or cesarean birth. In this situation the clinician will provide information about the risks and benefits of vaginal versus CD. In the vast majority of situations, the pregnant woman will agree to attempting vaginal delivery. In one study of 458,767 births, only 0.2% of women choose a "maternal request cesarean delivery."[4]

After thorough counseling, if a woman and her clinician jointly agree to schedule a primary CD it will be the result of hours of intensive discussion, not an imprudent and hasty decision. In this case, the delivery is best characterized as a "maternal request cesarean delivery," not an "elective" CD.

Stop using the terms "elective termination of pregnancy" and "elective abortion"

Janiak and Goldberg have advocated for the elimination of the phrase elective abortion.[5] They write[5]:

> Support for abortion varies depending on the reason for the abortion—whether it is "elective" or "indicated." In the case of abortion, these terms generally differentiate between women seeking abortion for reasons of maternal or fetal health (an "indicated abortion") defined in contrast to women seeking abortion for other reasons (an "elective abortion"). We argue that such a distinction is impossible to operationalize in a just manner. The use of the phrase "elective abortion" promotes the institutionalization of a false hierarchy of need among abortion patients.

My experience is that pregnant women never seek an abortion based on whimsy. Most pregnant women who consider an abortion struggle greatly with the choice, using reason and judgment to arrive at their final decision. The choice to seek an abortion is always a difficult one, influenced by a constellation of hard facts that impact the woman's life. Using the term elective to describe an abortion implies a moral judgment and stigmatizes the choice to have an abortion. Janiak and Goldberg conclude by recommending the elimination of the phrase "elective abortion" in favor of the phrase "induced abortion."[5]

Time for change

Shockingly, in searching the *International Statistical Classification of Diseases and Related Health Problems,* 10th revision (ICD10), the word elective is most commonly used in the context of health services provided to pregnant women, including: elective induction of labor (Z34.90), elective cesarean delivery (O82), elective termination of pregnancy (Z33.2), and elective fetal reduction (Z031.30X0). In ICD10, other specialties do not describe the scope of their health services with the adjective elective.

There are many definitions and interpretations of elective. The most benign use of the word in the context of surgery is to contrast procedures that can be scheduled in the future with those that need to be performed urgently. In this context elective only refers to the timing, not the medical necessity, of the procedure. By contrast, describing a procedure as elective may signal that it is not medically necessary and is being performed based on the capricious preference of the patient or physician. Given the confusion and misunderstanding that may be caused by describing our important health services as "elective," I hope that we can permanently sunset use of the term. ●

RBARBIERI@MDEDGE.COM

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