The Ethics of Court-Mandated Cesarean Sections

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Recently, in certain parts of the country, we have seen a shift in the way society, its laws, and the medical community respond to pregnant women. Where the focus had been on the pregnant woman and her well-being, it has now shifted to the infant and, at times, the well-being of the fetus at the expense of the mother. This shift is evident in the contentious dialogue taking place around the country on abortion and substance use in pregnant women, and in medical communities, about cesarean sections. In many of these cases, a forensic expert is asked to contribute to the discussion. It is the role of the expert to educate the medical professionals and courts on the pertinent ethics principles, provide guidance on consent and capacity to consent, and emphasize that a competent pregnant woman retains her ability to make medical decisions. The American College of Obstetricians-Gynecologists agrees with this principle, noting that "The College strongly discourages medical institutions from pursuing court-ordered interventions."[1] Decisions wherein a court orders a cesarean section is not without medical consequences, is often made quickly based on medical facts that are not absolute, and can lead to significant alienation of patients from the medical community.

The first cesarean delivery is credited to Dr. John Richmond in 1827 in Ohio. He had been called to a primiparous woman who was having seizures. There was difficulty with the procedure, and Dr. Richmond is recorded as having made the decision that "a childless mother is better than a motherless child, I determined to do all I could for the preservation of the mother."[2] The mother survived, but her child did not. Times have changed, and in the country today, the rate of cesarean deliveries has increased dramatically, particularly in the past decades, from 5 to 25 percent in the 1960s through the 1980s, to a third of deliveries today,[3] significantly higher than the World Health Organization's optimal rate of 10 percent.[4] The increase has been attributed to many causes, including improved surgical techniques and better fetal monitoring. However, cesarean sections are not without significant risks. In addition to the risks associated with anesthesia, risks include those connected to any surgery (such as infection and inflammation), as well as uterine rupture and fertility problems, injury to the bladder and surrounding organs, hemorrhage, and blood loss. The procedure also carries a three- to four-fold increased risk of death compared with vaginal delivery.[5]

One problem that arises from the increased frequency of cesarean sections is the conflict between the mother's wishes and the infant's well-being. Clinicians may be placed in situations where they must weigh the benefits of this intervention for the infant versus the desires of the mother. The ethics principles of autonomy and beneficence may be at odds; that is, the autonomy of the mother versus the desire of the physician to ensure beneficence toward the fetus. This maternal–fetal conflict has led to debate in the medical and judicial/legal systems.

When thinking about the ethics underpinnings of this debate, it is first important to remember that, based on the principles of autonomy and self-determination, all patients have the right to refuse treat-

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ment if they are competent to do so, based on our doctrine of informed consent, defined as informing the patient of the proposed treatment, risks, benefits, and alternatives and the risks and benefits of foregoing the treatment. In *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972), the court of appeals held that a physician performing a procedure without consent may be guilty of battery.

The challenge many courts have in making decisions in cases of maternal–fetal conflict is that the decision must be made hastily. There is no luxury of time to process the information. Unfortunately, medical information is not certain. This fact is illustrated in the case of *Jefferson v. Griffin Spaulding County Hospital Authority*, 274 S.E.2d 457 (Ga. 1981). In this case, the mother was refusing to undergo a cesarean section, which was recommended by physicians because of the presence of placenta previa, a condition in which the placenta obstructs the cervical opening. The information presented to the court was that the mother had a 99 percent chance of dying without intervention, and the infant had a 50 percent chance of dying. In the end, the mother delivered vaginally, and both were healthy. The fact that medical experts are not infallible is also an important element of the informed-consent process. In addition, the hurried nature of these decisions often means insufficient time is spent with the patient to elicit reasons for the decision and the patient's value system, which are integral to medical decision-making. I have found, not infrequently, that taking this additional time with the patient when a question of capacity arises can often solve the problem, as a patient's refusal may be related to insufficient information, education, or anxiety.

Several cases over the years have emerged when courts had to weigh in on the medical recommendation of a cesarean delivery when a patient has refused. One of the first and most notable cases took place in 1990 in Washington D.C.[6] A young pregnant woman who had terminal cancer was forced to undergo a cesarean section at the order of a lower court. The infant died within hours, and the mother died two days later. The family of the young woman sued, stating that she did not give informed consent for the procedure, and the operation violated her body integrity. The D.C. Court of Appeals ruled in the family's favor, stating, "A fetus cannot have rights in this respect superior to those of a person who has already been born."[6] Their ruling hinged on the primary point that the patient had not had the opportunity to provide informed consent.

