MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY WINTER 1984

MEDICAL ETHICS CASE CONFERENCE: ETHICAL AND LEGAL ISSUES IN A COURT ORDERED CESAREAN SECTION

The patient is a 29-year-old, Gravida II Para I African wife of a foreign graduate student who was admitted in active labor and failed to progress satisfactorily. Internal fetal monitor pattern at 5-6 cm cervical dilation revealed repetitive late decelerations. Fetal scalp blood sampling was not done. At this point an obstetrician was consulted and advised delivery by C-Section. Risks and benefits were explained to the patient. The patient refused consent, with approval of the husband. Their view was that, after returning to Africa, no facilities for repeat C-section would be available within more than a hundred miles, and they wished above all else to maintain the wife's fertility for a return to that setting. If necessary, they were willing to sacrifice the life of this infant in order for the mother to be able to deliver more children vaginally in the future. The family was also swayed by their experience with their first pregnancy, which also occurred in this community. There was failure to progress and C-section had been advised; but the wife had delivered vaginally after all.

The obstetrical staff was uncomfortable with this refusal and contacted the hospital administrator. Administration elected to contact the Circuit Court judge in order to assure that the hospital had fulfilled its legal responsibility in protecting the interests of the unborn child. The judge indicated his willingness to order a C-section over the mother's refusal if this was felt necessary to protect the infant's life. However, while this discussion was taking place, the mother suddenly progressed rapidly to the second stage of labor and vaginally delivered an infant with Apgar scores of 8/9.

Questions for Discussion:

1. Is it ethically permissible to order a woman to have a C-section over her objections? If so, under what circumstances?

2. How should treatment decisions be made for individuals whose cultural values differ markedly from U.S. norms in medical matters? If there is a major conflict between the parents' cultural norms and standard U.S. practice, and the life or health of an infant is in question, should health professionals seek to impose U.S. standards on parents from another culture, or should they serve as advocates for the parents' right to choose according to their values?

3. How much intrusion into the body and health of the mother is justifiable in order to protect the life or health of a fetus? Does it make a difference if the fetus is at term or if it is at 18 weeks gestation (an issue in experimental, in utero fetal surgery)?

Introductory comments by Howard Brody, M.D., Ph.D.

The issue of court-ordered cesarean section appears to be one of the more perplexing ethical problems to arise recently in the area of obstetrics. The case we are discussing today follows upon higher court rulings in Georgia and Colorado (see George Annas, "The Most Unkindest Cut," Hastings Center Report, June 1982), and according to rumor such cases are becoming more frequent around Michigan. Furthermore, the potential scope for such interventions will be expanded as physicians continue to perfect techniques for fetal surgery, in which defects detected by fetal ultra-sound can sometimes be corrected with surgical intervention around the 20th or 25th week of gestation; some of these interventions require surgical entry into the uterus. One can imagine similar court orders to subject women to these sorts of fetal surgery over their own objections.

The issue raises profound ethical difficulties because it is a very fundamental conflict of values. On the one hand, we wish obstetricians to recognize the fetus, and not just the pregnant woman, as a patient when it comes to management of labor and delivery. The obstetrician is praised legitimately, when he or she tries to use the latest medical technology to maximize the chances that a healthy infant will be delivered, when this can be done at reasonable risk to the health of the mother. On the other hand, we have traditionally held that one of the most basic rights, both legally and morally, is the right to be free from unconsented bodily intrusion. If not ordered by a court, c-section against the wishes of a competent woman, carried out to preserve the health of the newborn, would nevertheless constitute a tort of battery against the woman for which the surgeon would be answerable.

Let us suppose that a judge finds it ethically correct to order a c-section against the wishes of the mother--and that the obstetrician, knowing that the judge will rule this way, finds it ethically correct to make the fateful choice to involve the court system in the treatment of a reluctant patient. Based on Annas' analysis, we might ask two further questions. First, supposing that a woman had a 12-year-old child who needed a kidney transplant to survive, the mother is the best match, and medically a matched related donor kidney carries a much higher success rate than a cadaver kidney. If the mother refuses, would it be proper to order her to donate a kidney against her will? Second, suppose that a woman (presumed mentally competent) engages in some health behavior during pregnancy that is at high risk of harming the fetus (like smoking or alcohol use). Should the court incarcerate her against her will for the duration of the pregnancy to prevent this behavior? These questions may seem ridiculous on first glance. But they challenge those who would appeal to the mother's obligation to undergo some slightly increased risk to her own health, as well as loss of liberty--simply to produce the best possible health outcome for her child--to state clearly where they would draw the limits of that line of argument.

