Case Commentary

Case: Jane is a twenty-seven year old woman who is thirty-six weeks pregnant with her third child. Jane lives with her partner Tom and two daughters on a lifestyle block thirty kilometres from the hospital. Her first two children were born by normal vaginal delivery. Jane has a family history of mental illness, with her mother diagnosed with paranoid psychosis which is currently well controlled. Previously there have been some concerns over Jane's mental health with a couple of episodes when the community psychiatric team were involved, but no diagnosis was made or treatment commenced. She has also suffered a paranoid episode following drug use and she had severe post-natal depression following her first child. At twenty-eight weeks in this pregnancy, Jane had a small antepartum haemorrhage and she was referred to an obstetrician by her midwife. A grade three (plus) placenta praevia was diagnosed by an ultrasound scan. The obstetrician has advised that Jane should move into hospital in case she has a further bleed. He also recommended that the baby be delivered at thirty-eight weeks by c-section if there was no improvement in the position of the placenta. Jane does not want to move into hospital and does not want to have a c-section, she tells everyone to just leave her alone.

Commentary One

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Introduction

The case of Jane illustrates not only the potential dangers to herself but also the possibility of loss to the family and the sometimes underestimated trauma and stress to her attending physicians. In this pregnancy, there are significant obstetric risk factors which may or may not be present at the time of delivery. I will briefly discuss the conventional management plan that is normally proposed to such a patient and it would also be pertinent to talk a little about contingency plans should the management plan not be adhered to.

Obstetric Risk Factors and Conventional Management

Jane has a history of drug taking which may pose a problem for the baby's growth. This necessitates serial ultrasound scans and Doppler flow measurements in the umbilical artery. She also has a history of psychiatric problems, which have implications for the baby, and the social worker and psychiatrist need to be involved early on in the pregnancy. The main problem presently seems to be the antepartum haemorrhage as a result of placenta praevia. This is potentially life threatening, and the careful management of admission to hospital and caesarean section at thirty-eight weeks if there is persistent placenta praevia is crucial for the safety of mother and baby.

Contingency Plans and the Ethical Issues

The most vexing problem for any caregiver in this position is that the patient is refusing the above conventional management plan. In all this it is important to remember respect for autonomy. Respect for autonomy, a central principle of medical and obstetric ethics, obliges the physician to acknowledge and respect the patients' values, to elicit patients' preferences, and in the absence of compelling constraints to implement these preferences. Unfortunately in this case there is compelling evidence for the conventional treatment. If there is resistance from the patient, I would seek the assistance of the people whom she trusts and has known for a long time, i.e. her midwife/GP. Getting the family's opinion is also important and this includes not only the partner but also parents if they are close to the family. The patient refusing conventional treatment obliges us to re-examine the issue – the best case scenario would be a normal birth because the placenta has migrated up; in this instance the patient could perhaps be persuaded by her partner and others to have another ultrasound scan. If this shows the placenta to be now normally situated, then she could certainly have a normal delivery.

If she does not have an ultrasound scan then we have to assume that there is placenta praevia and renew our efforts to have a conference with the patient and partner and GP/midwife to explain the dangers of labouring at home with the real danger of a maternal mortality. I think that in the worst case scenario there should be an air ambulance standing by, and at the first sign of bleeding, fresh appeals should be made to the woman about going to hospital. In desperate situations the baby has been used as

a tamponade to prevent bleeding but this is not recommended.

If the partner and family are willing and feel that the woman is not capable mentally of making these decisions, then the individual merits of treatment may have to be decided by the courts. This may be a desperate measure to save her life and that of her unborn child.

Commentary Two

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The International Confederation of Midwives Code of Ethics states:

> Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting their health and that of their family.[1]

The New Zealand College of Midwives Code of Ethics states:

> Midwives accept the right of each woman to control her pregnancy and birthing experience.[2]

Both codes also state that:

> Midwives accept that the woman is responsible for decisions which affect herself, her baby and her family/whanau.

