

LIVES AT STAKE

How to Respond to a Woman's Refusal of Cesarean Surgery When She Risks Losing Her Child or Her Life

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In June 1987 a judge in Washington, DC, ordered a cesarean section to be performed on Angela Carder, who was 26 weeks' pregnant and near death from cancer. She had discussed with her physicians the hope that her life could be prolonged to the 28th week of pregnancy, when the potential outcome for the fetus would be much better. When it appeared her death was imminent, however, the hospital, unable to get consent for a cesarean section from patient or family, obtained a court order for immediate delivery of the fetus. The cesarean surgery was performed; the infant died within a few hours; Carder died two days later.

Nearly three years later, the District of Columbia Court of Appeals determined that the lower court should first have determined Carder's competency. If she had been declared competent, the court should have followed her wishes. If she had not been competent, the court should have

used substituted judgment (i.e., determined what she most likely would have wanted). The appeals court stated, "We hold that in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus."¹

The hospital involved in the case, George Washington University Medical Center, settled the lawsuit brought against it by Carder's parents at the same time it announced a new hospital policy on decision making with pregnant patients (see **Box** on p. 21). This policy on decision making with pregnant patients incorporated the appeals court decision that supports patient and family decision making and stated that judicial intervention is almost never the appropriate way to resolve ethical issues.

Although courts have ordered cesarean sections in other cases, few have received the publicity given the Carder case, and only one other case

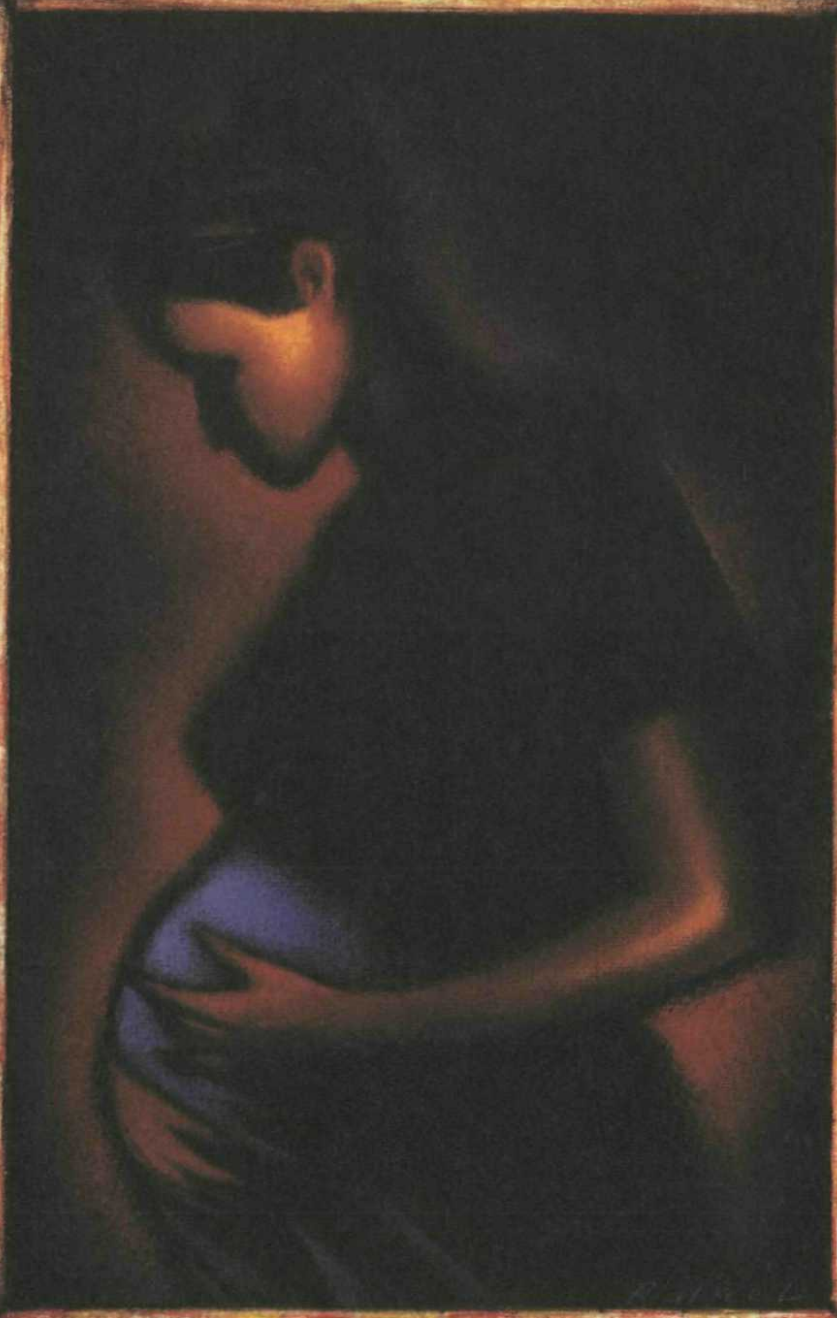
Summary What can healthcare providers do if a pregnant woman refuses cesarean delivery when the life of the fetus and perhaps her own life are in jeopardy? Only in exceptional circumstances would it be morally permissible, or morally required, to compel her to submit to invasive medical procedures against her will.

