RCoA inside the Ethics Committee session at Anaesthesia 2021, 20th May

We will discuss the case of Cerena which has been brought to the attention of the Ethics Committee by the obstetric team looking after her.

The case is actually that of CA which was heard in 2016 in the Court of Protection:
***Re CA* (Natural Delivery or Caesarean Section) [2016] EWCOP 5.**

The full judgement can be found at:
https://www.bailii.org/ew/cases/EWCOP/2016/51.html

Issues raised by this case for possible discussion during the session:

- Capacity – with reference to capacity in pregnant women
- Best interests – mother's and fetus's
- Mental Health Act – what it legislates for and what it permits
- Restraint – the law and practicalities
- Deprivation of Liberty Safeguards
- Timing of application – "No later than 4 weeks before expected delivery".

Supporting resources:

- David's article "Caesarean sections without consent". P16 of RCoA Bulletin
- The Court of Protection judgment in Re CA (Natural Delivery or Caesarean section) [2016]
- Kate's editorial, *Anaesthesia* 2017 "Your lack of planning does not constitute my emergency" – caring for obstetric patients with mental illness.

SCENARIO

You are a member of the Trust ethics committee. The clinical leads* for Labour Ward:

- ***Consultant Obstetrician, Miss Smith***
- ***Consultant Obstetric Anaesthetist, Dr Jones***
- ***Head of Midwifery, Sister Dawson***

approach the ethics committee for advice about the management of a patient, Cerena.

**NB in the actual case of CA the obstetrician was Mr G, the anaesthetist Dr K, and the midwife, DW. These abbreviations appear in the extracts from the judgement below.*

Cerena's background

Cerena is a 24-year-old woman who is approximately 36 weeks pregnant with her first baby. She is refusing any interventionist health care in respect of her pregnancy.

Cerena was born in Nigeria and came to the UK with her family in 2007. She was subsequently diagnosed with autism and learning difficulty, and was assessed as having an IQ of 60 – 70. There is relatively little information about Cerena's background but as a small child in Nigeria, she experienced one, or possibly two, episodes of cutting. The evidence for the first incident is a series of superficial scars on her abdomen radiating from the umbilicus. These scars have been described as "tribal"and Cerena's mother said that these were inflicted on her when she was unwell, to release "bad blood". The precise circumstances in which these incisions were inflicted are unclear, but it seems likely that Cerena was conscious at the time and under some form of physical restraint.

Secondly, Cerena's mother says that Cerena underwent genital cutting as a child. It has not been possible to confirm this because Cerena has refused to permit anyone to carry out a genital examination. Hence, the type of mutilation is unknown although her team thinks it is likely to have been "type 1" (partial or total removal of the clitoris), as opposed to the more extreme "type 2" (involving, in addition, the removal of the labia minora or, in some cases, the labia majora), or "type 3" (the narrowing of the vaginal opening by creating a covering seal formed by cutting and repositioning the labia).

Cerena lived with her family until, in 2019, she moved into a supported living placement, where she was known to social services and received 20 hours of support each week from Autism Care. A couple of months ago she visited her parents who suspected that she was pregnant and took her to the GP to confirm this. She is currently thought to be 36 weeks gestation. The father of the child is unknown, as are the precise circumstances in which the baby was conceived.

Cerena is under the care of Miss Smith, consultant obstetrician, and her team. She has been largely uncooperative with medical examinations and, on occasions, with midwifery staff. She refuses to provide blood samples, or to undergo gynaecological examinations, or almost any examination of her body. She does, however, agree to have ultrasound scans. Cerena's midwife has managed to secure, to some extent, Cerena's confidence and trust, and, as a

result, Cerena will allow her to listen to the fetal heartbeat and to palpate her abdomen and test her blood pressure.

Cerena demonstrates little, if any, understanding of what would be involved in labour or childbirth. Her midwife has offered her a DVD about the process. Initially, Cerena was reluctant to take it, but subsequently she did so and watched it. Cerena seems to have a very limited understanding of, or interest in, childcare, saying that her mother will deal with it. She is adamant that she wants to have the baby at home and, when she was shown round the maternity ward and delivery room at the hospital, showed an aversion to the machinery and a mistrust of medical staff, saying "no one can touch you at home, I trust no one." In discussion about childbirth, she said simply "they just come out when they're ready and that's it". According to her midwife, she had no expectation of possible pain or bleeding. When she eventually watched the DVD, she did not seem inquisitive about the mother's evident pain, and has said that she would definitely not have an epidural. The midwife has noticed that Cerena never relays back the information which professionals have given her and despite their forming a reasonably good relationship, the midwife continues to find Cerena challenging and, on occasions, unpredictable and difficult.

