Why Forced Cesarean Sections Are Never Ethically Appropriate

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This paper will discuss the ethical concerns surrounding forced emergency cesarean sections (CS) when a viable fetus, mother, or both are at risk. First, I will discuss the various reasons why a woman may be opposed to the procedure and the medical reasons it may be necessary. Second, I will discuss cases in which a woman refused and was forced into CS. Finally, I will discuss the potential counterargument from the perspective of utilitarianism. The conflicting interests in balancing maternal autonomy with the duties of beneficence and nonmaleficence toward fetal life will be discussed. I will argue that the fundamental right to autonomy and maternal self-determination regarding treatment outweigh the unborn fetus's. Therefore, a woman should never forcibly be subject to a CS. I will support my thesis by discussing the primary importance of autonomy and justice, legal cases, and the opinions of the American Medical Association and the American College of Obstetrics and Gynecology.

In the vast majority of pregnancies, a woman will assume significant risk to protect the fetus's welfare. However, instances do arise in which the interests of the woman and the fetus are at odds, sometimes deemed maternal-fetal conflict. The Department of Obstetrics and Gynecology at the University of Nigeria Teaching Hospital in Enugu, Nigeria, studied the attitudes of women who refused CS delivery between 2004 and 2006. Sixty-two women refused recommended CS, and the reasoning was divided into five categories. Maternal fear of death during the surgery was the most commonly cited reason (n = 32). Reasons cited for fear included the death of relatives during cesarean sections, unpleasant experiences with previous caesareans sections or unpleasant stories heard from other women. Desire to experience vaginal delivery (n = 31) was another common reason for refusal due to the pervasive perception that CS was an

indication of reproductive failure amongst Nigerian women. Twenty-four women stated that economic reasons accounted for the refusal of CS. Thirteen women gave inadequate counseling as a reason for cesarean refusal. Responses categorized in this group included claims of not being informed of the CS earlier in the course of care or complaints of uncaring attitudes of the treating obstetrician. Religious belief was the least common reason for refusing CS, with only one woman citing this as the reason (Chigbu, 1263). The Nigerian studies report that aversion to CS based on fear of health complications or the socio-cultural implications are likely to lead to delays or refusal to the procedure, "whilst the biomedical explanatory model considers CS appropriate treatment, the prevailing cultural model does not… patriarchy and the social construction of gender roles in Nigeria -and many other countries - constrain women's autonomy and access to resources" (Ugwu & de Kok, 33). The study also discusses the fact that some women schedule multiple hospital bookings in order to seek a backup plan if one provider advised a cesarean delivery. Additionally, in some Arab cultures, cesarean delivery may be perceived as a form of mutilation. Hmong women are also known to refuse cesarean delivery for cultural beliefs and motivation for vaginal delivery" (Deshpande & Oxford, 2012). Though these attitudes are probably less common in the United States, we are diverse with many unique patient populations. We must be attuned to a variety of cultural perspectives.

Probably more common in the US are the endemic attitudes that CS's are not 'natural' births and the guilt put on women regarding this, "the emotional impact of a Caesarean section should not be discounted…cesarean mothers are likely to feel disappointed, angry, frustrated, guilty, helpless, and depressed…they may also experience a sense of failure" (Espinoza, 223). In a study of women after having CS, Cohen and Estner found that women often felt a loss of control and a disappointment in the loss of trust and confidence in their body and a loss of

femininity. Letters from women who experienced CS expressed the following feelings: "I have been physically bisected and emotionally dissected." "It has made me feel less than a total woman. I felt like I had failed..." “The times I try to explain to others the depths of my disappointment and heartache over my CS, the words just will not come out right… I always felt guilty thinking I was feeling sorry for myself, that I was ungrateful for my healthy child.” "I feel cheated in a way and am still blaming myself and feeling like I did something wrong" (223).

The American College of Obstetrics and Gynecologists cite the most common reasons for the recommendation of cesarean delivery. These reasons include failure of labor to progress, fetal concern such as the umbilical cord may become pinched or compressed, or monitoring may detect an abnormal heart rate, multiple pregnancies, problems with the placenta, large baby, breech position, maternal infections, such as HIV or herpes, or maternal medical conditions like diabetes or elevated blood pressure The likelihood of needing a cesarean birth increases with the number of babies a woman is carrying. It is also common to require a CS following a previous CS (ACOG, 2018).

In the case of *McFall v Shimp* (1978), the court considered an order to compel Shimp to undergo a bone marrow extraction to save the life of his relative. The request was denied, and Judge John Flaherty stated that "one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue" and "for a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence" (*McFall v Shimp* 1978).

Additionally, robbery suspects cannot be forced to undergo surgery to remove critical evidence, such as a bullet, from their bodies. Persons suspected of drug dealing cannot be forced

to have their stomachs pumped if they swallow the evidence. Suspected rapists cannot be forced to undergo involuntary blood tests for AIDS. Parents cannot be forced to donate organs to their children, even if the child's life is at stake and the parent is the only appropriate donor. One may not be forced to donate bone marrow to a relative, as was upheld in *McFall v Shimp*. Organs cannot be taken from a cadaver without the prior consent of the person or next of kin (Daniels, 33). All of the above instances violate a person or patient's autonomy.