Ethical analysis of all maternal-fetal issues depends on how the maternal-fetal dyad is conceptualized. The pregnant woman and her fetus may be viewed as an organic whole (the one-patient model) or as two distinct individuals (the two-patient model).

The one-patient model balances prospective benefits to the fetus with possible harm to the mother. In exceptional situations, such as near certainty of serious harm to the fetus and the mother if a cesarean is not performed, a physician or insti-

tution wishing to override the woman's refusal within the one-patient model invokes paternalism. Recourse to the courts to force the woman to undergo the cesarean would probably not be feasible when applying the one-patient model.

The two-patient model focuses more on fetal well-being because it views the fetus as a distinct individual and patient. Catholic institutions usually subscribe to the two-patient model. When near-certain harm to the fetus is coupled with probable benefit to the woman, the institution may ethically override her right of refusal of a cesarean. However, the institution must be prepared to face legal scrutiny should they override the woman's wishes. Other means of achieving the goals of medicine (such as persuasion based on a good doctor-patient relationship) are preferable from both an ethical and a human standpoint.



has reached the appeals court level. These cases are often categorized as maternal-fetal conflicts, suggesting that the rights of mother and fetus are in opposition to each other. In a situation where the pregnant woman's wishes do not appear to be consistent with what is best for the fetus, a physician or institution may believe that the woman's autonomy is overridden by the need to protect fetal life or well-being.

However, the decision of the District of Columbia Court of Appeals seems to indicate that, even in these cases, the pregnant woman's choices have priority. Although this is a legal determination, rather than an ethical one, it agrees with policy statements of both the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA).²

Healthcare providers and administrators in institutions that recognize the fetus as a second patient (as is increasingly the case) may wonder what implications these legal and ethical statements have for their institution's policies. Have the District of Columbia Court of Appeals, the ACOG, and the AMA taken positions ethically unacceptable to persons who recognize independent claims and interests on the part of the fetus?

This article examines healthcare providers' responsibilities when faced with a pregnant woman's refusal of recommended medical interventions, in particular, cesarean delivery. I maintain that if the woman is competent and well informed, and if all attempts at persuasion and reasonable alternatives have been explored, then the provider should ordinarily accept refusal. Only in exceptional circumstances would it be morally permissible or morally required to compel her to submit to invasive medical procedures against her will.

BACKGROUND: COURT-ORDERED CESAREANS

Reports of court-ordered cesareans are difficult to locate because many of them are reported only in local newspapers, if at all. A 1987 survey of 90 obstetricians in leadership positions reported 15 court orders requested in 11 states.³ In all but one state (Maine) the orders were obtained; in two

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cases the orders were not enforced because the patient finally agreed to the procedure. Of the women involved, 80 percent were African-American, African, or Asian; for 27 percent, English was not their native language.

The diagnoses leading to the majority of the requests for court orders to perform cesareans fell into three classes: fetal distress (47 percent), placenta

previa (20 percent), and placenta previa (13 percent).⁴ These three categories have different implications. The viewpoint that vaginal delivery should not be attempted after a cesarean is gradually changing, and diagnoses of fetal distress have a significant level of uncertainty (with false positives estimated at 18 to 80 percent).⁵ Placenta previa, on the other hand, indicates that vaginal delivery would almost certainly be fatal for the fetus and possibly also for the mother.