The argument in this case also rested on prior cases of bodily integrity and battery, as well as those that speak to the fact that a court cannot compel a person to undergo intrusion on her bodily integrity for the benefit of another's health (see *McFall v. Shimp*, 10 Pa. D.&C.3d 90, (1978)). The counterargument in this maternity case was that the mother had made the choice to lend her body to her child and therefore had a duty to ensure the welfare of the infant. I point out, however, that her being compelled to ensure the welfare of her child does not mean that she can be compelled to submit her body to surgical intervention. A court would not, for example, order a woman to donate a kidney to her ailing child.

In *In re A.C.*, the court of appeals noted two important points:

> Rather than protecting the health of women and children, court-ordered caesareans erode the elements of trust that permits a pregnant woman to communicate to her physician. . . . An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications . . . out of the health care system.[6]

The second consequence is significant. An illustrative case that made it to the courts was that of a multiparous woman in Philadelphia who had delivered six large infants vaginally and was informed that she would have to deliver by cesarean because of the seventh child's macrosomia.[7] She declined and left the hospital; the hospital turned to the courts to order the procedure, and the hospital received legal permission to become guardians of the fetus and to carry out the cesarean section if the patient returned.[8] She did not. She went to another hospital and delivered her infant vaginally.

The idea that women may become more distrustful of the medical community because of such court-ordered interventions is troubling for women who may already be more disenfranchised and less likely to seek medical care, such as those of minority populations or those with mental illness. A survey conducted by the *New England Journal of Medicine* in 1987[9] of court-ordered obstetric interventions found that among the 21 cases wherein a court order was sought, 81 percent of the women were minority, and 24 percent did not speak English as a primary language.

These results lead to questions of whether some women are more likely to be considered incompetent and incapacitated, as can often happen with individ-

uals with mental illness, unfortunately, but mental illness does not automatically translate into incompetence, even in situations of maternal–fetal conflict. Mothers with mental illness, like others, are presumed to be competent until proven otherwise. Any pregnant woman should be presumed competent and has the right to accept or refuse any medical intervention, including cesarean section. The problem is much more complicated when a pregnant woman appears to have diminished capacity because of mental illness or substance use. Capacity often changes as substances are metabolized and their effects lessen; treating symptoms of mental illness can affect capacity as well. The time course, however, is unknown, and surgical deliveries may be urgent and deemed necessary before capacity can be restored.

Fetal guardianship, such as that discussed in the Philadelphia case, raises additional controversy in the fetal rights debate. Although the full extent of this debate is beyond the scope of this editorial, I will note that the District Court of Appeal of Florida, 5th District, attempted to answer this question. The court ruled that a lower court correctly denied a petition to assign a guardian to the fetus of an incapacitated woman. In that case, a woman with mentally incapacity was pregnant after a sexual assault and was assigned a guardian, whereas the fetus was not.[10]

The consequences of refusing a cesarean delivery can be severe. A woman in New Jersey lost custody of her child for five years when she refused to consent to the procedure.[11] Her child was born vaginally, but then was removed from her care, because her refusal was deemed child abuse. This case underwent two appeals before being remanded to the lower courts. In another case,[12] a woman in Utah was charged with murder when one of her twins died. Prosecutors said that the death was the result of failure to comply with a medically recommended cesarean delivery.

The exemptions that are made on these matters of autonomy and patient self-determination with pregnant women are notable. That is, courts force pregnant women to forfeit their autonomy in ways that are not required of competent nonpregnant women or of men. It is inconsistent to allow competent adults to refuse therapy in all cases but pregnancy. If a mother refuses a procedure that could help her unborn child, oftentimes she is assumed to lack capacity. It is important to recognize that pregnancy does not decrease a woman's decision-making capacity, and autonomy should be respected, even if the decision is against medical advice. In those instances, the ethics principles of self-determination must be upheld during the informed-consent process. The clinician should take the time to explore the reasoning behind the patient's decision and understand the potential negative consequences of turning to the courts for a forced decision. A clinician's personal moral discomfort with a potential decision should be addressed outside the scope of the patient's medical decision-making.

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