Autonomy is defined as the ability for self-governance. In most instances of refusal of CS, the woman is acting competently, and it cannot be argued otherwise. The three-condition theory of autonomy includes intentionality, understanding, and no coercion from external sources. Beauchamp and Childress define *competence* as the ability to perform a task, usually regarding medical treatment. Some of the various requirements of incompetence include: "inability to express or communicate a preference or choice, inability to understand one's situation and its consequences, inability to understand relevant information, inability to give a rational reason" (Beauchamp & Childress, 115-116). There are three reasons previously in which courts have overridden the autonomy of a patient: prevention of suicide, an interest in protecting third parties (usually in cases of parental refusal for treatment of young children), and the need to protect the integrity of the medical profession (Espinoza, 218). The only applicable argument from this reasoning is the protection of a third party. However, as stated previously, there is no precise determination of whether the fetus can or should be considered a third party. A mother and fetus have a relationship different from a parent-child relationship where the two are separate beings.

The law supports removing personal autonomy when a negative action or right is in question, meaning the restraint of an action to avoid harming others. Positive actions, usually requiring aid to others, are, on the other hand, usually not punishable. For example, this would

mean that smoking or taking drugs while pregnant (negative action) would be punishable. In contrast, refusal of surgery or other procedure for the benefit of the unborn would not be justifiable as this would be considered a positive action. Similarly, in the *McFall v Shimp* case, it was determined that the donation of bone marrow (a positive action/right) against Shimp's wishes was not justifiable.

In 1987, a woman arrived at a Washington, DC hospital after two days of labor. After eighteen hours, she still had not delivered, and there was evidence of fetal distress. Physicians recommended a cesarean section, but the patient did not consent. Protected by a court order, they forced the surgery on her. However, other court cases have come to different conclusions. In New York, a female judge refused to order a cesarean section despite the physicians' predictions that the cord was wrapped around the baby's neck would strangle the baby if a vaginal birth were attempted. The judge reasoned that no one can be forced to have surgery for the benefit of another person, even if the other person is her unborn child. (Devettere, 282). Therefore, we cannot look to courts for guidance based on inconsistent rulings, and additionally, "data on court-ordered obstetric interventions suggests that in almost one-third of cases in which court authority was sought for a medical intervention, the medical judgment was wrong in retrospect" (Harris, 787).

The principle of *justice* is also a factor to be considered when forcing CS. Justice is the "fair, equitable, and appropriate treatment in light of what is due or owed to affected individuals or groups" (Beauchamp & Childress, 268). Because pregnancy is an innately female burden, the fact that we live in a patriarchal society matters, "at best, women who do not adhere to the ideal of motherhood are thought to have improper motives, be of poor character, or simply thought of as bad mothers…at worst the trust these women placed in their doctors is betrayed, their fate is

decided quickly by a judge, and they are forced to have major surgery-all in an attempt to reinforce the belief that a mother should act selflessly" (Harris, 788).

Not only is there potential for gender to influence the outcome, but a 1987 study analyzing court-ordered CS and published in the New England Journal of Medicine found that in eighty-one percent of the cases, the women were black, Hispanic, or Asian. Twenty-four percent of these women did not speak English as their primary language (Espinoza, 226). The survey concluded that discrimination based on race and financial resources was a factor in the court ordering of CS. Further, poor women cannot afford to appeal a decision through the court system. CS's are also more of a burden to poor women who may not have paid maternity leave and thus have a more limited recovery time due to economic burdens. Further, these lower-income workers often work in occupations involving physical labor.

Court orders for obstetric interventions on behalf of the fetus are more often sought against poor women of color, deemed a 1990 Florida study of drug and alcohol use during pregnancy. The study showed that although the rate of positive urine test results for drug and alcohol use among pregnant women was slightly higher among white women than black women, black women were ten times more likely to be reported to health authorities. Speaking of the vulnerability to racism that is embedded in the maternal-fetal conflict, Harris in *Obstetrics & Gynecology* writes, "when we separate the moral obligations owed to the pregnant woman and fetus, racism might become masked as fetal protection…racial and social prejudices might find their way into the identification of fetal interests and so-called conflicts" (Harris, 788).

As of 1987, the American College of Obstetrics and Gynecology (ACOG) tends to support the maternal wishes stating that "actions of coercion to obtain consent or force a course of action limit maternal freedom of choice, threaten the doctor-patient relationship, and violate

the principles underlying the informed consent process" (14). In obstetrics, typically the obstetrician and the woman work in tandem toward the wellbeing of the fetus, "however, the pregnant woman may decide that the risk is greater than she wishes to accept, or she may doubt the benefit to be realized…because of the inability to determine absolutely when a situation is harmful to the fetus and to guarantee absolutely that the pregnant woman will not be harmed, great care should be exercised to present a balanced evaluation of maternal and fetal expectations." ACOG notes, however, that upon refusal, the doctor should not abandon fetal interests but rather supply her with counseling from a variety of other sources, including pediatric or neonatal specialists, so that the woman can clarify her position knowing all the available facts. Also recommended if the issue is a consultation with the hospital ethics committee. ACOG warns against court orders, noting the destructive effect on autonomy and the doctor-patient relationship, stating that "in light of the preceding considerations, resorting to the courts is almost never justified" (14).

