The Rights and Responsibilities of Pregnant Women

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Editor’s Note: The goal of this column is to address ethical dilemmas faced by patients, families and healthcare professionals, offering careful analysis and recommendations that are consistent with biblical standards. The following ethical analysis is a commentary on a legal case that has caused some controversy in the clinical ethics community.

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Question

Is it ethically permissible for a woman to forego potentially life-saving treatment for her unborn child?

Case
Melissa Rowland, a 28 year old woman who had been pregnant with twins, was charged by the State of Utah in 2004 with murder and child endangerment for refusing to permit a timely cesarean section that resulted in the death of one of her twins. The story is complicated by the fact that Melissa had four other children (two of which were previously delivered by cesarean section): two were given up for adoption, and one was taken away by child protective services. She carried a diagnosis of oppositional defiant disorder and had been convicted of felony larceny, as well as endangerment of another child in the past. She apparently had traveled from Florida to Utah in order to give these twins up for adoption, and had sought no prenatal care.

In the three weeks prior to her eventual delivery, Melissa did contact two different hospitals in the Salt Lake City area. On December 25 she contacted one hospital by telephone complaining of no fetal movement and was advised to go to a hospital immediately. She did not. She was then seen on January 2 by a physician at another hospital who recommended an immediate cesarean section due to oligohydramnios (abnormally small amount of amniotic fluid), fetal growth retardation, and repetitive fetal heart rate decelerations, but Melissa left against medical advise stating that the scar would ruin her life? (in spite of the fact that she had had two previous cesarean sections and was warned of the risk of death or brain injury to her twins if she refused treatment). She presented to another hospital on January 9 to see if her babies were alive; no heart rate could be found on one of the twins by external monitor, but again Melissa left against medical advice. Finally she returned to one of the hospitals on January 13, and was delivered by cesarean section; twin A was a stillborn male infant, and twin B, a girl, was found to have cocaine and alcohol in her blood at birth. The medical examiner determined that the stillborn male had no congenital anomalies and had died about two days prior to delivery.

After being charged with murder and child endangerment, Melissa ultimately pled guilty to two counts of child endangerment. Her sentence of consecutive prison terms and fines were suspended in lieu of 100 hours of community service and 18 months of probation, including completion of outpatient mental health and substance abuse treatment, a rehab program, and a parenting skills class. Melissa, however, left the state and complied with none of her probation stipulations. Ultimately, her surviving child was removed from her home as well. The Utah district attorney declined to have Melissa returned to the state.

Discussion

This case generated a great deal of controversy in the court room as well as in the media. Charging a mother with murder for willfully contributing to the death of her unborn child was seen by many as an egregious violation of a woman?s autonomy rights, as well as another step in the drive to undermine abortion rights by conferring the status of personhood on the unborn. In the December 2004 issue of Obstetrics and Gynecology there appeared two editorials written by prominent physicians and an attorney criticizing the charges brought by the State of Utah and delineating the ramifications for women?s health and reproductive rights should such actions become a precedent.[1] Their position was reiterated by the American College of Obstetricians and Gynecologists (ACOG) in a Committee Opinion published in November 2005 entitled, Maternal Decision Making, Ethics, and the Law.[2] In it, a predominantly child-centered approach? to reproductive ethics that views the fetus as separable and independent from the mother was criticized as paradigmatically adversarial? in its emphasis of the divergent rather
than convergent interests of the mother and fetus. In spite of its emphasis on "shared interests," the article maintained that the autonomy and personhood of the woman (as opposed to the unborn child) is indisputable, and that informed consent from the mother for any intervention on the part of the fetus is an ethical obligation of the obstetrician, which must be respected and adhered to regardless of the consequences. The fallibility of physicians and of medical knowledge was cited as justification for such maternal right of refusal: "Criminalizing women in the face of such scientific and clinical uncertainty is morally dubious."[3] In their view, coercive and punitive policies with regard to pregnant women would adversely affect infant mortality rates by undermining the physician-patient relationship, and would create the potential to criminalize many types of otherwise legal maternal behavior (smoking, obesity, etc.).

These opinions, however, are based on the erroneous presupposition that autonomy is an absolute right which must be protected in all circumstances and at all costs. To the contrary, autonomy is not a "right" but a principle which is neither absolute nor inalienable. In its original sense, as developed by Kant and Hume, autonomy referred to social enablement of individual responsibility—to empowering one to take responsibility for one's choices rather than making one's choice the standard of right and wrong. As such, autonomy is understood to be limited by one's responsibility towards others, especially when a potential for harm exists. Pregnancy, with its inherent maternal fiduciary and beneficence-based responsibility for an "other," is one circumstance in which individual autonomy is limited.[4][5]

Legal precedents for the prosecution of mothers for injuring their children in utero are equivocal and contradictory. There is no consistent message in state or federal courts regarding the liability of a mother for the death of a child in utero from failing to consent to medical treatment.[6] Both editorials noted above cited McFall v Shimp (10 Pa D&C3d 90, CP Ct 1978) as a precedent for their position that a woman not be required to undergo a cesarean section for the benefit of her unborn child. In McFall v Shimp, the courts declared that a man could not be compelled to donate bone marrow to his cousin, even though he was the only compatible donor. What the authors of the editorials fail to acknowledge in citing this case is that there is a vast difference between the relationship and responsibility of first cousins (as in McFall v Shimp) and that of a mother and unborn child. The maternal-fetal relationship is qualitatively unique in the realm of medical ethics. The maternal decision to carry a child to term creates a beneficence-based fiduciary obligation on the part of the mother (and physician) to act in the best interest of the unborn child, and to sacrificially care for and nurture that child, an obligation which does not exist between first cousins.[7][8]