Almost any medical diagnosis has some chance of being incorrect, and even placenta previa is misdiagnosed in an estimated 1 percent of cases.⁶ Opponents of court-ordered cesarean have focused on cases where, despite medical testimony indicating a cesarean was necessary, the woman went on to deliver vaginally without adverse consequences to the baby or herself. And when surgery was ordered in the Carder case, the baby died anyway and the mother's death may have been hastened.

Individual cases, viewed retrospectively, do not tell us what was medically or ethically the right decision, however. Medical judgment must be based on the usual course of events and the weighing of risks and benefits. Ethical decisions must be based on principles that uphold basic moral norms, protect the rights of individuals, and consider the expected or predictable consequences.

PROMOTING FETAL WELL-BEING

Medical and ethical perspectives recognize a strong obligation to protect the life and well-being of the fetus, as well as of the pregnant woman. Usually these objectives are consistent with each other, and the goals of the medical profession accord with those of the woman.

Most pregnant women who intend to bring

their fetuses to term are concerned about the health of their fetuses and want to do what is best for them. Most women are willing to inconvenience or even endanger themselves for the well-

being of their unborn children. Women rarely express these maternal choices in terms of a moral obligation, although pregnancy does carry moral responsibilities.

POLICIES ON DECISION MAKING WITH PREGNANT PATIENTS

GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER'S POLICY ON DECISION MAKING WITH PREGNANT PATIENTS

As a result of the Angela Carder case, George Washington University Medical Center, Washington, DC, recognized its need to have clearer policies on patient and surrogate decision making, particularly with regard to pregnant patients. In November 1990 the medical center's executive committee approved its Policy on Decision Making with Pregnant Patients, summarized as follows*:

- Respect for patient autonomy requires that, whenever possible, professionals accept treatment decisions made by a competent pregnant patient.

- If a pregnant patient makes a decision that unnecessarily disserves maternal or fetal welfare, care givers must ensure that the woman is well-informed and has good understanding before they accede to her decision.

- When a care giver requires additional input regarding a patient's treatment decision, that input should be sought within the hospital community, including individual consultants and the ethics committee.

- An individual care giver may feel compelled ethically or professionally to withdraw from a particular case.

- Given the following circumstances, the hospital may find it ethically appropriate to withdraw from a case:

- Near certainty of substantial and imminent harm to fetus exists.

- Proposed treatment is likely to reverse or prevent anticipated harm to fetus.

- Proposed treatment presents minimal risk to mother.

- Maternal refusal of treatment is unresolvable.

- Withdrawal of hospital is unlikely to cause harm to pregnant patient or to result in her abandoning medical care.

- It is rarely (i.e., virtually never) appropriate to seek judicial intervention to resolve ethical issues.

This policy urges that decision making be kept within the physician-patient relationship and, more broadly, within the hospital setting. The act of last resort is more likely to be withdrawal rather than recourse to the courts.

OTHER POLICIES

Other hospitals follow George Washington University Medical Center in keeping decision making within the clinical context, but generally they do not have specific written policies that apply to pregnant patients. The American Hospital Association recommends that hospitals defer to standards of professional organizations regarding clinical matters.[†] The treatment of pregnant women is regarded as a clinical matter, and hospitals are referred to the American College of Obstetricians and Gynecologists (ACOG) standards of professional and ethical behavior.

The ACOG's Committee on Ethics has come to the following conclusions*:

- The role of the obstetrician is that of educator and counselor, who must weigh the risks and benefits to both patients, while realizing that tests, judgments, and decisions are fallible.

- Consultation with others, including an institutional ethics committee, ought to be sought when appropriate.

- Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman.

- The use of the courts to resolve conflicts violates the pregnant woman's autonomy, and it is almost never warranted.

MORE THAN A CLINICAL MATTER

In the past, all ethical decision making in the hospital setting was subsumed under the professional standards of the clinician. Today, however, hospitals have policies about do-not-resuscitate orders, patient and surrogate decision making, limited or supportive care plans, and medically provided nutrition and hydration. These areas are no longer regarded simply as clinical matters.

It may therefore be advisable for healthcare institutions to consider whether ethical conflicts involving pregnant women require specific hospital policies. Minimally, a hospital should be aware of the ACOG standard and should examine its implications for that healthcare institution. In a press release accompanying the announcement of the George Washington University Medical Center policy, Christine St. André, administrator, stated, "I would urge every hospital that has the potential for facing a situation similar to that faced by George Washington University Medical Center . . . to review its own policies to insure that there is an appropriate model for decision making."[§]

* "Policy on Decision Making with Pregnant Patients," George Washington University Medical Center, Washington, DC, November 16, 1990, with clarification by Christine St. André, administrator, November 21, 1990.

