Virtual Mentor
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CASE AND COMMENTARY

Responding to a Request for Early Delivery, Commentary 2

Commentary by Mary Briody Mahowald, PhD

Case

Maggie Olsen is 6-months pregnant with her third child and first son when she and her husband, Dave, receive news that his unit is being sent overseas. Dave, a Marine pilot, is not sure how long he will have to stay or how dangerous this mission will be. Maggie understands that the separation is part of being married to a military man but worries about her husband and the possibility of his getting hurt or even killed. Maggie and Dave have planned to name the little boy after his father, and the couple would really like Dave to be able hold his first son before he leaves.

At her next appointment with her obstetrician, Maggie brings all of this up with her doctor, Dr. Anita Beal. With her first daughter, Stephanie, Maggie had difficult and long labor and, when Stephanie's heart rate started to fall, Dr. Beal decided on a cesarean. Stephanie was a healthy baby and has been a healthy child, but she weighed just 5 lbs 10 oz at birth. Maggie had her second daughter, Christine, by cesarean as well; the baby weighed 6 lbs 3 oz. Maggie is scheduled to have this baby by cesarean on June 12, which puts her right at 39 weeks. Maggie asks Dr. Beal if it would be okay to reschedule the surgery for May 30 since her husband has to report on June 1.

Although Dr. Beal understands Maggie's desire for her husband to meet his son she worries about the possibility of complications if the baby is born too soon. Dr. Beal notes that Maggie's two daughters were on the light side and thinks this baby might really need those last two weeks in utero for weight gain. Dr. Beal explains the risks of moving back the delivery date to Maggie and her husband. The couple talks about it and decides they would still like to have the baby before the first of June.

Commentary 2

Any doctor who assists a woman in delivering her baby is morally, legally, and professionally bound to weigh the expected harms and benefits of the timing and choice of alternative modes of delivery to both the woman and her expected child. Respect for her and her partner's wishes are also relevant to the doctor's calculation. However, when a patient asks for treatment that involves a health risk to her or to another, without countervailing medical benefit to either, no doctor is bound to give priority to her request. Respect for patient autonomy does not impose the obligation of conformity to a patient's request for treatment that is not medically indicated.

Two distinctions are particularly relevant to this case. The first is between treatment for health reasons and treatment for other-than-health reasons. Operative procedures such as cosmetic surgery are routinely performed for nonmedical reasons that may be frivolous in comparison with those that motivate Maggie and Dave, but only when the health risks associated with the intervention are relatively minimal. In the hands of an experienced practitioner, cesarean section at 37+ weeks gestation involves minimal risk to Maggie and her potential child. An infant born at this gestation falls within the threshold of a term pregnancy, and therefore, if the gestational age is correct, does not face the risks of prematurity. However, to insure that the risk is minimal, fetal lung maturity should be tested and fetal weight should be estimated, and both should be judged adequate to healthy survival after delivery on May 30. As long as the risks are small, and Maggie is fully aware of them, Dr. Beal may, but is not obliged, to perform the surgery on that date. Dave's wishes are morally relevant, but Maggie's consent is ethically indispensable because she, not he, will undergo the risks of surgical delivery.

The second important distinction is between the right to refuse treatment, regardless of whether it is medically recommended, and the right to obtain treatment that is not medically recommended. The latter is never as compelling as the former because practitioners may not justifiably be coerced to perform procedures that are professionally inappropriate or morally unacceptable to them. If Maggie were to refuse rather than request surgical delivery, even if cesarean section were considered necessary to preserve her life or that of her fetus, going ahead with it would legally be considered assault. Although some would argue that her refusal is overridable if the surgery is necessary to save or reduce disability in her potential child, this rationale is not generally supported by legal statutes or by medical organizations. However, Maggie is requesting rather than refusing treatment, and the treatment is not only medically unnecessary but entails some risk to her and to her fetus. If the treatment were medically beneficial to either, the physician would be legally, professionally, and morally bound to provide it with Maggie's consent. As it is not medically beneficial to either, Dr. Beal may refuse to perform the cesarean section on May 30. If she cannot in good conscience do so, she should transfer Maggie's care to a colleague for whom the early delivery does not pose a moral problem. Maggie and Dave should not object to this because the ethical principle of respect for autonomy applies to practitioners as well as patients and family members.

If Dr. Beal chooses to perform the surgery, her rationale should be based not only on respect for the couple's autonomy but also on the calculation that nonmedical benefits to them outweigh the health risks to Maggie and her soon-to-be-born son. Presumably, the principal nonmedical benefit to her and Dave is the comfort and joy of both being present to welcome their son into the world on his first day of life. The fact that this is a son rather than a daughter is, or ought to be, irrelevant to the calculation of benefit.

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