To discuss the case before us today, we are privileged to have two panelists. The first is the judge who would have had to decide the case, had it become necessary to pursue the issue all the way to a final court order. The second is a distinguished anthropologist who has extensively studied cultural beliefs regarding childbirth. In almost all cases that have arisen to date, the woman refusing c-section is a member of some religious group or subculture which holds beliefs at variance with the majority in our country. So the anthropological perspective is useful even when we are not, as we are in this case, dealing with patients whose home is halfway around the world from us.

Robert Holmes Bell, J.D., Circuit Judge, Ingham County

Let me initially preface my remarks by making two observations. First, a situation similar to this would normally be brought before a Probate Judge whose jurisdiction extends to child neglect or abuse cases. My participation as a Circuit Judge was due to the unavailability of a Probate Judge on short notice. The time for reflection, analytical thought and consultation both with research attorneys and legal treatises was lacking. Secondly, a court order per se was never issued. Rather, it was a conversation with the particular doctor and hospital personnel in which the doctor made known the facts and circumstances which then existed. He was questioned by me as to what his best medical judgment assessed as the procedure for saving the life of the fetus and alleviating additional stress upon the mother.

Initially, the issue of nonconsensual operative procedures raises the question whether the health professional has committed a legal assault and battery (i.e. Can the patient claim an unconsented bodily invasion?). Probably the clearest examination of this issue is where the surgeon, while operating, encounters an additional or different situation than originally anticipated. Certainly, common sense and medical wisdom dictate that he not "sew up" the patient, secure a new consent and reoperate. The initial consent for the specific operative procedure carries with it the explicit consent for any other necessary procedures encountered in the surgery. So, non-consent is not equated with an assault and battery.

Procedurally, a patient entrusts himself or herself to the health care professional for a specific medical result. The methodology for performing the end result will normally be selected by the health care professional. Therefore, we must clearly focus, in a medical emergency such as the one here at issue, on the desired end result sought. Is it the delivery of a medically health baby? If so, is the methodology of delivery of that baby, then, left to the health care professional?

If the patient retains the right to dictate his or her care, including the methodology or procedure of care, what happens when it conflicts with the professional judgment of the health care professional? The doctor is held to the legal standard of duty to exercise the degree of skill and learning ordinarily possessed and exercised under similar circumstances by other members of the profession in good standing. I would submit, then, that the doctor's (for example) legal duty should prevail over that of the patient's --particularly where the patient's demands are medically unthinkable, unreasonable and irrational.

What, then, are the woman's rights to dictate a procedure which under extenuating medical circumstances will jeopardize the life of a full-term fetus? The famous United States Supreme Court abortion case of Roe v Wade indicated that in the last trimester of pregnancy the "state" had a "strong, compelling interest" in protecting a viable fetus. Therefore, the mother's right of decision will be weighed against the rights of the unborn during this period to create three interests; mother's, child's and state's. By analogy, we can observe the state's interests in preserving life in children when observing that in the Jehovah's Witness blood transfusion cases, the state ordered the transfusions of blood into children of non-consenting parents. The full-term fetus, I submit, has the right to life which the state must fully accord, just as in the blood transfusion cases.

This case is even more complicated when we understand that while the risk of fetal life was represented to be lessened by cesarean surgery, the risk to life or health of the mother was increased by the same surgical procedure. Thus,

relief of stress on the child increased stress on the mother. It will be incumbent upon the health care professional to assimilate as much data from the various personnel, monitoring devices and patient history as is possible in the short amount of time allotted. This documented information and the health care professional's good judgment will dictate whether the cesarean should be performed. Although this result may appear to you to be shockingly invasive, the law would look at the medical decision supported by the facts then known--not what happened after the fact.

The case before us raises the cultural question of those persons whose cultural values, even of life, differ from those of this Western culture. I believe this is a non-issue. A double standard of medical practice cannot exist. The specter of havoc, malpractice lawsuits and tragic medical results insist that only one medical standard of care be employed. We may better be concerning ourselves with more informed medical consent and psychological assistance in these situations.

Lastly, is there a universal ethic which has ready application to the health care professional faced with a situation similar, legally and ethically, to the one before us? It appears in our Western culture, we hold a distinctive value of life which dictates that our paramount concern is the preservation of life. This should be our guiding principle to be weighed against cultural differences, religious differences and seemingly unreasonable and illogical refusal to follow the health care professional's advice.

