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Responding to refusal of recommended cesarean section: Promoting good parenting

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ABSTRACT

Consideration of what a "good parent" would do in controversial perinatal cases has been largely absent from to ethics literature. This article argues when a cesarean section is required to prevent death or serious disability for a fetus, the pregnant woman has an ethical (although not legal) obligation to undergo that procedure even when she has concerns or conflicting commitments. Further, a clinician may be justified in using persuasive counseling when there is grave harm at stake that the patient has a moral obligation to prevent. This conclusion is tested by exploring its implications in several other analogous controversial contexts.

A case: Ms. N

Ms. N, a 28-year-old married woman, is 37 weeks pregnant with her first child. She received appropriate prenatal care throughout her pregnancy and prenatal screening did not raise any concerns. Ms. N presented in the emergency department after premature rupture of membranes and onset of labor. Electronic fetal monitoring initially showed normal patterns but shortly after her arrival worsening fetal bradycardia was detected. A pelvic examination revealed umbilical cord prolapse with the head of the fetus compressing the cord. Attempts to reposition the fetus were unsuccessful and the obstetrician is recommending an emergency Cesarean section to prevent anoxic fetal brain injury.

Ms. N refuses to agree to undergo a C-section, even after being informed that the fetus is at high risk of significant harm or death. She states that she understands the possible outcomes but wants a vaginal birth nonetheless. Ms. N's husband explains that Ms. N's mother had nearly died 18 years ago from complications after a cesarean section and that they are not willing to jeopardize Ms. N's well-being in that way; they could have another baby but would not have that chance if something happened to Ms. N. The obstetrician's explanation that such adverse events are very rare has not reassured the couple and they continue to refuse the surgery. The obstetrician is uncertain how to proceed.

An angle: The ethics of parenthood

Clinicians may first worry about the legal liability that they could be exposed to in a case like Ms. N's. However, the legal picture is quite clear. There is no legal directive in the United States that requires a health care provider to act to benefit a fetus over the objections of the pregnant woman. Further, performing surgery on a woman without valid informed consent violates established legal standards. In 1990, the landmark case In re AC was decided in favor of a woman's rights to decline a C-section to save the life of the fetus, creating legal precedent.[1] Additionally, physically forcing a woman to undergo the procedure could reasonably be viewed as wrongful violence or constraint inflicted on a person

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without that person's consent and so could constitute battery. Although no known physician to date has been convicted of battery in such a case,[2] legal support for the requirement for informed consent continues to grow and the possibility therefore remains. As a result, an obstetrician has no legal obligation to act on behalf of Ms. N's fetus without her consent and, in fact, could be violating the law by doing so.

Professional practice guidelines on forced treatment for fetal benefit are in line with the relevant legal requirements. The American College of Obstetrics and Gynecology's (ACOG) Committee on Ethics offered the following opinion:

> Pregnant women's autonomous decisions should be respected … In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine, judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.[3]

This statement leaves little room for interpretation, clearly establishing that member physicians would be expected to follow the pregnant woman's wishes in a case like Ms. N's above. Although ACOG's Committee on Ethics' opinion is not enforced by regulatory authority, it does establish normative guidelines that would apply to a wide range of cases (at least any imaginable ones) involving refusal of recommended cesarean section for fetal indications.

Ethical analysis too has largely concluded that obstetricians should not perform a cesarean section over a woman's objections for the benefit of her fetus. Such analyses generally conclude that under most circumstances clinicians' duties to respect a woman's autonomy and not to cause her harm outweigh any beneficence-based duties that they may have to a fetus.[4] Because the right of a woman to control what happens to her own body typically is recognized as the most important moral consideration, respecting the woman's refusal is identified as the most ethically defensible course of action. This position found additional ethical support in a 1987 article[5] that identified trends in the use of forced C-sections that raised significant justice concerns. Others have argued that doing unwanted surgery on a pregnant woman that would not be done on a non-pregnant woman also violates the demands of justice. Forced cesarean section for fetal benefit therefore has not received extensive ethical support.

It appears that legal and professional practice standards offer unequivocal direction in a case like Ms. N's. Further, there is loose ethical consensus on the appropriate response to most cases of this nature. So is there anything left to say about this case? Is the obstetrician's path forward clear? On the contrary, there is something about a case like Ms. N's that resists a comfortable resolution, perhaps explaining why high-profile cases involving forced cesarean section continue to arise despite established guidelines.[6,7] Support remains for obtaining court-ordered cesarean sections among the medical community. Samuels et al.[8] concluded that "our data provide no evidence that physicians and health lawyers are now generally opposed to the use of court orders… 51% of the respondents were highly likely to support the use of judicial authority." It therefore seems that there is significant tension between the normative established guidelines and the actions and attitudes of health care providers.

Looking at the case of Ms. N from a different angle may help explain why management of a patient refusing cesarean section for the benefit of her fetus is so challenging. Instead of focusing on protection of health care providers from legal liabilities, it may be helpful to consider the moral responsibilities of the woman making the decision. Taking parental obligations seriously has shed light on other questions in reproductive ethics[9] and may enable a better understanding of the ethical tensions in cases like these. The next section therefore addresses the question: When finding herself in Ms. N's shoes, what would a good parent do?

A question: What would a good parent do?

There is no univocal definition of "good parenting." What it means to be a "good parent" differs among individuals, varies among cultures, and has changed throughout time. A thorough exploration of this concept is far beyond the scope of this article, but at least two complimentary conceptualizations can be distinguished. First, a good parent can be described using virtue theory or the ethics of care: a parent who is patient and consistent, loving and firm, nurturing and respectful; who is generous with her child but encourages moderation; who is both protective of her child and appreciative of the child's need for independence. Such a description identifies character traits, attitudes, and emotions that those deemed to be good parents would have. Second, a deontological approach holds that a good parent is one who fulfills her parental obligations. The specific obligations at stake may be the subject of debate, but would likely include protecting a child's interests to a minimal degree and promoting a child's interests beyond that minimal level whenever reasonable. This description focuses on the parent's actions and whether she fulfills the duties associated with parenthood.

For the purposes of this article, explicating a precise definition of good parenting is not particularly important. The rough conceptualizations offered above may be sufficient to answer the relevant questions: Is Ms. N doing what a good parent would do? Is she fulfilling her parental obligations? Under any reasonable definition of good parenting, it is difficult to understand Ms. N's decision to refuse a C-section as what a good parent would do. Refusal of a C-section under these circumstances does not demonstrate protective tendencies or nurturing habits. It fails to promote a child's interests and likely endangers the parent's ability to protect those interests to a minimal level.

This conclusion is defended by the recognition that the choice to go down the path to becoming a parent generates obligations that are serious and robust. They are not easily declined or transferred. They entail substantial self-sacrifice. Creating a person—bringing a being of moral status into the world who is helpless and vulnerable to harm—is an act that also creates stringent duties regarding that being. Because moral status can plausibly be believed to develop over