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Bullying by Court Application

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Jo Murphy-Lawless talks about the application for a court-ordered caesarean in Ireland

On 9 March 2013, there was an emergency sitting of the High Court in Dublin to consider the application of Waterford Regional Hospital for an order to compel a woman to have a caesarean.

The court heard that the woman, identified only as A, was refusing the caesarean. The barrister acting for the hospital made the following points:

- 'A' was 13 days 'overdue' but could be even 'further along' than they estimated,
- she had previously had a caesarean in 2010 for her first baby, weight 3.6 kgs,
- similar to the first pregnancy, the fetus was said to be 'high and not engaged',
- the results of a CTG trace, carried out on the morning of 9 March were said to be 'non-reassuring'.

The barrister for the hospital said of 'A' (who appears not to have been represented in court at all) that she contested the due date given by the hospital, arguing:

- she was eight days over 40 weeks, not 13,
- that she had wanted to give birth vaginally,
- that while now agreeing in principle to the caesarean section, she wanted to defer it until Monday 11 March, when her partner, who was abroad, would be returning and could be present for the birth of their child.

The expert witness for the hospital, consultant obstetrician Dr John Birmingham, stated by telephone link to the court that; *'I have told her she doesn't have 24 hours ... I cannot be sure of the fetal well-being in 24 hours.'* He also declared that in Ireland, a caesarean is *'almost risk-free'* as an intervention. In the affidavit submitted to the court by the locum obstetrician whose care 'A' was under in the hospital, it was further argued that:

- the uterine scar from the first caesarean presented 'a grave risk' to the woman and her baby,
- the baby could die or sustain serious brain damage,
- at 13 days 'overdue' the placenta was aging, with diminishing blood supply increasing 'the risk of uterine death',
- the woman could haemorrhage. Judge Hedigan was on the point of delivering his decision when word came through that the woman had consented to the caesarean, received a spinal anaesthetic and the surgery was about to be performed. The woman and her baby were later reported to be

'doing well'.1

At present, we must rely on the press reports alone in assessing the circumstances that ended with a courtroom hearing and the woman's compliance under pressure. There is much that we do not know, for instance whether in A's previous labour she was induced before having a caesarean and whether her uterine scar was a horizontal lower segment one. However, even as reported, there are multiple concerns about the court action. As set out above, it points to a serious breakdown in communication with the woman, if not a classic case of shroud-waving. The ease with which the expert consultant obstetrician states as a matter of fact that a caesarean is virtually 'risk-free' is especially disturbing. The latest data on maternal mortality suggests that the risk of death is increased with elective repeat caesarean delivery (ERCD) compared with planned VBAC.2

Current data on uterine rupture with planned VBAC is estimated at 0.21 percent compared with 0.03 percent with planned ERCD.3

Dr Birmingham's view flies in the face of current concerns about the rates of caesarean in Ireland and internationally, and the concomitant efforts to increase the rates of VBAC. While as yet, there are no published national rates of VBAC here, the caesarean rate ranges from 22 percent to 43 percent in Irish maternity units, indicating that there is no common agreement on what constitutes best practice, or even good practice. In 2010 the Irish Institute of Obstetricians and Gynaecologists, began, very belatedly as it was established in 1976, to produce a series of guidelines for clinical management. In its guideline entitled 'Delivery after Previous Caesarean Section' the Institute quotes VBAC rates with a trial of labour of 74 percent and 65 percent respectively (figures are taken from the 2002 annual clinical reports of two major maternity hospitals in Dublin, the Coombe and the National Maternity Hospital) but points out that this may have involved only a small number of low risk women selected to attempt a trial of labour.4