Brigitte Jordan, Ph.D., Department of Anthropology, MSU
This case raises several significant issues. Some of them have to do with the particular situation of this couple, namely, that they come from a different culture. One might want to ask, for example, what jurisdiction our legal system has over persons who are not citizens of this country. Can everything that is legally sanctioned for citizens of a country be applied to aliens? Consider, for example, the following case. Suppose that an American citizen travels to China, six months pregnant with her third child. In China, where overpopulation is a matter of grave social and legal concern, once a citizen has exceeded the state limit on the number of children permitted per family, state-initiated abortions are legally sanctioned. Does this mean that the Chinese can then legally coerce an American citizen to have an unwanted abortion? There are questions of the medical management of this case, including the possibility that the acute anxiety generated by the negotiations about the cesarean section contributed to arrest of labor and fetal distress (Sosa et al. 1980). And there are further questions about how compelling the evidence was for recommending a section (Banta and Thacker 1979). But I think that there are also other questions which transcend the special circumstances of this case and speak to much larger issues. I will begin by discussing some of the crosscultural considerations, which will lead up to what I believe to be the central issue here, namely, the nature of informed consent.

A basic question, which I am sure has occurred to everybody who has considered this case, is the question of crosscultural communication. By that I mean not only language difficulties (which I understand were not a problem in this particular case) but the larger issue of cultural differences in the meanings imputed to objects, persons and events. What, for example, does the fetus represent to persons from another culture? Now I don't know what the belief system of this particular Nigerian couple is. Nevertheless, we might consider that there are societies, particularly in Africa and Australia, where the fetus has a very different status than it has in our society (Ford 1964). For example, in some of these other societies, the fetus is in some sense immortal. It exists as a spirit before it takes up residence in the mother's womb and if it should "die" (in our sense), it will return to the spirit realm. The

woman's pregnancy, then, is a way for the spirit to try out whether or not it wants to be born as a human being. It may well decide not to, conditions may not be right for it, and in that case it will simply try again some other time. Now an ancestor spirit ready to be incarnated is something quite different from our view of the fetus/baby as an individual. And for parents who subscribe to this sort of belief system what we call "fetal death" is not the same sort of event for them as it would be for us. It is not that a baby has died, but rather that a spirit has made an unsuccessful try. Although this will be a sad event, there is no "death" in our sense. So communication that speaks about the potential death of the baby will have for them a different meaning than it does for us.

But even assuming that the fetus has the same sort of status for this couple (and for other couples like them) as it does for us, what might it mean for this woman to have a section? In our society, though there are certainly some negative aspects, a section is not a dreadful disaster anymore. It even has some positive valences attached to it. The scar of honor. The convenience. The civilized status as compared to women who just "drop" their babies. The sick role. And so on. We have no idea, on the other hand, of what this kind of surgery may mean to a Nigerian woman and her family. Not being able to fulfill her normal function as a woman may certify her, for all to know, for all to see, as not properly female, not an appropriate mother, not an acceptable wife. Her husband may divorce her or take a second wife. It could certainly have a powerful influence on her status within her family and community when she returns. And it is my hunch that considerations of this sort would be more important to this couple than the issue of the unavailability of facilities for repeat sections. One might also want to consider what the possibility of death in childbirth might mean, which for us is so remote as to be almost irrelevant. Among some tribes in West Africa, death during childbirth is considered to be a terrible, shameful disgrace, one that causes the woman to be ridiculed even after her death and to be ritually expelled from the community not only of the living but also of the dead. (Ford 1964). This prospect alone, which is certainly more in the forefront with surgery than with a normal vaginal delivery, could explain the couple's adamant refusal to have a section.

But I believe that it would be a mistake to see the central issue in this case as crosscultural miscommunication. It may well be that the most important question lies in the area of informed consent.

Now I take it to be self-evident that informed consent has to include the possibility of informed refusal (Hahn 1982). In other words, some decision-making power must reside in the patient in order to speak meaningfully of informed consent. Otherwise, the patient is simply certifying that he/she has been informed about what is going to be done to them. In this particular case, from the little information available to us, it appears that providers made every effort to inform the couple, who seemed to understand what they were told, and after weighing this information decided (for whatever reasons) that they did not want the section. What we have here then is a two-way communication process which acknowledges that patients have the right to either consent to or to refuse the suggested course of action. The outcome of this exchange may not be to the liking of, or in accordance with, the professional judgment of the providers, as one would imagine it wasn't in this particular case. Nevertheless, the process of requesting consent implies that a refusal will be respected. And there is every indication that honoring the decision was the intention of the providers. Now, my understanding of what happened in the case under discussion here is that a third party became involved. Administration, by taking steps to obtain a court order for a section, negated the privileged negotiation process between patient and provider, by in effect

attempting to make sure that only one kind of outcome would obtain, namely, the section. This raises a number of significant questions: First, who are the appropriate parties to the consent/refusal negotiation? Is it physicians and patients? Or are there others who can override their decision? Secondly, if the physicians involved honor the contract and refuse to do a section, is this third party entitled to override not only the patient's refusal but also the physicians' decision to abide by the agreement? In other words, could the administration also get a court order to force the physicians to perform surgery?

I believe that it is issues of this sort that lie below the exotic surface issues having to do with the rights of patients from a different culture. These inevitably reflect back on our own cultural notions about what is right and what is wrong. In the end, the chickens tend to come home to roost.

