Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery

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The doctrine of informed refusal may become difficult to adhere to in obstetric practice, especially in situations in which the fetus's life is at risk. One rare yet potentially problematic situation of informed refusal is the case of a pregnant woman who refuses to undergo a medically indicated cesarean delivery that would ensure the well-being of her fetus. Although some would argue that patient autonomy takes precedence and the woman's informed refusal should be respected, others would argue that beneficence, justice, and doing no harm to the viable fetus should ethically overrule the refusal of a surgery. This article explores the profound conflict between maternal autonomy and the rights of the fetus, provides a framework to address when the two diverge, and poses suggestions for how providers can better navigate this dilemma.

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KEY WORDS

Cesarean delivery • Informed refusal • Fetal risk management • Intervention • Ethics

Obstetrics is the only field in medicine in which decisions made in the care of one person immediately affect the outcome of another. The fetus relies completely on the mother to survive in utero. The moral duty to protect vulnerable populations is dogma in ethics and research principles. One would have to argue that the fetus is the utmost of vulnerable populations and yet there are circumstances in which the protection of the fetus is effaced in a maternal decision to refuse delivery by cesarean. However, the maternal-fetal relationship is such that maternal and fetal interest may sometimes be divergent. The first type of maternal-fetal conflict occurs when the pregnant woman's behavior

and actions may be deleterious or harmful to the fetus (eg, if a pregnant woman engages in behaviors during pregnancy such as smoking, illegal drug use, or alcohol abuse). The second type of maternal-fetal conflict occurs when "the pregnant woman may refuse a diagnostic procedure, medical therapy, or a surgical procedure intended to enhance or preserve fetal well-being."[1]

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The doctrine of informed refusal may become difficult to adhere to in obstetric practice, especially in situations in which the fetus's life is at risk. Examples of maternal refusal could range from refusing advised bed rest, amniocentesis for diagnostic purposes, corticosteroids for enhancing fetal lung maturity, or tocolytics to prevent preterm birth. One rare yet potentially problematic situation of informed refusal is the case of a pregnant woman who refuses to undergo a medically indicated cesarean delivery that would ensure the well-being of her fetus. Although some would argue that patient autonomy takes precedence and the woman's informed refusal should be respected, others would argue that beneficence, justice, and doing no harm to the viable fetus should ethically overrule the refusal of a surgery. This article explores the profound conflict between maternal autonomy and the rights of the fetus, provides a framework to address when the two diverge, and poses suggestions for how providers can better navigate this dilemma.

Factors Influencing Maternal Refusal

One out of three births in the United States is currently performed by cesarean delivery.[2] In fact, cesarean delivery has become the most common surgical procedure in American hospitals.[2] Most women who undergo this procedure voluntarily agree to invasive abdominal surgery to maximize the potential healthy outcome for their babies, even though there may not be any direct health benefit for the mother. However, there are a small number of women in the United States who may choose to refuse a cesarean delivery despite their obstetrician's recommendations. There are many reasons a woman may choose to refuse a physician-recommended cesarean delivery. These include concern or fear of postoperative pain, harm, and death for both mother and fetus; concern of cost and hospital fees; desire to avoid repeat cesarean deliveries; cultural or religious beliefs; and a lack of understanding regarding the gravity of the situation.[3]

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It is a known fact that cost associated with cesarean delivery is greater than that of a vaginal delivery. A recent report from the Centers for Disease Control and Prevention states that hospital charges for a cesarean delivery are nearly twice those of a normal vaginal delivery.[2] In addition, many hospitals have specific guidelines regarding allowing women who have previously delivered by cesarean to attempt labor and delivery vaginally.[3] Fewer than 10% of women who have had prior cesarean delivery will elect to deliver vaginally, but the success rate for vaginal delivery after cesarean can be as high as 80% under the right circumstances.[4] Thus, some women may refuse cesarean delivery simply because they are confident of having a successful vaginal delivery.