It has been argued that the ruling of the Utah court invalidates the notion of "informed consent," depriving pregnant women of customary rights. In reality, the court simply held Ms. Rowland culpable for the death of her unborn child, as it would anyone who knowingly caused the death of another human being. Conversely, what is advocated by those who would oppose any interference with a woman's autonomous reproductive rights, is that pregnant women be granted a privileged status, one that would exempt them from the responsibility and culpability for their choices and actions, placing their "informed choice" beyond accountability—a responsibility to which we would hold any other competent individual. For example, while we allow people to choose to drink alcohol and to assume the responsibility of operating a motor vehicle, we prosecute them for driving while intoxicated, or for killing or endangering the life of someone by driving under such conditions. Why should pregnancy, a state of heightened responsibility,
exempt women from accountability for irresponsible and illegal behavior? Was Melissa Rowland competent to make an informed choice? Interestingly, while the court did not directly address the issue of Ms. Rowland’s competency, it did so implicitly by justly suspending her sentence while simultaneously sanctioning care.

The employment of a ‘slippery slope argument,’ evidenced in all of the above editorials, is a non sequitor. While tobacco abuse or excessive weight gain during pregnancy do have detrimental effects on the unborn child and are not ideal, they are not illegal; cocaine abuse and murder are. Such speculation does not offer a viable prudence-based objection.

Obstetrics has always been a uniquely privileged specialty where responsibility and care must be rendered for the needs of two individuals—two living human beings—simultaneously. Historically, those practicing obstetrics have been advocates for both mother and child, a fact which has always been ripe with both challenges and rewards; the ‘art’ was finding the ‘win-win’ solutions—the balance between autonomy and beneficence—to the dilemmas posed. Nevertheless, abortion advocates would now have us believe that the unborn child is not a person, and therefore not a patient separate from the mother, but merely a parasitic appendage to be cared for only with the mother’s consent. In this perspective, taking the life of the unborn is not murder. (In Illinois, charges of murder do not apply unless the child is killed after the umbilical cord is cut and full separation from the mother has occurred.)[9] Our failure as a culture to define ‘personhood’ (and hence ‘rights bearer?’) based on non-arbitrary grounds has resulted in a highly controversial, yet still flawed, definition based on convenience—one that has led to such inconceivable devaluation of life. However, while we have chosen not to grant the at-term fetus the status of independent moral agent, it is still a patient, with beneficence-based rights, like any other dependent, non-autonomous living human being.[10] Regrettably, as the focus of responsibility in obstetrical care has thus shifted solely to the mother, no advocate for the unborn child remains in circumstances where their ‘interests?’ are divergent, a fact which is morally repugnant and intuitively unjust.

Minkoff and Paltrow stated that ‘the best protection for a fetus lies in the protection of the rights of the individual best positioned and most highly motivated to defend its interests: an informed and empowered mother.’[11] Melissa Rowland was ‘informed and empowered?’ and yet unreasonable, displaying a ‘depraved indifference to human life.’ A vaginal birth in a woman with two prior cesarean sections, a twin pregnancy, oligohydramnios, fetal growth restriction, and abnormal heart patterns was certainly a choice, but not an evidence-based, medically indicated alternative by any criteria. The risk of maternal death in this situation was commensurate with, if not greater than, the maternal risk from a repeat cesarean section. Conferring the status of absolute right to maternal autonomy not only places it beyond accountability but threatens the integrity of our profession as well. As human physicians, our knowledge is imperfect, and we and our medical judgments are fallible; but they are made with prudence, without malice, and with the intent of balancing the interests of both parties, in accordance with our responsibility to ‘do no harm.’ Can we in good conscience allow our medical judgments—whether to fight to save the life of an unborn child or to sit idly by and watch it die unnecessarily—to be determined merely by the autonomous will of the mother?

As human beings, we are not independent, autonomous, self-sufficient monads but interdependent, social beings. Our existence, individually and corporately, is as dependent upon mutual responsibility as it is upon rights. We were conceived and born in the hopes, dreams, and
desires of others and are bound together by duties of care, responsibility, and compassion. Unfortunately, we have been so blinded by the tyranny of autonomy that we no longer recognize the necessity for responsibility in our choices and behaviors. Likewise, in our promotion of women’s reproductive rights, we have divorced rights from their corresponding responsibilities and neglected the fact that pregnancy is more than a right; it is a self-sacrificial responsibility, one in which a mother gives of herself that another may live.

What kind of people do we wish to be? Do we wish to live in a society founded on mutual respect and responsibility, or one ruled by the tyranny of unbridled autonomy and self-centered irresponsibility? As a profession, we are in a unique position to positively impact our culture through respect, education, and compassionate concern for all individuals entrusted to our care, born and unborn alike. Nevertheless, there will continue to be tragic individuals and situations, such as Ms. Rowland, for whom we have no reasonable recourse in the exercise of our moral and fiduciary responsibilities except legal sanctions. Yes, women should be free to make informed choices in the context of their beneficence-based responsibilities, but such freedom should not exempt them from culpability when their autonomous decisions harm others.

Endnotes


[3] Ibid., 1133.


[7] Ibid.


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