

COERCED FATHERS: CONSENT IN THE DELIVERY ROOM

By Tony Whitman



I often hear stories about labouring women forced to undergo medical procedures against their will. I sometimes wonder if these stories are urban legends, or political propaganda against established medical organizations. My main question is how can OB/GYN's bypass a woman's consent? Furthermore, how does the consent of her partner play into these scenarios? It's not hard to come across stories where dads say they were coerced to consent to a procedure the mother stated she did not want. And further yet are legal cases where the mother was court-ordered to undergo a procedure against her will, such as episiotomy, epidural, or c-sections.

A 2007 poll by the Department of Obstetrics and Gynecology had this issue as its focus: "Despite court rulings suggesting that court-ordered cesarean sections should rarely be undertaken, they are performed. Our objective was to determine characteristics of providers and patients that make their use more likely." Obstetricians and gynecologists at an American Congress of Obstetricians and Gynecologists (ACOG) convention and also lawyers at a separate American Health Lawyers Association convention were given a number of different scenarios and asked if they would support a court-ordered

decision to force a c-section in each of the scenarios. Their conclusion: "The perceived likelihood of performing a court-ordered cesarean section varies with characteristics of the patient and the provider."

How can we corroborate the existence of court-ordered procedures with the stories of coerced fathers? I searched the legal documents of three OB/GYN organizations. I looked for the definitions of "consent" on the websites of Britain's Royal College of Obstetricians and Gynaecologists (RCOG), The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and ACOG.

The first step to coercion involves viewing the laboring woman as incapacitated. Britain's definition of consent is the most liberal, but some comments still caught my attention. In the online document named "Clinical Governance Advice No. 6: Obtaining Valid Consent,"² Section 4.1 is this paragraph: "Care must be taken when obtaining consent from women who are in labour. This applies particularly if they are in pain or under the influence of narcotic analgesics. Women who are pain-free in labour as a result of effective epidural anaesthesia can consent normally." This stance views the laboring women as not totally incapacitated. Later on is this sentence: "If consent

has to be obtained from a woman during painful labour, such as to perform a vaginal examination, operative delivery or to site an epidural, information should be given between contractions.” These sentences open the door to a grey area. An OB/GYN can deem the woman incapacitated by pain or drugs. The OB/GYN can then determine whether the mother can give consent. Nowhere in this document is there reference to seeking secondary consent, for example the woman’s partner or immediate relative.

The next example is RANZCOG. On their website is a document that has some references to consent. College Statement “C-Obs 1-Obstetricians and Childbirth: Responsibilities,” describes the standards that its’ respective OB/GYN’s should adhere to.³

- Provides the pregnant woman with the opportunity to participate in decisions about her care, and that of her baby before and after delivery.

- Discusses the possibility that a woman’s preferred management may not be possible in an emergency situation, and that planning for birth must be flexible and subject to modification if necessary, particularly in the event of complications.

- Accepts that if the woman suffers harm, the obstetrician must act immediately to rectify this where possible, and to inform the patient of what has occurred and of its likely long and short term effects.

The first two bullets say a woman may participate in decision making, but her choices may not be possible. The last bullet simply directs that the mother be informed of what HAS happened, and the possible side-effects.

These comments are legal carte blanche for the OB/GYN’s to do whatever they want. As with RCOG, no instructions are given for seeking consent from the woman’s partner or immediate relative once the mother is deemed incapacitated. In fact, the OB/GYN is the primary when consent is considered: “The obstetrician is the key health professional responsible for the care of the pregnant woman and as such coordinates her care and acts as her advocate.⁴” This is a double-edged sword for fathers saying they were coerced in an Australian hospital. If the OB/GYN is the mother’s advocate, there would be no need to coerce the father. However, if the OB/GYN is confronted after the fact, any rationalization could be stated for the procedure.

The last example of the definition of consent comes from ACOG. On their website is the document: “ACOG Committee Opinion #439”, by their Committee on Ethics.⁵ Of the three organizations reviewed, this

was the only version that had reference to seeking the secondary consent of a 'surrogate,' namely the father. This may be more a reflection of American laws than the views of ACOG. Section 7 states: "When informed consent by the patient is impossible, a surrogate decision maker should be identified to represent the patient's wishes or best interests. In emergency situations, medical professionals may have to act according to their perceptions of the best interest of the patient; in rare cases, they may have to forgo obtaining consent because of some other overriding ethical obligation, such as protecting the public health." This stance implies that if the OB/GYN's decision is not given from the mother and then the surrogate, they may declare an emergency to override all consent. Bypassing a mother's consent is all but sanctioned.

Examining documents from three different medical associations it is clear that consent is a polite illusion. In regards to fathers, only one of the organizations recognizes a secondary decision maker. And even if the father is recognized as a decision-maker, coercion is a useful tactic.

The next question that comes to my mind is what methods could be used to coerce fathers? Worst case scenarios, legal threats, and condescending superiority come to mind. The fact that scenarios involving these methods could be happening at any moment to override a basic human right, that of choice, scares me.

References:

1. <http://www.ncbi.nlm.nih.gov/pubmed/17403468>
2. <http://www.rcog.org.uk/files/rcog-corp/CGA6-15072010.pdf>
3. <http://www.ranzcog.edu.au/publications/statements/C-obs1.pdf>
4. <http://www.ranzcog.edu.au/publications/statements/C-obs1.pdf>
5. http://www.acog.org/from_home/publications/ethics/co439.pdf

Tony Whitman participated in his wife's HBAC. The experience greatly affected him and he now researches the interactions of fathers at childbirth. He writes for Birth Action, and is currently working on a book called "The Role of the Father."