† Bonnie Jellen, senior staff specialist, Section for Maternal and Child Health, American Hospital Association, personal communication, June 8, 1992.

‡ Committee on Ethics, American College of Obstetricians and Gynecologists, "Patient Choice: Maternal-Fetal Conflict," *Opinion*, August 11, 1987.

§ Christine St. André, statement issued November 28, 1990.

A woman who plans to give birth has a responsibility to do what she can to ensure her child is born healthy. It is particularly wrong for her to knowingly do harm to it, but it is also wrong for her to refuse positive interventions known to have beneficial results (e.g., prenatal care) when inconvenience or risk to her is minimal. The woman may also have a moral responsibility

to accept a higher level of risk if the intervention in question is likely to prevent serious harm to her fetus.

Current discussions of the moral responsibility of pregnant women are surprisingly unified. Prochoice supporters often state that a woman who decides to give birth is obligated to promote her fetus's welfare. Some legal scholars suggest that a child (who has a right to sue a stranger having done permanent harm to it prenatally) may also have a cause of action against its mother for having caused prenatal harm. And advocates of fetal rights argue that what is done to a fetus is morally equivalent to a similar act harming a born human being.

But is legal enforcement the best way to promote maternal responsibility for fetal well-being? In answering this question, one must consider that:

- A broad moral duty of this type would be difficult to monitor, since it encompasses a wide range of life-style choices such as smoking, drinking, exercise, diet, and sexual intercourse.

- Using the medical system to enforce compliance could drive away the women who need prenatal care and medical help the most.

- A woman may be penalized for not acting in the best interests of her fetus when she was unable to obtain the resources to help her do this (e.g., chemical dependency treatment or prenatal care).

- Alternative and less intrusive ways exist to promote maternal interest in fetal well-being, a concern that is easily evoked in almost all women.

It may be inadvisable to translate a pregnant woman's broad moral responsibility for her fetus into a legal duty. But are there some specific circumstances, such as medical indications for cesarean delivery, where a woman who refuses to

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consent should be legally required to comply?

PREVENTING HARM TO COMPROMISED FETUSES

Medical judgments are based on clinical standards that obtain the best results in the majority of cases. Bound by the precept "First, do no harm," physicians prescribe or recommend treatments to minimize the risk of harm, and hence they are sensitive to measurements that indicate risk.

Ethical standards require that physicians inform competent patients of their condition, prognosis, recommended treatment, alternative treatments, and the consequences of each option. A provider may not impose treatment on an unconsenting competent patient. If the treatment in question is surgery, imposition without consent is a serious violation of the patient's autonomy and bodily integrity. It also involves legal violations: assault, battery, or both, depending on the state.

The physician's obligation to avoid harm and promote well-being may conflict with the pregnant patient's refusal of a medically indicated cesarean surgery. In this situation patient and physician are in conflict, not mother and fetus. However, the fetus's interests are at stake because its future welfare may be severely compromised by the pregnant woman's refusal. Let us examine this situation in detail to draw out the ethical implications.

With the advent and widespread availability of electronic fetal monitoring, physicians have a new tool for assessing the condition of the fetus and therefore predicting the risk of permanent damage (e.g., irreversible brain damage). To maximize the possibility of a good outcome for the fetus, clinicians recommend cesarean delivery on the basis of these predictions. Physicians make similar recommendations if a woman has been in labor too long, since the fetus is in danger of infection.

If a woman refuses the recommended cesarean delivery, for whatever reason, providers may find her refusal irrational. The physician has based the recommendation on generalized standards for assessing the risks and benefits to both mother and fetus. If the fetus could die or be severely harmed through vaginal birth, the increased risk

to the mother from cesarean surgery is usually considered acceptable, and the surgery is medically indicated.

A woman who understands the situation usually agrees to the surgery for the sake of her baby. A physician may encourage her to consent and may provide complete information and resources to help her decide. However, the physician may be tempted to overstate the case. As Alan R. Fleischman, MD, writes, "Recommendations to clinicians on how to use the fetal monitoring data are biased in support of cesarean delivery."⁷ In other words, many cesarean deliveries are not really required, but there is no way to know ahead of time which ones are unnecessary.