Underpinning this ethical construct is of course each woman's right to *informed* choice and consent throughout her childbirth experience. Without appropriate knowledge upon which to make decisions a woman is unlikely or unable to safely participate in the decision making process.

It is essential therefore that the midwife involved in Jane's case has current and appropriate information to share with her before any actions are taken.

Providing Jane with further information, outlining her options and giving her time to consider may bring her to another decision. Another scan to confirm the position of the placenta is indicated as diagnosis was made at twenty-eight weeks gestation before the lower segment of the uterus is fully formed and normally it can be expected that the placenta may change its position.

Jane does have options other than hospitalisation at thirty-six weeks gestation as current research supports outpatient management as safe and appropriate irrespective of degree of praevia.[1] The history of one antenatal bleed does not indicate the degree of praevia or likely outcome. Outcomes are however highly variable and cannot be confidently predicted and Jane needs to understand that there are significant risks for both her and her baby. Her situation is also complicated by her distance from hospital and emergency services. However in terms of time this may not be any different for a woman living in a busy city with traffic congestion. Jane may have relatives or friends in town with whom she could stay if hospital stay is not possible for her.

While Jane's mental health history serves as an alerting factor it is not a basis for excluding her from making her own decisions or taking responsibility for her actions. Her reaction to her diagnosis and advice may be simply an indication of resistance to loss of control. The midwife's role here is as both a confidante and an information giver. Involving Jane and her husband Tom in a discussion which honours and accommodates her viewpoint is necessary to gain her trust and reestablish her sense of control over her life. This may be a useful place to invite Jane to consider talking to the community psychiatric team for support. The midwife can also advocate for Jane at a meeting with the obstetrician.

If Jane's position remains unchanged the midwife then defines her own practice boundaries. If unable to support Jane's decisions the midwife may choose to withdraw but she must do this in a timely and structured manner. That the midwife's beliefs 'should not deprive any woman of essential health care' is a worldwide ethical stance. Consequently the onus is on the midwife to explain her withdrawal and to assist Jane to find alternative caregivers or arrangements. The dilemma arises when there is no alternative. All health professionals in this situation act in accordance with their ethical codes when they are obliged to attend if summoned in an emergency.

The midwife may however feel she still has a duty of care that goes beyond her professional disquiet. She may feel her continued involvement is ethically sound and that her presence will help diminish any possible harm and could do some good. Indeed planning her involvement under these circumstances may be preferable to being called into an established emergency. The midwife is likely to explain to Jane that her continued involvemnet would extend to alerting all emergency and secondary care facilities that Jane will soon be giving birth.

In both cases the midwife must document all discussions and decisions.

Notes

1 Love, C.B.D., Wallace, E.M. *British Journal of Obstetrics and Gynaecology*, 103 (9), Sept 1996, 864-7.

Commentary Three

Refusal of Treatment, Mental Illness and Incompetency

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In an article written for *Ethics and Perinatology*, Ruth Macklin says that some pregnant women are found incompetent to make medical decisions on the basis of merely refusing medical or surgical interventions such as caesarean sections.[1] In Jane's case, if the position of the placenta does not shift and her refusal of treatment continues, there is a chance that she could be forced to undergo treatment and surgery. This forced treatment occurs as a result of the political, theoretical and structural institutionalisation of medicine, especially in areas of pregnancy and childbirth. Through the institutionalisation of medicine, bodies have become normalised, pathologised and centralised, contributing to women's oppression through loss of power and control over routine bodily function. As foetal medicine and technologies advance, the foetus also becomes viewed as a patient and attains rights to medical intervention. The body of the pregnant woman is often seen as a mere foetal container and can even become invisible to the medical establishment.[2]

