Title: Discuss the ethical issues which arise when a pregnant woman refuses consent for caesarean section.

Abstract:
A pregnant woman’s refusal of consent for caesarean section presents a unique ethical dilemma. Her pregnant state means the decision impacts on not one but two entities; herself and the fetus. Irish law differs fundamentally from other jurisdictions as the right to life of the unborn is protected under Article 40.3.3° of the Irish Constitution. This has profound ramifications for how such a case might be dealt with in an Irish setting as the central ethical question becomes how to balance and reconcile the rights of the woman as an autonomous individual with the unborn’s constitutional right to life (Mills, 2007). Though this dilemma has not yet been encountered in Ireland, a number of cases heard in the USA and UK present key lessons and give some indication as to how an Irish court might respond (Madden, 2011). This paper uses Beauchamp & Childress’s (2009) four principles framework to examine ethical issues concerning the woman’s autonomy, fetal rights, maternal competence and the impact on other stakeholders, particularly the healthcare team, when an adult pregnant woman’s consent for caesarean section is withheld. In its analysis, this essay invokes differing viewpoints from critical writings and considers relevant Irish and international cases. A primary consideration is the woman’s autonomous right to make decisions about her body, a right enshrined internationally in The Universal Declaration of Human Rights (1948) and domestically under Article 40.3.1° of the Irish Constitution. Furthermore, refusal of treatment is legitimised by articles 3 and 8 of the European Convention on Human Rights (Wicks, 2001) and recognised as an articulation of autonomy and a legal right by Irish courts (Dooley & MacCarthy, 2005). As such, were the surgical team to proceed with the caesarean without the woman’s consent they could be accused of trespass, assault or battery (Jackson, 2010). However, the crux of the matter lies in deciding whether maternal autonomy is subordinate to the fetus’s right to life. In Ireland Attorney General v X (1992) highlighted for the first time contentious issues that arise when maternal and fetal rights are seemingly juxtaposed (Casey, 2000). While this case did not concern caesarean-section it bears relevance, though critics remain divided in their interpretations. In jurisdictions where the fetus is not accorded rights, courts have
ruled a competent woman may refuse treatment, even if this causes fetal death. However, in Ireland the unborn’s status means a balancing of rights would be necessary (O’Donoghue, 2004). How to strike this balance, however, remains elusive.

While the scenario discussed remains hypothetical in Ireland, it is perhaps a matter of time before this very real predicament arises. This paper concludes the issue raises complex ethical questions for which straightforward answers cannot be given under Irish law as it currently stands (Mills, 2007). What emerges is a sense of uncertainty for health professionals and a realisation of the potential vulnerability of Irish pregnant women who refuse consent for caesarean. Thus clear guidance is needed on the matter from both the courts and professional bodies (Sheikh & Cusack, 2001).
Introduction

A pregnant woman’s refusal of consent for caesarean section presents a unique ethical dilemma. Unlike other situations where patient consent to treatment is withheld, the woman’s pregnant state means her decision impacts on not one but two entities; herself and the fetus. The degree to which this is of value, both ethically and legally, is rooted in the moral and legal status of the fetus (Scott, 2000). From a moral perspective, viewpoints vary regarding the point at which the fetus attains viability, personhood and if or when it should be accorded rights (Kluge, 1988). The legal perspective is more defined, with Irish law differing fundamentally from other jurisdictions as the right to life of the unborn is protected under Article 40.3.3° of the Irish Constitution (Madden, 2011). This has profound ramifications for how such a case might be dealt with in an Irish setting as, if the indication for caesarean is to save the fetus, the central ethical question becomes how to balance and reconcile the rights of the woman as an autonomous individual with the unborn’s constitutional right to life (Mills, 2007). Though this dilemma has not yet been encountered in Ireland, a number of cases heard in the USA and UK present key lessons and perhaps give some indication as to how an Irish court might respond (Madden, 2011).