The literature consistently describes medical judgments regarding the necessity of a cesarean as uncertain.⁸ Examples of dire predictions that turned out to be wrong abound.⁹ (For ethical reasons, it is impossible to do the controlled experimentation that might resolve the uncertainty.) But even if the medical prognosis were correct less than 50 percent (or as little as 10 percent) of the time, the predicted harms are very serious. Even a low probability of serious harm can be considered a high risk to the fetus's well-being.

The woman who decides to have a cesarean has a higher risk of death—estimated at 3 to 30 times greater—than with a vaginal delivery. Again, objectively quantifying this risk is difficult, since women who undergo cesareans are often at higher risk to begin with. However, abdominal surgery clearly presents a risk of postsurgical infection 5 to 10 times greater than vaginal birth. In virtually all cases the woman will be hospitalized longer and will have an extended recuperation period during which she will experience pain, weakness, inability to lift, and difficulty in caring for her newborn and any other children. Her ability to give birth to future children may also be affected, and she may need to have repeat cesareans, which submit her to increased risks in each pregnancy.¹⁰

Thus in most situations a cesarean is based on an uncertain prediction of very serious harm to the fetus and imposes a significantly increased (but still small) risk of serious harm on the mother. This combination of an uncertain prognosis for the fetus and the possibility of harm to the mother also characterizes cases like that of Angela Carder.

Ethical principles support the use of persuasion to encourage a pregnant woman to accept some risk and suffering to prevent potential serious harm to her unborn child. But if the woman cannot be persuaded to consent to a cesarean, she should not be forced to do so, by a court or oth-

erwise. The following section provides ethical analysis supporting this conclusion.

ETHICAL ANALYSIS

The ethical analysis of all maternal-fetal issues depends on how the maternal-fetal dyad is conceptualized. The pregnant woman and her fetus may be viewed as an organic whole (the one-patient model), or they may be considered as two distinct individuals (the two-patient model).

Recently Susan S. Mattingly pointed out the pitfalls of shifting between the two models without making the necessary conceptual and ethical modifications.¹¹ She describes obstetric medicine as, until recently, being "unable to interact with the fetus in clear distinction from its host." Obstetricians thus tended to conceptualize and treat the maternal-fetal dyad as a single, complex patient—the pregnant woman. Because providers can now observe, assess, and offer therapy for the fetus alone, they are better able to view and treat the dyad as two individual patients.

A shift is occurring in obstetrics from the one-patient to the two-patient model. But as with other shifts from one conceptual model to another, practitioners often continue to incorporate aspects of the older model while adopting the newer one. Clear thinking requires that each model be given its own ethical analysis. Logical and moral confusion may result from inadvertently combining elements of the two different models.

One-Patient Model Traditionally, obstetrics followed the one-patient model in which treatment is prescribed for the maternal-fetal *unit*. The physician's ethical obligation to promote well-being is fulfilled by maximizing benefit while minimizing harm within this unit. The one-patient model balances prospective benefits to the fetus with possible harm to the mother. If a cesarean delivery offers substantial prospective benefit to the fetus, with comparatively little harm or risk to the mother, then the physician would recommend it. The risk-benefit analysis is applied to the maternal-fetal unit, treating it medically and ethically as a single patient.

In the one-patient model the pregnant woman speaks for herself and her fetus as an organic whole. Physicians must ask her to consent to treatment, and she must make her own assessment of the risks and benefits of recommended treatments. In the fetal distress situation described, fetal outcome is uncertain, and perhaps half the predictions of harm have turned out to be incorrect. Medical recommendations are highly risk averse and formulated partially as defense against legal liability. On the other hand, medical professionals themselves are concerned

about performing unnecessary cesareans. The woman is being asked to face a somewhat greater risk of dying from major surgery, in addition to other adverse consequences. Hence her choice represents a legitimate assessment on her part of what risks she chooses to take for what possible benefits within the maternal-fetal unit.

Although the physician's assessment of risk may be objective and scientific, that alone does not determine the choice to be made. If it did, there would be no practice of informed consent. Fleischman has observed, "A patient's assessment of the degree of risk she is willing to assume for the sake of predicted benefits is a wholly subjective matter . . . [and] reasonable people disagree."¹² People vary in the amount of risk they are willing to assume for the sake of certain predicted benefits. The entire practice of informed consent is based on the legitimacy of these differing viewpoints.