A good example of a ruling of incompetency due to refusal of treatment is found in a recent English High Court case where the court authorised a compulsory caesarean section on a pregnant woman by finding her mentally incompetent under the Mental Health Act 1983.[3] *S* refused to undergo a caesarean section because she wanted to give birth to her child naturally in a barn in Wales. Due to this refusal, *S* was detained under the Act 'for assessment' and was found to lack the capacity to make medical decisions for herself and on behalf of her distressed foetus. Four days after the caesarean section was performed *S* was found to have no evidence of mental illness and was discharged from the hospital. The diagnosis of incompetency was used to detain and treat her physical condition rather than any mental disorder she may have had.[4]

In Jane's case, no diagnoses was made or medical treatment commenced during her episodes with the community psychiatric team so she is presently considered competent to make medical decisions. In New Zealand, a competent adult has a legally protected right to refuse medical treatment under Section 11 of the New Zealand Bill of Rights Act 1990 and Right 7(7) of the Code of Health and Disability Services Consumers' Rights 1996. Overruling a competent patient's right to refuse a caesarean section would result in an 'offence against the person' and could result in criminal prosecution under the New Zealand Crimes Act 1961.[5]

Before dismissing Jane's case as one involving a competent adult refusing medical intervention it is necessary to determine her reasons for refusing this treatment. According to Macklin, women refuse caesarean sections on religious grounds, for fear of operations, needles or hospitals, or for other reasons – some rational, others irrational.[6] In Jane's case, employing narrative ethics to tease out her story and reasons she may have for refusing hospitalisation and treatment may be one method of remedying the problem or determining whether she is, in fact, competent to make medical decisions. But it is important to remember that until Jane is found to lack the capacity to refuse medical interventions, the obstetrician must respect her wishes, as a competent adult, to control her body by deciding whether to undergo medical treatments or surgeries.

Notes

1. Macklin, R . 'Maternal-Fetal Conflict II'. In *Ethics and Perinatology.* Edited by Amnon Goldworth, William Silverman, David K. Stevenson and Ernle W.D. Young. 1995. New York: Oxford University Press, 33.
2. Purdy, L.M. 'Are Pregnant Women Fetal Containers?' In *Reproducing Persons: Issues in Feminist Bioethics.* 1996. New York: Cornell University Press, 88-105.
3. *R v Collins, ex parte S* [1998] 3 All ER 673.
4. Peart, N. 'Compulsory Caesarian Section: Discusses *R v. Collins* and its implications in New Zealand'. *New Zealand Law Journal.* November 1998. p. 398.
5. *Ibid.*
6. Macklin. p. 33. See r.1.

Commentary Four

Psychiatric Viewpoint

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The scenario outlines the case of a woman who is thirty-six weeks pregnant with her third child. She is referred for specialist obstetric care following a small antenatal bleed and is found to have grade three placenta praevia. Her obstetrician recommends, in view of her living so far from the hospital, that she move into the hospital in case of further bleeds and that she have the child by Caesarian Section at thirty-eight weeks if the situation has not altered. She refuses and wishes to be left alone.

The scenario outlines a complex case in which a mother's serious obstetric condition has the potential for a fatal outcome as regards her and the baby and her decision not to follow medical advise may well greatly increase the risk of a fatal outcome. While Jane has a probable biological vulnerability to developing psychiatric illness, there is nothing in the scenario to suggest she is currently mentally unwell, or incapable of making her own decisions. As such, one could argue that there is no role for a psychiatrist in this case. It may, however, be appropriate for the Obstetric Team to liaise with the Community Psychiatric Team who cover Jane's area to alert them to the situation so they can immediately become involved if Jane's mental state deteriorates. Should she be admitted to hospital following further complications, psychiatric input may well be appropriate through a Consultation-Liaison Psychiatrist. In this instance the psychiatrist's role would be to provide on-going assessment of her mental state, make Jane aware of all the facts surrounding her condition including possible risks to herself and the baby and correct any misunderstandings in regards to the proposed management. The psychiatrist would also see it as important that her husband Tom is brought in on the decision making process.