The Unkind Cut of Forced C-Sections

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In the mid 1990s, a pregnant woman in the early stages of labor was admitted to a Chicago area emergency room. It did not take long for the attending obstetrician to realize that there were serious problems with the pregnancy. He diagnosed the mother with placenta previa, a condition that would be potentially fatal for the fetus, should delivery continue naturally. He recommended an emergency C-section, which she refused, citing her religious beliefs. She was a Christian from a Pentecostal tradition who claimed she trusted God for the safe and successful delivery of her baby. The hospital went to court to get an order permitting them to perform the C-section. The ACLU defended the woman in court, citing the exercise of her religious beliefs as a fundamental right that the hospital was attempting to violate. The court ruled in the woman's favor, denying the hospital's petition to perform the C-section. The baby was delivered naturally and successfully—though not without some very anxious moments. In retrospect, since things turned out well, the press lauded the woman's courage and the court's wisdom. But what would the response of the press and public have been if the baby had died during delivery?

Forced C-sections are at the center of one of the most difficult autonomy-beneficence conflicts in bioethics. In most such conflicts, competent adults have rightly weighed autonomy more heavily than beneficence, allowing patients to make their own decisions and accept the medical consequences of those choices. Exceptions arise when one person's autonomy conflicts with the obligation of beneficence toward another who is in the decision-maker's care. In the case of children, hospitals frequently go to court to ensure that children receive the treatment they need. Generally, courts rule in favor of those who want to provide treatment, but in the case of the unborn, the decision to provide treatment for the baby requires invasive surgery on the mother, heightening the conflict between autonomy and beneficence.

There is sharp division in the obstetrics community on this issue. Physicians are understandably reluctant to allow the progress of pregnancies that they feel would jeopardize the baby's life or health. At the same time, doctors are loath to subject women forcibly and against their will to surgery that they are refusing.

For some time, obstetric practice operated on what is called a 'one patient model,' in which the pregnant woman and the baby were viewed as a single patient, analogous to the way abortion advocates argue that 'the fetus is part of the mother's body.' Under the one patient model, the fetus and the mother are seen as an organic
whole in which burdens and benefits are balanced with both mother and child in view.

With the increasing body of research recognizing the fetus as its own developing person, most OB practice is moving toward a "two patient model"—a proper shift. One of the main causes responsible for this shift is the improvement in diagnostic tools for observing the fetus. The mother is no longer the only source of the data regarding the condition of the fetus; the fetus is regarded as a patient in its own right.

Interestingly, the distribution of benefits and burdens is irrelevant when applied outside the OB setting in the two patient model. In this model, one cannot generally justify imposing risk on one patient in order to benefit another. Common examples include organ donation, bone marrow transplantation, and blood donation. These procedures cannot be forced upon a person, irrespective of the benefit to another, even if the one who would benefit is a close relative or family member. From a Christian perspective, we might say that the virtuous thing to do would be to subject oneself to the requisite risks in order to benefit another. However, to use the language of obligation or the law may be too strong. Under a strict application of this model, when treatment is indicated for the fetus and contraindicated for the mother, it would not be justified, and the C-section would be refused. Thus, what appears at first glance to be a move toward greater protection of the fetus may turn out to offer less protection.

Perhaps there is another, better way. Consider that the maternal-fetal relationship—even the relationship with one’s own child after his or her birth—is unique, qualitatively different from any other relationship. The in utero relationship is unparalleled in the reliance of the fetus upon the mother. It is not a relationship of strangers, but of total dependence. The argument that one need not undergo risks for which another benefits may not apply. It would seem that in cases in which the mother has decided to carry to term, there has been a decision either to become a parent or give up the child for adoption. In either case, the decision to go to term creates an obligation to act in the interests of the child a woman is carrying. Children in utero have a prima facie claim to be protected from injury inflicted during pregnancy. Should the mother choose not to act in the best interests of the baby, the baby has no one else to serve as its advocate.

The better way to look at this situation is to weigh the comparative risk to the fetus and to the mother. When the exercise of a liberty costs someone his or her life, life generally overrides liberty. Cases of forced C-sections can be seen as the conflict between grave risk to the fetus and moderate risk to the mother. Even the Supreme Court in Roe v. Wade admits that in the third trimester when these cases occur, the life of the fetus admits significant protection, and infringes the liberty of abortion. In addition, though the mother will most likely recover from the C-section, if the procedure is not performed the fetus most likely will not recover. Thus the degree of risk involved to the fetus and the unique relationship of mother to child in utero gives cause for caution in applying to this relationship the principle that one cannot be forced to assume risk for another’s benefit.

Valid concerns about weighing fetal interests ahead of maternal interests remain. Fetal diagnosis is not always exact. A number of anecdotal cases report initial apparent fetal distress, yet go on to describe the vaginal delivery of a healthy baby. Further, forced C-sections can foster an adversarial relationship between a woman and her physician, which may deter some women from delivering in hospitals. In addition, it may be the beginning of a slippery slope in which women will be forced to submit to fetal surgery, legal prohibitions on smoking and drinking, and the like, during pregnancy. That being said, due to the comparative risks to the baby and mother, in cases where the baby is in a clearly diagnosed life-threatening situation that cannot be managed without an emergency C-section, a hospital would be justified in going to court to secure an order to perform the surgery. If time does not allow for legal procedures and the situation is genuinely an emergency, in those rare cases in which a mother does not consent to a C-section it is justifiable to weigh the life of the baby more heavily than the risk of surgery to the mother, and perform the C-section against the will of the mother.
For example, in a well-publicized Orange County, California, case, a couple conceived a child in the hope that it would be a bone marrow match for their teenage daughter with leukemia. Great ethical concerns were raised about the consent of the donor (the conceived child) to the donation. The ethical analysis of this case was based on the two patient model, and reflects a commonly held sentiment that another cannot be asked to assume risk for the benefit of another.

Susan Mattingly states, “A woman’s failure to volunteer for fetal therapy may seriously violate her fiduciary responsibilities to the fetus, thus disqualifying her as a proxy, but the physician’s duties to her as patient remain intact.” “The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model,” Hastings Center Report 22 (1992): 16.