Thus, if informed consent is to mean anything within the one-patient model, the woman must be allowed to refuse cesarean delivery on the basis of her own assessment of the situation. The AMA's policy statement opposes coercion for similar reasons: "Through a court-ordered intervention, a physician deprives a pregnant woman of her right to reject personal risk and replaces it with the physician's evaluation of the amount of risk that is properly acceptable. This undermines the very concept of informed consent."¹³

Two-Patient Model The two-patient model has only recently become explicit in obstetric practice. This model seems to focus more on fetal well-being because it views the fetus as a distinct individual and patient. A physician who invokes this model, however, must recognize the problem of balancing harm and benefit to the fetus against harm and benefit to the mother. Mattingly suggests, "It is no longer appropriate [in the two-patient model] to consider effects of treatment on the two combined."¹⁴ Rather, the physician is obligated to consider what is "best for each individual considered separately."

In the situation of fetal distress (or dubious fetal viability), under the two-patient model the physician is not ethically justified in performing a cesarean on a woman who has persisted in refusing consent. Here the prospective benefits are entirely to the fetal patient, while the woman is put at risk of harm. Medical ethics explicitly prohibits putting an unwilling person at risk of harm solely to benefit another person.

Catholic theology supports this ethic. The *Ethical and Religious Directives for Catholic Health Facilities* include the following statements¹⁵:

Directive 1. The procedures listed in these *Directives* as permissible require the consent, at least implied or reasonably presumed, of the patient or his guardians. This condition is to be understood *in all cases*.

Directive 5. Any procedure potentially harmful to the patient is morally justified only insofar as it is designed to produce a proportionate good.

Directive 6. Ordinarily the proportionate good that justifies a medical or surgical procedure should be the total good *of the patient himself*.

Directive 15. Cesarean section for the removal of a viable fetus *is permitted*, even with risk to the life of the mother, when necessary for successful delivery. It is likewise permitted, even with risk for the child, when necessary for the safety of the mother. (Emphasis added)

Possible exceptions to the patient benefit criterion "ordinarily" required by directive 6 are a matter of continuing debate, particularly regarding transplantation of organs from living donors. As recently as 1986, theologians Rev. Benedict M. Ashley, OP, and Rev. Kevin D. O'Rourke, OP, described this issue as difficult and controverted.¹⁶ They concluded such transplants are ethically acceptable under five conditions, one being that "the donor's consent is free and informed." They support the courts' refusal to compel organ donations, even from a parent to a child.

The *Directives* clearly permit cesarean section when necessary, and they do not prohibit organ transplants from living donors. But even though they sometimes allow one person to endanger herself for the sake of another, they require consent "in all cases" (directive 1). Catholic theologians who discuss these issues (such as Frs. Ashley and O'Rourke) stipulate the same requirement.

As Mattingly notes, "The injunction against harming one patient involuntarily to help another is virtually absolute."¹⁷ Within the two-patient model, the pregnant woman may not be forced to accept harm to herself for the sake of the fetus.

Legal Does Not Mean Ethical The ethical analysis will vary depending on whether one uses the one-patient or the two-patient model. In both models, however, coerced cesarean delivery is unethical when fetal prognosis is uncertain and the woman will not benefit. Thus there is no justification for requesting a court order. Legal approval does not make an unethical act into an ethical one. Recourse to the courts is never appropriate as a strategy for avoiding ethical responsibility.

EXCEPTIONAL SITUATIONS

Obstetricians attest that situations involving uncertain outcomes are by far the most common,¹⁸ and the majority of requests for court orders come in cases with uncertain prognoses.¹⁹ Some situations arise, however, where the probability of fetal death or severe morbidity may approach 100 percent. In many of these situations, a pregnant woman's refusal of a cesarean may also endanger her because an attempt at vaginal delivery may carry greater risk to her than a cesarean.