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KALAMAZOO CHM MEDICAL ETHICS CONFERENCE, by Shirley Bach

On February 11, a half-day conference on medical ethics was held for the 3rd and 4th-year CHM students at the Kalamazoo campus. Participants from the Medical Humanities Program were Shirley Bach, Ph.D., Visiting MHP Professor and MHP Assistant Directors Howard Brody, M.D., Ph.D., Bruce Miller, Ph.D., and Kenneth Howe, M.A. Joining in the discussion of ethical issues in decisions to extend or withdraw life support was CHM graduate (74) Dr. James Carter, Associate Professor, CHM (as of July 1984) who discussed the reasoning he uses in deciding whether or not to write a "no code" order for a particular patient. The first half of the conference focused on the various senses in which patient autonomy can be understood, the clinical assessment of patient autonomy, the involvement of the family in clinical decision making, and the recommendations of the President's Commission for the Study of Ethical Problems in Medicine regarding treatment decisions for the patient with reduced capacity to participate in his or her own decisions. In addition, there was discussion concerning the recent article by Clements and Sider (JAMA, October 1983) which might be seen as a kind of "backlash" to the growing acceptance of the centrality of the autonomy principle in medical decision making. The second half of the meeting consisted of small group discussions of the possible sources, and possible ways to prevent the destructive effects, of the cynicism which tends to develop in medical students when they enter their clinical years. Participating in the discussions were Ms. Diane Cornelius, Adjunct Instructor, CHM, Dr. Robert Nicholson, Professor, CHM, and Dr. Van Keder, a Kalamazoo area physician.

TEACHER-SCHOLAR AWARD FOR DR. BRODY

Howard Brody, M.D., Ph.D., Assistant Coordinator of the Medical Humanities Program and Assistant Professor in the Departments of Family Practice and Philosophy, was the recipient of one of six Teacher-Scholar Awards awarded this year at MSU for devotion and skill in undergraduate teaching. Nominations for Teacher-Scholar Awards are based primarily on undergraduate teaching and are limited to instructors or assistant professors who have served on the faculty for at least three terms, but not more than five academic years. Nominations are submitted to college committees, which then forward not more than two nominations to the University Awards Committee. This committee of faculty and students appointed by the Provost makes the final selection. The MSU News Bulletin (March 1, 1984) says of Dr. Brody that he "is a superb lecturer and a physician who has bridged the road between science and philosophy. His two books and numerous articles have earned him a national reputation." The award, which carries with it a $1500 grant, was presented on March 5 at the University's annual Awards Convocation. Funds to support the awards program, which includes Distinguished Faculty Awards for senior faculty members and Excellence-in Teaching Citations for graduate assistants, are provided by alumni through the MSU Development Fund. In recent years, the Amoco Foundation, Inc. has contributed funds to support the Teacher-Scholar Awards program.

MEDICAL/NURSING ETHICS JOURNAL CLUB ACTIVITIES

The November meeting of the Medical/Nursing Ethics Journal Club was devoted to a manuscript on primary care ethics by Larry Churchill and Alan Cross of the University of North Carolina. The group was not totally complimentary in their criticisms of the paper; and as had been promised when they agreed to make their manuscript available for our review, Churchill and Cross received a detailed summary of the criticisms and suggestions.

Dr. Churchill has written back to express his thanks for the critique: "It did us a great service by indicating where we had been misunderstood and needed to clarify or simplify our points...Unfiltered criticism is usually the most helpful, so we do appreciate the time you took to give us an unwashed appraisal and sense of the group."

The Journal Club continues to meet every first Wednesday of the month at 7:30 p.m. Please contact the Medical Humanities office, 355-7550, for details.

THE MEDICAL HUMANITIES PROGRAM IN GRAND RAPIDS

A priority of this final year of the grant to integrate ethics into the medical curricula has been to provide ethics instruction in the third and fourth years for CHM students. Ken Howe and Bruce Miller met with Grand Rapids Assistant Dean, Robert Richards and the Clerkship Directors, Dr. Donald Waterman (Pediatrics) and Dr. Robert D. Johnson (Medicine). This resulted in Ken and Bruce meeting with the medicine students on January 27. The students were asked to submit cases in advance; two were selected for discussion. The students had had exposure to medical ethics issues in their first and second years. It was gratifying to note their awareness of, and ability, to address ethical issues. On February 14, Ken and Bruce spent most of the day in Grand Rapids with the Pediatric service. There were presentations and discussions at grand rounds and at meetings with residents and students of the new DHHS regulations regarding treatment for seriously ill newborns. The response reported by Dr. Waterman was very favorable. A regular schedule will be set up in Grand Rapids to further develop medical ethics in years three and four.

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