The American Medical Association agrees with ACOG regarding forcible CS. The AMA feels strongly that court orders or judicial intervention are not recommended in these cases. The judge must make a quick decision without a formal background in medicine. Only the physician who ordered the court interference can provide a medical perspective. The woman is most likely unable to provide a defense. All of this aside, court orders are harmful to the patient-physician relationship and future patients. They create an adversarial relationship and may discourage patients from seeking medical treatment in the future based on the dissolution of trust and respect.

Beneficence refers to the general moral obligation to act for the benefit of others (Beauchamp & Childress, 218). The argument in favor of promoting beneficence of the fetus is

challenging based on the disagreements surrounding the right to life of a fetus and when that right becomes compelling. The fetus has the potential for life, and thus some consider it a person, but others do not take this perspective until birth. Thus, it is challenging to claim that the fetus's rights outweigh those of the mother. Science, philosophy, and religion have not reached a clear consensus on this matter and most likely will not anytime soon. Some argue that if the woman elected not to get an abortion in the first or second trimester, she has revoked her autonomy or right not to act in the fetus's best interest. However, Espinoza astutely states, "pregnant women do not waive their right to the primacy of their own health by their decision to engage in the reproductive process for as long as possible" (Espinoza, 219). Following this flow of reasoning, some say that only at viability should a fetus be treated as a person.

Paternalism reflects the conflict between beneficence and autonomy. Paternalism is defined as the "intentional overriding of one person's preferences or actions by another person" (Beauchamp & Childress, 232). Paternalism is especially problematic when looked at along with justice. For example, forcible CS involves traditionally male doctors deciding for a woman based on the presumption that they are more knowledgeable and should be trusted. Additionally, this view is substantiated in light of the studies of forced CS occurring more often on minority women. Not only is paternalism problematic, but it is also particularly so in the situations of female minority patients.

The utilitarian perspective based upon utility or the single principle of beneficence argues that one is compelled to maximize the good for all parties involved when possible or that the ends justify the means. This perspective can be used to support forced CS when the fetus's life is in danger, and the CS will likely not cause significant harm to the mother. This is because the emotional and physical harm to the woman would most likely be lesser than that incurred by the

fetus if the surgery were not performed. According to Savulescu, a proponent of this utilitarian opinion, the state is justified in compelling emergency medical interventions like cesarean sections because the state can rightly demand circumstantial sacrifices of citizens. State intervention is justified, he argues, if the harm to A (mother) of I (intervention) is below an acceptable threshold, and the harm to B (fetus) of no intervention (I) is great. He gives the example of requiring a patient to donate a drop of blood for another patient who will otherwise die, quoting Mill—"everyone who receives the protection of society owes a return for the benefit… what smaller return could be asked than a drop of blood to save a life?" (Savulescu, 14). The utilitarian view would negate the case of *McFall v Shimp* because it would see a net benefit come from forcing Shimp to donate bone marrow to save his cousin's life. Similarly, it would condone forcing one person to donate their organs if the organs would save two or more lives, even if it harmed the donor. Beauchamp and Childress agree that the principle of beneficence is not sufficiently foundational to ground all other moral principles and rules in the way utilitarian's have argued (218). I agree that beneficence cannot take precedence over the other equally apt principles.

The utilitarian perspective is not frequently cited in medicine, however. The framework best supported by medicine is a deontological perspective. Deontology ensures that the means justify the ends and holds that every action is inherently right or wrong. Right actions are usually those that respect the rights of others and our duties to others. The rights and duties are not forsaken for the purposes of a particular outcome, "in the world of doctor and patient if the doctor suggests a course of treatment, the patient has a right to refuse the treatment, and the doctor has a duty to respect her refusal…this familiar deontological model currently guides decision making in the doctor-patient relationship, in the form of the doctrine of informed

consent" (Knopoff, 507). Beauchamp and Childress describe the mutually beneficial relationship stating, "the moral demand that we treat others as ends requires that we assist them in achieving their ends and foster their capacities as agents, not merely to avoid treating them solely as means to our ends" (105). I support the deontological perspective in medicine because it preserves patient autonomy and supports the unique doctor-patient relationship, and the future goods to come out of it remain sacred.

Based on the principles of autonomy and justice and the dark side of beneficence being paternalism, forcible CS is never justified. The deontological perspective is more applicable to medicine and the plight of maternal-fetal conflict. Both the AMA and ACOG support the mother's decision when she is supplied with the vital information to decide based on her life and her family's best interest. So long as the woman acts competently and makes informed decisions with the necessary tools, no one has the right to force an unwanted procedure on someone, even if potential life is intrinsically involved.

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