In cases of complete placenta previa, for example, vaginal delivery is almost certain to be fatal to the fetus (99 percent) and also carries a substantial risk of maternal mortality (50 percent).²⁰ Frank A. Chervenak and Lawrence B. McCullough argue that well-documented, complete placenta previa limits a woman's right to refuse a cesarean.²¹ Although cases have been cited in which placenta previa reversed itself naturally, Chervenak and McCullough believe these cases to be so unusual they should not influence treatment recommendations. They maintain that if complete placenta previa has been correctly diagnosed, the woman must be persuaded to accept cesarean delivery. If she persists in her refusal, they assert, "Court orders are not unjustified."²²

In the case of hydrocephalus, fluid buildup can enlarge the fetus's head so that normal vaginal delivery is impossible.²³ Once the fetus's lungs reach maturity, cesarean delivery is indicated for safety and also to permit early treatment of the hydrocephalus. The alternatives to cesarean are to wait for labor to occur spontaneously or to induce early labor. If the fetus's head is too large to pass through the birth canal, the physician can use a needle to extract fluid and reduce the head size. However, this sudden decompression almost always results in fetal death. The only other option the physician has at this point is to do nothing, which would result in disaster for both fetus and mother.

Ethical Considerations Come First In situations like these, medical judgment clearly favors cesarean delivery; however, the decision as to whether to coerce the woman must again be made on the basis of ethical considerations. If the provider's

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decision is ethically unacceptable, then recourse to a court will not make it ethical. Neither can a court resolve uncertainty as to the ethical appropriateness of coercion. Courts provide legal decisions, which are distinct from moral determinations. Before considering a request for a court order, physicians and institutions must resolve their own ethical questions.

ETHICAL ANALYSIS OF EXCEPTIONAL SITUATIONS

Two elements in the exceptional situations described are morally relevant:

- The near certainty of serious harm to the fetus if a cesarean is not performed
- The potential benefit to the woman from cesarean rather than vaginal delivery

Let us apply both the one-patient and two-patient models to exceptional situations, incorporating these two elements.

One-Patient Model Because of the near certainty of fetal outcome, coupled with the woman's probable benefit, the risk-benefit assessment within the maternal-fetal unit strongly mandates cesarean delivery in exceptional situations.

If a woman is fully informed and understands that a cesarean is the only medically acceptable option, does her right of informed consent allow her to refuse surgery? This question raises the issue of limitations on the right of informed consent. If this right is to be limited within the one-patient model, there must be justification for paternalistically overriding the patient's autonomy. To prevent serious harm to the patient (the maternal-fetal dyad), is it justifiable to be paternalistic?

Paternalism is generally justifiable when a physician assesses a patient as being incapable of making a competent, informed decision. Healthcare professionals sometimes argue that a patient who chooses a course of action that is not a legitimate medical option is, by that fact, demonstrating his or her inability to make a competent decision. That argument is dangerous, however, because it appears to require every patient to accept medically recommended or medically indicated treatment. Even if the woman were deemed incompetent, the decision maker would likely be a husband or family member

rather than the physician—and in all cases of court orders thus far, the husband or family has agreed with the woman's refusal. Thus a pregnant woman may personally have a moral obligation to accept treatment, but this obligation does not necessarily mean that treatment may be forced on her.

A physician or institution wishing to override the woman's refusal of a cesarean within the one-patient model is on shaky ground in invoking

paternalism. Although the right of informed consent is not an ethical absolute, its limitations do not clearly apply to the competent woman's refusal of cesarean surgery. Moreover, U.S. law "has in general steadfastly refused to recognize a right to interfere with a competent patient's voluntary choice on purely paternalistic grounds."²⁴ Thus recourse to the courts would probably not be feasible when applying the one-patient model.

Two-Patient Model Catholic institutions, along with many others, will most likely subscribe to a two-patient model of the maternal-fetal dyad. This model does provide moral justification for overriding a woman's refusal of cesarean delivery in exceptional situations.

In these situations vaginal delivery is almost certain to be fatal or seriously harmful to the fetus. Hence, in insisting on vaginal birth, the woman is choosing a course of action that will almost certainly do serious harm to another. Moreover, she is not selecting this option because it is less risky or harmful to herself as a distinct individual. If that were the case, she could not be forced to accept harm for the sake of another. But in this situation, the option essential for fetal well-being is also more beneficial to her.

Thus a legitimate ethical limitation on autonomy, the harm caused to others, comes into play. The pregnant woman could ostensibly refuse treatment if she were the only one at risk of being harmed. But she does not have the right to harm another by refusing treatment that is also beneficial to her. In this situation, intervention promoting the welfare of a vulnerable individual (the fetus) while actually benefiting a second individual (the woman) is ethically justifiable.