Language barriers and cultural differences can lead to communication difficulties and prevent complete ascertainment that the patient is fully informed and understands the situation. In a report from the United States, 81% of women refusing cesarean delivery were black, Hispanic, or Asian; 44% were unmarried; 24% did not speak English as their first language; and 100% were treated in a teaching-hospital clinic or were receiving public assistance.[3,4] In situations in which there is a difficulty with communication, the obstetricians and clinical team must spend sufficient time to overcome the patient's fear and lack of understanding.

Although physician court orders are an option that can be pursued by obstetricians, it is important to note that the process is time consuming, and this delay further increases the risk for fetal morbidity or mortality. In addition, the legal process of obtaining a court order can irreversibly damage the patient-physician relationship.

Professional Guidelines

By law, physicians are neither compelled nor required to seek judiciary intervention requiring their pregnant patients to undergo treatment or change behavior for the best interest of the fetus. There is also no legal penalty placed on physicians for their failure to seek a court order when a pregnant woman has knowingly exposed her fetus to a risk of harm.[5] A physician

who performs surgery on a patient in the context of her refusal may put him- or herself at legal risk.

The American Academy of Pediatrics Committee on Bioethics outlines recommendations for physicians who may face circumstances in which maternal and fetal interests are not the same.[6] The Committee states, "In cases where a treatment poses personal risk to the mother and her bodily integrity, a physician should honor a woman's right to refuse treatment. Under the following conditions a physician might consider actively challenging a woman on her decision: (1) the fetus will suffer irrevocable harm without the treatment, (2) the treatment is clearly indicated and likely to be effective, and (3) the risk to the woman is low. When a pregnant woman persists in refusing, the physician should consult with a hospital ethics committee; the courts should be petitioned only as a last resort."[6]

The American Congress of Obstetricians and Gynecologists (ACOG) Committee on Ethics also has a policy statement that advises physicians to counsel and educate their patient in the case "in which a mother refuses a diagnostic or surgical procedure, and thus endangers her fetus, or in which a mother's lifestyle or health practices endanger her fetus."[7] ACOG holds that counseling and education are the best strategies for a doctor to convince a woman to accept and abide by his or her advice. ACOG also "condemns the use of coercion on a pregnant woman, as this threatens the physician-patient relationship and violates the intent of the informed consent process."[7] The Committee states that, when "faced with a continuing disagreement with a pregnant woman, a physician should turn to an institutional ethics committee. Resorting to the legal system is almost never justified."[9]

Finally, the American Medical Association also discourages physicians from seeking court-ordered intervention. "[P]hysicians should refrain from using the courts to impose personal value judgments on a pregnant woman who refuses medical advice meant to benefit her fetus"; however, "[i]f an exceptional circumstance could be found in which a medical treatment poses an insignificant—or no—health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention."[8]

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Constitutional Rights

In today's legal and professional landscape, there is an inclination toward the viewpoint that supports maternal autonomy and patient preference. Historically, under US Constitutional law, legal rights have centered on the pregnant woman. A woman has the constitutional right to refuse unwanted medical procedures and uphold her right to bodily integrity, self-determination, and privacy. Regardless of the woman's rights to individual liberty and privacy, it is important to consider that these rights may not always be absolute. This is because when a woman is pregnant, the life of the fetus is directly dependent on the actions and choices of the woman. When a pregnant woman uses illicit drugs, consumes alcohol in excess, forgoes medical treatment, and refuses to follow her doctor's advice, it may adversely affect her fetus. The dilemma of how society can best deal with the problem of intentional prenatal substance abuse has inundated lawmakers since the late 1980s. Some states have tried to criminalize prenatal drug use, specifically cocaine and amphetamines, and treat it as grounds for terminating parental rights. There are rare instances in which women have been prosecuted for fetal harm. However, few attempts at incarceration have been successful because advocates of women's reproductive rights have been staunchly opposed to the state's regulation of a pregnant woman's behavior.

The underlying questions here are as follows: (1) to what extent is there a difference between the rights of pregnant women and those of nonpregnant women?; (2) can we as a society, medical system, or legal system, uphold pregnant patients to the same responsibilities and obligations toward future unborn children as we expect mothers to have for their living children?; (3) when, if ever, can a government legitimately intervene to usurp the rights and privacy of a pregnant woman in the interest of the fetus?