A current Irish-led EU research project, Optibirth, seeks to increase the levels of VBAC by 20 percent in selected centres in Ireland, Germany and Italy, and perhaps in time such research might sway Irish clinicians to think differently. On the other hand, the dominance of obstetric-led care with accompanying high rates of intervention may not be easily dislodged, especially in a context where there remain very high rates of private obstetric practice and very little space and support for publicly available midwifery-led care. There is one further disturbing layer to the recent court application. The hospital's barrister referred to the eighth amendment to the Constitution, Article 40.3.3, the 1983 pro-life amendment. This controversial amendment says that the state 'acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.' Quoting this article, the hospital's barrister argued that the court must balance the wishes of 'A' with the right to life of the unborn. This casts quite a different light on the issue of the decisions and needs of women in beleaguered circumstances. It is true that the Institute guideline states that the decision about a VBAC must be a joint one: 'Such decision-making is best made in partnership with the woman following a full discussion which also takes into account a

woman's plans for future pregnancies. The decision may be influenced by the healthcare setting and ideally, in larger maternity units should be informed by the hospital's own rates of UR and VBAC.4

Yet with Article 40.3.3 as the overarching legal context, a clinical decision can be made without that partnership. Moreover, if that decision reflects poor clinical understanding, in this instance of VBAC, and, notwithstanding a woman's opposition, the logic is that the court can be used to compel women to accept a caesarean. This arose in a case in 2010, where a woman with HIV did not wish her baby, when born, to receive anti-retroviral drugs. The HSE, the national health authority, contested this in court and requested an order for the administration of drugs, but also 'suggested' to the woman that she have a caesarean to which she agreed.5

While the judge had already stated that the woman could not be forced to undergo the caesarean, when she then agreed there was no legal ruling from him as such. The legal scholar, Katherine Wade, commenting on this earlier case and on the Waterford case, argues that at this juncture, we simply do not know what the scope of Article 40.3.3. is in relation to a woman's autonomy and decision- making in refusing a caesarean.6

Unfortunately, we are bound to know sooner rather than later, and in fraught circumstances. The HSE has issued a Draft National Consent Policy, which states in section 7.8.1 'Refusal of Treatment in Pregnancy': 'The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the 'unborn', there is legal uncertainty regarding whether a pregnant woman's right to refuse treatment extends to the refusal of treatment which puts the life of the fetus at serious risk. This matter can ultimately only be decided by the Courts. Thus, where a pregnant woman refuses treatment and this refusal may impact on the life of the fetus, it is essential that the consequences of the refusal are fully and clearly explained to the woman, and legal advice should be sought if she persists in the refusal.7

Court-ordered caesareans are an issue that birth activists and feminists have been confronting for over three decades in various jurisdictions internationally and our work is clearly far from done. It is worth returning to what Susan Irwin and Brigitte Jordan wrote in 1987: 'A court-ordered caesarean section not only determines the authority of a particular doctor over a particular woman, it confirms medical authority in birthing'.8

In the Waterford case, have we seen yet another instance of clinicians seeking court sanction to further authorise their poor clinical skills?

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AIMS Comment

Women in England and Wales are not in danger of court- authorised caesarean section thanks to an important decision of the Court of Appeal in S v St George's Healthcare Trust [1998] 2 FCR 685. The Court held that: 'In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment.

Although human, and protected by the law in a number of different ways set out in the judgment in Re MB, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it.

Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant. In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways … an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights.' As long as a woman has mental capacity to make decisions for herself, she cannot be compelled to accept medical treatment said to be in her child's interest. There is no UK law for 'fetal supremacy', even if the baby is at risk. The expectant mother calls the shots, not the doctors caring for her fetus. As far as AIMS is aware, there have not been any cases on forced caesarean in Scotland or Northern Ireland, which operate their own legal systems, but they could be expected to follow the approach of the Court of Appeal.

The Guardian reported a case where the Scottish Public Services Ombudsman ruled that coercion was not acceptable (www.guardian.co.uk/lifeandstyle/2012/dec/16/mothers-fighting-against-birth-intervention

).

The position in Ireland may be different (we cannot say for sure because the woman consented to the procedure before judgment was given in the Waterford case) thanks to the constitutional guarantee of the fetus' right to life in Article 40.3.3 which obliges the Irish state, and its courts, to 'defend and vindicate' the right of the unborn. Whether forcible treatment of a mother for the sake of the fetus is compatible with the mother's right to private life under Article 8 of the European Convention on Human Rights is a question that urgently needs to be addressed by the European Court of Human Rights in light of the worrying developments in Ireland.