Recourse to the courts would probably not be feasible under the one-patient model.

An institution whose philosophy stresses responsibility to the fetus as a second patient should have a clear policy delineating the situations in which it would limit the pregnant woman's refusal of treatment. The institution that asserts its adherence to the two-patient model must take care to be consistent. It may not ethically require a woman to accept treatment nonbeneficial to her solely for the benefit of the fetus. But in the exceptional circum-

stances, where near-certain harm to the fetus is coupled with probable benefit to the woman, the institution may ethically override her right of refusal of a cesarean.

In a case where coercive intervention is ethically justifiable or required, a court order should be sought. Although a court order does not assure medical practitioners they are doing what is right, it does protect against legal liability for performing surgery without consent. In response to a reported case in which an emergency cesarean was performed even though the patient persisted in her refusal, a lawyer comments, "Despite his responsiveness to medical and humanitarian imperatives, the physician should realize that acting without consent and in direct defiance of a patient's refusal does expose his actions to legal scrutiny."²⁵

THE HUMAN INTERACTION

This general ethical analysis is intended to provide a framework for further discussion of maternal-fetal issues. Through application of ethical principles in a variety of cases, I propose an ethically defensible policy, consistent with ethical determinations in other areas and with well-established legal standards. In its generality, however, such a policy could lose sight of the woman: her beliefs, values, motivations, fears, future plans, and relationships.

For each patient the physician must ask, Why is she refusing a medical procedure that is strongly recommended for the sake of a good fetal outcome, and possibly also to benefit her? Almost every woman who intends to carry a pregnancy to term wants to do what is best for her unborn

child, even at substantial cost to herself. So it is important for the physician to know what leads a small number of women to refuse recommended interventions. The physician must learn why a woman refuses a cesarean delivery to be able to work with her effectively.

Published and unpublished reports of court-ordered cesareans include a wide range of reasons for a woman's refusal. She may not believe surgery is really necessary, remaining confident she will have a successful vaginal delivery. She may fear surgical procedures and the medical system in general. She may oppose surgery or projected blood transfusions for religious reasons. She may not wish to jeopardize her chance of having children in the future or to risk forcing all future deliveries to be cesarean. She may be part of an ethnic community (e.g., the Laotian Hmong) that has a unified cultural and religious opposition to cesarean delivery. Or she simply may not understand what is going on.

Obstetricians who deal with high-risk perinatal situations say the crucial factor is *how* the situation is explained to the pregnant woman. Virginia Lupo, MD, director of maternal-fetal medicine at Hennepin County Medical Center, Minneapolis, states that if given a good explanation, the resistant woman will almost always consent to a cesarean. Even when the woman's extended family joins in enforcing her refusal (e.g., the case of Hmong relatives encircling the bed to prevent medical professionals from touching the woman), Lupo has found that when they realize the situation is one of immediate danger, they will usually permit surgery or other invasive treatment.

Although a hospital may need a policy for crisis situations, its focus should be on prenatal care. Women who have had adequate prenatal care, beginning early in the pregnancy, are more likely to trust and understand their physicians. Likewise, physicians are in a better position to understand each woman's beliefs, values, motivations, and life plans. Good decision making rests on good communication.

In addition, the pregnant woman should be offered other hospital resources to help her decide. Chaplains, social workers, and a patient representative can play a role here. The hospital ethics committee might facilitate a consultation that would include all interested parties and could lead to a resolution; however, discussions should begin well before a crisis is reached.

As in most areas of medical ethics, the exploration of options and alternatives is crucial. Although in some exceptional circumstances cesarean surgery could be imposed on a woman by court order, these situations should be

extremely rare. Other means of achieving the goals of medicine are highly preferable from both an ethical and a human standpoint. □

NOTES

1. *In re A.C.*, 573 Atl. Rpt. 2d 1235, 1237 (D.C. Court of Appeals, April 26, 1990).
2. Committee on Ethics, American College of Obstetricians and Gynecologists, "Patient Choice: Maternal-Fetal Conflict," *Opinion*, August 11, 1987; Law and Medicine/Board of Trustees Report, "Legal Interventions during Pregnancy," *JAMA*, November 28, 1990, pp. 2,663-2,670.
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4. Kolder et al., p. 1,193.
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