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When a woman is pregnant, the state may or may not have the ability to intervene in certain circumstances. This precedent was first established in the 1973 *Roe v Wade* case, when the state held

that a viable fetus merits state protection based on the Constitution as well as statues that prohibit the arbitrary termination of life of an unborn fetus. However, still up for debate is the degree to which the government can control a pregnant woman's choices based on the doctrine of compelling state interest. Although the 14th Amendment states that the fetus is not a person, the US Supreme Court has also maintained that the state has an "interest in protecting the life of the fetus after viability—that is, after the point at which the fetus is capable of living outside the womb."[9] This was, in fact, what prompted the provision, which permitted states to outlaw termination in the third trimester of pregnancy, unless necessary to sustain the life of the pregnant woman.

Obligation to the Fetus

Proponents of maternal autonomy would argue that if a woman has the right to terminate or to sustain her fetus at the beginning of the pregnancy, then why should this right change moments before birth? In the scenario in which a woman has accepted her pregnancy after conception, it is assumed she has now invested some obligation and responsibility toward the well-being of the fetus.

With the advent of new and improved medical technology, the fetus is now more visible and increasingly accessible to medical intervention, and the gestational age at which a fetus is considered viable has decreased over time. "Advances in the knowledge of fetal physiology and the development of new technology have enabled physicians to see the fetus in detail with ultrasound, to assess its condition with amniocentesis and fetal heart rate monitoring, and to operate on it in-utero."[5] This new ability to assess and treat the fetus in utero with increasing accuracy and precision has led to a common perception among physicians of the fetus as an individual patient.

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In the United States, there are currently 36 states that recognize the unborn fetus as a legal victim under the Unborn Victims of Violence Act of 2004.[10] Under this law, everything from a zygote to a fetus is recognized as an independent victim with legal rights that are unique and distinct from the mother. In 2002, the US Department of Health and Human Services also expanded the definition of the term *child* in the State Children's Health Insurance Program to ensure that individuals in the period between conception and birth are also eligible for coverage.[11] In many European nations, such as Norway, it is assumed that the fetus has almost the same legal status as an already born child.[3] Because the unborn child is still attached to the woman's body at the time of birth, any intervention that will secure the child's best interests overrides the patient's autonomy, provided that the risk for the unborn child is high and the associated risk for the mother is low. This European practice is in striking contrast to that of the United States.

"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)."[12] One could argue that with increasing visualization of the fetus over the years, obstetric care is evolving more toward the two-patient model.

Religious and Cultural Considerations

Another important point to consider is the woman's right to exercise freedom of religion and preserve her cultural values. It is common in many cultural and/or religious groups for women to refuse a cesarean delivery. For instance, in many Arab cultures, a cesarean delivery may be perceived as a form of mutilation.[13] Hmong women are also known to refuse cesarean delivery for cultural beliefs and motivation for vaginal delivery.[13] A small fraction of women who begin spontaneous labor end up being delivered by cesarean because of an arrest of dilatation for 2 or more hours during the active phase. During these situations, when immediate action must be taken, there may not be time to convince a woman to follow the physician's recommendation. Although formulating a birthing plan prior to labor may not avoid forced and unwanted interventions, it will provide time beforehand for an obstetrician to discuss the absolute reasons for cesarean delivery and minimize the extent of the discussion when time is of the essence. Here, it is also important for obstetricians to display empathy for the patient's wishes while clearly explaining that there may be changes in the birthing plan that may contradict the patient's wishes.