This essay will use Beauchamp & Childress’s (2009) four principles framework to examine ethical issues concerning the woman’s autonomy, fetal rights, maternal competence and the impact on other stakeholders, particularly the healthcare team, when an adult pregnant woman’s consent for caesarean section is withheld. This analysis will invoke differing viewpoints from critical writings and consider relevant Irish and international cases.

Maternal Autonomy and Refusal of Treatment

A primary consideration is the woman’s autonomous right to make decisions about her body, a right enshrined internationally in The Universal Declaration of Human Rights (UN, 1948) and domestically under Article 40.3.1° of the Irish Constitution (Donnelly 2002). While Beauchamp & Childress (2009) describe autonomy as self-rule, others define it in terms of agency and self-determination (Mills, 2007). Though a prima facie obligation, autonomy might be overridden in this circumstance, a
possibility that prompts disagreement among critics (Haak, 2005). Gillon (2003) argues autonomy should invariably trump other principles, whereas Glick (2000, p.395) counter-argues the case for beneficence, stating “autonomy is of no value to a dead person.” Thus if the caesarean was indicated to save both woman and fetus, Glick (2000) asserts allowing the woman to end her life would honour her short-term autonomy whilst deny it in the long-term.

From a legal perspective, refusal of treatment is legitimised by articles 3 and 8 of the European Convention on Human Rights (Wicks, 2001) and recognised as an articulation of autonomy and a legal right by Irish courts (Dooley & MacCarthy, 2005). In Re a Ward of Court (1996) Justice O’Flaherty stated a competent individual may refuse treatment even if this causes their death, while Denham J, echoing Re T (1992), added such refusal could be based on rational or irrational reasons, none of which necessitate approval. Though the unborn’s rights were not a consideration in the case, such comments demonstrate how highly self-determination and bodily integrity are valued under Irish law. As such, were the surgical team to proceed with the caesarean without the woman’s consent they could be accused of trespass, assault or battery (Jackson, 2010, Donnelly, 2002).

The situation described creates tension between autonomy and non-maleficence (Madden, 2011). On one hand, respect for autonomy demands the woman’s wishes be upheld. On the other, healthcare professionals may feel duty-bound to act in the spirit of non-maleficence and/or beneficence by providing life-saving treatment. In an Irish context, the principle of non-maleficence may be invoked by the state in protecting the ‘unborn’.

The healthcare team thus face a complex ethical quandary. Whilst the obstetrician may beneficently consider surgery the best course of action, to enforce treatment on the basis of best intentions would be acting paternalistically (Cahill, 1999). The medical team may also find professional codes fall short in providing specific guidance (Sheikh & Cusack, 2001). While the IMC (2008) advises doctors act in patient’s best interests, it is unclear how this may be achieved if the interests of two interconnected patients diverge. The midwife must also grapple with dual responsibilities (Dann, 2007). While ABA (2000, p.7) instructs midwives to ‘preserve life born and unborn,’ elsewhere it stipulates they must act as advocates for women
(ABA, 2001). Furthermore, the midwife must be cognisant her advocacy role is not stated in law (McHale, 2007) and in fulfilling it she may encounter professional conflict (Rowan, 1998). While striking a balancing-act between perceived duties, the midwife may struggle with her moral views if they run contrary to the maternal decision (Draper, 2004). However as Burrows (2001) rightly concludes, health professionals must remain impartial and objective, for if their clinical judgement is influenced by individual perspectives on right and wrong, then their practice is neither safe nor ethical.

Presuming the caesarean is an emergency, an added challenge for carers lies in ensuring ethical principles are upheld despite time-pressures. According to Meredith (2005), Re AC (1990) and Rochdale Healthcare Trust v C (1997) demonstrate how a woman’s autonomy may be undermined by hurried applications and hearings performed hastily without appropriate legal representation for the woman. As part of the team, the midwife must facilitate as full a discussion as possible, ensuring the woman’s voice is heard and she has legal counsel. Considering time-restrictions, Draper (2004) wonders whether midwives have an ethical responsibility to prepare women antenatally for possible emergencies. This solution may pose problems as it is impossible to predict the emergency’s context, which heavily influences decision-making.