Harm of Forced Cesarean Delivery

Some would argue that if the pregnant woman is medically stable and that if performing a cesarean delivery has no direct benefit to

the woman, a surgical intervention would actually cause unnecessary harm to the patient, or unnecessary malfeasance to the mother. Performing a surgery on a woman without her consent could be considered assault and battery. Cesarean delivery is a form of invasive surgery and a forced cesarean procedure bears the additional risk of inducing emotional harm and scarring. When compared with their vaginal delivery counterparts, women who receive cesarean delivery are more susceptible to acquiring acute postoperative infection, surgical injury, chronic pelvic pain and bowel obstruction, and adverse effects on their future reproductive capacity. In some circumstances, women who undergo a cesarean delivery may also have delayed contact with their babies and be less likely to establish early breastfeeding than those women who deliver by vaginal birth. These and other reasons contribute to the annual cases of maternal lawsuits against obstetricians for emotional and physical harm from medically indicated and/or forced cesarean deliveries. In addition, mothers who have had negative hospital experiences in the past are more likely to seek alternative care for future pregnancies, including midwifery, lay-midwifery, and unassisted home births. One could also opine that women with negative hospital experiences during their earlier deliveries are less likely to receive prenatal care and medical help for future pregnancies, and these are perhaps the women who will need it most.

Although the aforementioned arguments are valid, it is also important to consider the malfeasance to the fetus as a result of pregnant woman refusing a cesarean delivery. In one population-based study that compared 1898 women who refused and 164,064 women who did not refuse medical intervention during pregnancy and delivery, it was found that parturients who refused medical treatment experienced significantly higher rates of adverse perinatal outcomes, indicated by lower Apgar scores and higher rates of perinatal mortality and intrapartum death.[14] Thus, a woman's refusal to have a medically indicated cesarean delivery may often lead to greater complications for the fetus, the woman, or both. Refusal of medical treatment is correlated with greater rates of fetal death and disability. In addition, the emotional harm and scarring caused by the regret of an adverse pregnancy outcome that could have been prevented by a medically indicated cesarean delivery could impinge even more overwhelming and emotional trauma on the mother than invasive surgery.

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Framework for Addressing Patient Refusal

It is likely that during an obstetrician's training and practice, he or she may be confronted with a situation in which a pregnant woman refuses interventional surgery that could maximize the well-being of the fetus. In an attempt to help health care providers navigate this difficult and complex situation, we offer a framework to reach a potential solution (Tables 1-5).

There are numerous countervailing factors that must be considered when assessing this dilemma; these include "the legal due process, the ambiguous legal status of the fetus, the value of the mother's bodily integrity and privacy, the dangerous elasticity in the standards used to justify forced medical intervention, the undesirable and possibly insidious consequences of intervention, the unfair treatment of pregnant women, and existing legal precedent."[14]

TABLE 1

Enhance Your Understanding of the Patient Perspective
Question: Does this patient have the desire and willingness to care for this baby? **Question:** Does this patient have the financial resources and social support to provide care for this baby? **Question:** Is this a reaction to past negative experiences with medical staff and medical intervention? **Question:** Are there cultural or religious grounds for the patient's decision?
Action: Generate an accurate understanding of the rationale behind the woman's refusal. **Action:** Enlist the help of other professionals who have a broad and diverse understanding of different cultural, language, and/or religious backgrounds. **Action:** Request and involve appropriate consultation from social work, translation services, religious-cultural affiliations, and ethicists to augment your understanding of patient refusal.

TABLE 2

Ensure Patient Understanding

Action: Help your patient understand the relevant consequences of her refusal (both short- and long-term).
Action: Have your patient meet with a neonatologist to ensure that she understands the outcomes and care of the neonate if the baby's life was compromised at birth.
Action: If your patient is seeking an assisted home delivery, discuss the disadvantages of such an option over the advantages of conventional birthing at a hospital or medical facility.
Action: In the case in which your patient insists on home delivery, you may want to discuss the option of hospital assistance and home care and/or back-up planning in case of a complication that requires medical attention.

TABLE 3

Determine the Patient's Decisional Capacity

Question: Can the patient's refusal be attributed to carelessness or unwanted attitude toward the fetus, an irrational fear, a lack of understanding, and/or a psychiatric disorder?

Action: Evaluate the patient's decisional capacity during the course of the conversation.
Action: If necessary, request a psychiatric consultation, but realize that this may go against your ability to retain patient trust and a good relationship.
Action: You may find that it is appropriate to seek a surrogate decision maker, such as a guardian, spouse, adult child, or parent.