Aside from the healthcare-team, ‘society’ could be considered a stakeholder with a vested interest in preserving life and preventing harm to potential citizens (Bewley, 2002). Expanding on this concept, Campbell (2003) questions whether an individual’s autonomy should be sacrificed if they are sole provider for their children. Applying the argument to this case, one might consider whether the state would enforce surgery in an act of non-maleficence to protect the woman’s reliant offspring.

In weighing-up principles the situational context requires ‘specification’ (Beauchamp & Childress, 2009). A court may examine inter alia the rationale for surgery, the woman’s reasons for refusal, her mental competence (for further discussion in due course) and the threat to her life as opposed to health (Sheikh & Cusack, 2001), also establishing her decision was informed and free from undue influence (GMC, 2008).
The Right to Life of the Unborn

From an ethical and legal viewpoint, the crux of the matter lies in deciding whether maternal autonomy is subordinate to the fetus’s right to life; protected and held equal to the mother’s right to life under the eighth amendment of Article 40.3.3° (Madden, 2011).

In jurisdictions where the fetus is not accorded rights, courts have ruled a competent woman may refuse treatment, even if this causes fetal death. This was demonstrated in England by _St George’s Healthcare NHS Trust, R v Collins and others, ex parte S_ (1998) and by _Re AC_ (1990) in America. However, in Ireland the unborn’s status means a court would view the situation very differently. Harmonising maternal and fetal rights would be seemingly impossible, so a balancing or hierarchy of rights would be necessary (O’Donoghue, 2004). How to strike this balance remains elusive, though Kluge’s (1988) opinion is the more ‘fundamental’ right should outweigh the less ‘fundamental’, hence the right to life should prevail. However Mills (2007) concludes there is a lack of legislation clarifying what ‘equal’ constitutional rights means. The ECHR provides little illumination, having ruled in _Paton v UK_ (1980) that Article 2(1) concerning the right to life is inapplicable to the fetus (Thorpe, 2000).

In Ireland _Attorney General v X_ (1992) highlighted for the first time contentious issues that arise when maternal and fetal rights are seemingly juxtaposed (Casey, 2000). While the Supreme Court permitted abortion if a real and substantial risk to the mother’s life existed, Judge Hederman J stated maternal autonomy should never be prioritised over the unborn’s right to life (Madden, 2011). While this case did not concern caesarean-section it bears relevance, though critics remain divided in their interpretations. Sheikh (2004) argues the ‘X-case’ demonstrates an Irish court would override maternal autonomy, enforcing c-section to save the fetus unless the woman’s life (as opposed to health) was jeopardised. Madden’s (2011) analysis is less conclusive; instead suggesting the case reveals legislative flexibility. She posits if considered alongside the defence of autonomy displayed in _Re a Ward of Court_ (1996), as well as the resistance to state intervention in parental decisions demonstrated by _North Western Health Board v W.(H.)_ (2001), a court may not necessarily order the caesarean. Reinforcing this ambiguity, Denham J in _Re a Ward_...
of Court highlighted the constitutional right to life must be defended ‘as far as is practicable’ implying there may be instances where it cannot be protected.

Complicating the issue further, as identified in A, B & C v Ireland (2010) there is no legislation outlining what constitutes a ‘real and substantial risk’ to the mother’s life, an important point as the relative risk of maternal mortality posed by c-section must be weighed in the balance (Hewson, 2004). Confusion also surrounds whether the woman could be found guilty of negligence/murder if the fetus died due to her refusal, a predicament encountered in the Melissa Rowland case (Meredith, 2005). Such a situation could have major implications for women’s autonomy and civil liberty (Maclean, 1999).