TABLE 4

Evaluate Fetal Risk

Question: If the procedure is not performed, is there a high probability of serious harm to the fetus?
Question: Is there a high probability that this procedure/treatment will prevent or substantially reduce harm to the fetus?
Question: Are there comparably effective and less intrusive options to prevent harm to the fetus?
Question: Is the associated risk/harm to the woman low or negligible?
Question: Are there any benefits of the treatment or procedure for the pregnant woman?
Question: Is there enough time to seek a court order without putting the fetus at risk for demise and/or serious injury?

Action: Although your primary loyalty and duty is to the pregnant woman, you must not neglect the risk of death and irreversible injury to the fetus if the recommended cesarean delivery is not performed.

Through a combination of enhanced patient education, efforts to obtain the patient perspective, and an attempt to mediate and resolve conflict, an obstetrician should work to persuade a pregnant woman to accept a cesarean delivery if the risk of morbidity or mortality to the fetus is high. The biggest step is perhaps taking the time to understand the rationale and motivation behind the patient's refusal. This will help any provider reach the underlying crux of the maternal-fetal conflict and then determine strategies to mitigate this conflict. The pregnant patient should always be offered hospital resources, proper consultations, and adequate support to help her decide and come to an informed decision about her cesarean delivery.

Without a doubt, court order should be sought as a last resort, as it could replace trust and confidence in a patient-provider relationship with distrust and resentment. There are very few exceptional cases in which legal intervention may be appropriate. The ultimate goal is to maintain patient trust and find the best way to achieve an outcome that encompasses both maternal autonomy and fetal well-being.

Conclusions

There is sometimes a fine balance between the ethical principles that are to be applied in patient care when gravid patients are involved. In order to address the dilemma that may arise between mother and fetus, one must understand the historic and social context of a pregnant woman's refusal of a medically indicated cesarean delivery and analyze why both maternal and fetal viewpoints should be considered when evaluating this ethical issue. Obstetricians should work emphatically to encourage a pregnant woman to accept a cesarean birth if

TABLE 5

Obtain a Court Order if Indicated

Action: Based on the AAP, ACOG, and AMA guidelines, this final recommendation should be an ultimate last resort and must be justifiable and only considered in the case of *exceptional* circumstances.

Action: Become familiar with your hospital's risk management system as a source of guidance on obtaining a court order as the process and timeliness depend on the state and hospital of delivery.

Action: If you decide to seek judicial intervention, ensure that (1) your patient was informed about the decision to pursue legal action, (2) your patient is also given an opportunity to present her side, (3) your patient is represented by a lawyer.

Action: Understand that using the legal system to force compliance can drive away patients from future interaction with the medical system.

AAP, American Academy of Pediatrics; ACOG, American Congress of Obstetricians and Gynecologists; AMA, American Medical Association.

the risk of morbidity or mortality to the fetus is high. ■

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MAIN POINTS

- Obstetrics is the only field in medicine in which decisions made in the care of one person immediately affect the outcome of another. The first category of maternal-fetal conflict is when the pregnant woman's behavior and actions may be deleterious or harmful to the fetus. The second category of maternal-fetal conflict is when the pregnant woman refuses a diagnostic procedure, medical therapy, or a surgical procedure intended to enhance or preserve fetal well-being.
- The doctrine of informed refusal may become difficult to adhere to in obstetric practice, especially in situations in which the fetus's life is at risk. One rare yet potentially problematic situation of informed refusal is the case of a pregnant woman who refuses to undergo a medically indicated cesarean delivery that would ensure the well-being of her fetus.
- Many reasons influence why a woman may choose to refuse a physician-recommended cesarean delivery, including concern or fear of postoperative pain, harm, and death; concern of cost and hospital fees; cultural or religious beliefs; and a lack of understanding of the gravity of the situation.
- Most important is taking the time to understand the rationale and motivation behind the patient's refusal, and preserving the trust of the patient-physician relationship.
- Obstetricians should work emphatically to encourage a pregnant woman to accept a cesarean birth if the risk of morbidity or mortality to the fetus is high. Without a doubt, court order should be sought as a last resort.