Aside from the legal perspective, the debate’s moral dimension warrants exploration. Thomson (1971) argued that although the fetus may have a right to life, its right to use the woman’s body depends on her permission. Alternatively Scott (2000) pondered whether a woman has a moral obligation to protect the fetus if the pregnancy was voluntary. In opposition, Savage (2002) contests a person cannot be compelled to undergo organ-donation surgery for a relative (as illustrated by McFall v Shimp, 1978) therefore the woman cannot be forced into surgery for the fetus. These multiple perspectives further highlight the issue’s complexity, reinforcing the need for health-professionals to remain impartial.

The Question of Competence

The woman’s autonomous refusal of caesarean may be overridden if she lacks mental capacity to make that decision (Mills, 2007). This is an important ethical consideration, for her incompetence would allow an Irish court to enforce surgery in accordance with the fetus’s rights (as outlined) and her next-of-kin/spouse could not act on her behalf (Sheikh & Cusack, 2001). In other jurisdictions where the fetus is not constitutionally protected, incompetence has formed the basis of decisions to sanction c-sections (as in Re MB, 1997). Critics have subsequently claimed incapacity has been used to prevent fetal death and adhere to perceived medical expertise (Meredith, 2005). Furthermore, in Ireland it could allow the balancing-of-rights issue to be somewhat side-stepped. While Fovargue & Miola (1998) argue
pregnant women risk becoming a subsection of incompetent individuals, Justice Thorpe (2000) states incompetence verdicts facilitated judges in securing “the wellbeing of the child on the threshold.” This suggests in some cases judicial beneficence undermined maternal autonomy and even threatened the principle of justice, an assertion libertarian critics would consider alarming.

In Ireland Fitzpatrick and Another v K and Another (2008) dealt with capacity-assessment and treatment refusal (Madden, 2011). Echoing Re C (1994), maternal capacity to understand, weigh-up and apply information to the decision was evaluated. While the IMC (2008) and LRC (2006) support this functional approach, the ethical soundness of such assessments has been queried. Maclean (1999) criticises the Re C test’s subjectivity while White (2004) and Jackson (2010) suggest capacity-assessments enable paternalism, as initial evaluations are frequently performed by the doctor advocating the caesarean. Of further concern is how labour may be judged to impair competence (Meredith, 2005). In Fitzpatrick and Another v K and Another (2008) and Rochdale Healthcare (NHS) Trust v C (1997) pain, medication and exhaustion were deemed to have eroded maternal capacity. However the majority of labouring women experience these phenomena with widely varying effects (Brazier, 1997).

In light of these arguments and according to Irish law, the woman’s capacity cannot be queried because her refusal is perceived unwise (Madden, 2011). Furthermore, in accordance with the Mental Capacity Bill (2008) she must be presumed competent until proven otherwise.

**Conclusion**

While the scenario discussed remains hypothetical in Ireland, it is perhaps a matter of time before this very real predicament arises. Article 40.3.3° complicates the issue, raising complex ethical questions for which straightforward answers cannot be given under Irish law as it currently stands (Mills, 2007). While health professionals would grapple with seemingly conflicting duties, courts would face the challenge of carefully balancing rights. This analysis reveals a sense of uncertainty for health professionals and a realisation of the potential vulnerability of Irish pregnant women.
who refuse consent for caesarean. While clear guidance is needed on the matter from both the courts and professional bodies (Sheikh & Cusack, 2001), in the meantime the midwife must, armed with a knowledge of the legal situation, work non-judgmentally with both the woman and the medical team to secure the best possible outcome for all parties.
References


Fitzpatrick and Another v K and Another [2008] IEHC 104.


Paton v United Kingdom [1980] 3 EHRR 408.

Re a ward of court (withholding medical treatment) [1996] 2 IR 79.


Re C (adult: refusal of treatment) [1994] 1 All ER 819.


Re T (an adult: refusal of treatment) [1992] 4 All ER 649.


*St George’s Healthcare NHS Trust, R v Collins and others, ex p S* [1998] 2 FLR 728.