This week Cerena has became more unsettled and her team is increasingly concerned about her and her impending labour and delivery. Cerena is refusing to entertain the possibility of caesarean, and declaring she wanted to give birth at home. Her doctors and midwives feel that this is not in her best interests.

The clinical leads have approached the Ethics Committee for advice about the management of labour and delivery and have asked specifically:

1. ***Whether Cerena has the capacity to make decisions about her medical treatment, and in particular the management of her pregnancy***
2. ***If not, whether it is in her best interests to undergo a planned caesarean section***
3. ***If a caesarean section is in her best interests how can this be facilitated in the face of her refusal both:***
    a. ***procedurally - does a court order need to be obtained?***
    b. ***practically - is it acceptable to restrain Cerena to facilitate anaesthesia and surgery?***

The following is information for the panel which has been taken directly from the court judgement in *Re CA* (Natural Delivery or Caesarean Section) [2016] EWCOP 5.

Judge's capacity assessment:

CA was examined on 14th November (that is to say, the day before the final hearing) by Dr I, a consultant psychiatrist with considerable experience of autism and a special interest in autism in women. Dr I described CA as coming across as a vulnerable woman with a learning disability. She told him she did not like anything about the hospital and did not want to be

there. She confirmed that she does not like needles, and Dr I concluded this to be consistent with needle phobia.

She reiterated that she would not allow a midwife to carry out an internal examination. She said she wanted a normal delivery and did not anticipate suffering any pain. Dr I concluded that CA had a learning disability, estimating her IQ to be between 60 and 70.

Dr I also concluded that CA is autistic. In oral evidence, he described her as being a very obvious case of autism, although he said that he had come across patients with a more severe form. Dr I described the rigidity of thinking which CA demonstrated around a range of issues – for example, childbirth – as being typical of autism.

Dr I's evidence was that CA lack capacity in relation to the medical treatment and to the management of her pregnancy. In his interview with her, she was clearly very selective in retaining the information she wanted to retain, dismissing other information she did not want to hear. Dr. I described this selectivity as a direct consequence of her autism. He concluded that she was also clearly unable to weigh the information in order to make an informed choice, although she was able to communicate her views.

The picture painted by Dr. I was consistent with that provided by DW(the midwife). She concluded that CA did not have capacity or insight about what was going to happen, or likely to happen. DW also identified that CA was very selective about the information she retained about all aspects of labour and childbirth. She had, as previously described, been unable to relay back information given by professionals – for example, the information given by DW about pain relief. The same picture was provided in the evidence of the clinicians.

Conclusion:

Judge declared that CA lacks the capacity to conduct litigation and also to make decisions about treatment in pregnancy and labour. In this case, medical staff, and in particular the midwife DW, have tried their utmost to help CA make these decisions. Despite their best efforts, she is simply unable to do so.

Best interests assessment: (taken directly from the judgement)

CA's wishes and feelings were therefore a matter of considerable importance in the best interests analysis. She has clearly and consistently expressed her wish to have her baby at home rather than in hospital. She has shown a strong aversion to hospitals and medical equipment, a mistrust of doctors, and an extreme reluctance to be examined by medical staff.

She confirmed that she wanted to give birth at home but recognised that it was probably not going to happen. She explained that she wants to do it all herself and that she would see it as an achievement to be able to give birth in the house all by herself. She said that she did not want to spend one minute in hospital because "there are too many bad memories of my childhood and my life". She said that blood tests would be "out of the question". She gave the same answer when asked about her views on being examined by a doctor. She was

unable to think of any risks of having a baby at home and was sure that nothing could go wrong. The whole of the family would be there for her and the baby. She said that she had heard the term "Caesarean section" a lot of times but did not want it although she was unable to explain why.

The judge was struck by her strong independence and ardent wish to have the baby at home and do it all by herself, but that CA had little understanding of what is involved in labour and childbirth.

Mr G, in consultation with another consultant obstetrician, drew up a balance sheet of the advantages and disadvantages of the various options for delivery.

The benefits of an elective Caesarean section included:

1. it would allow CA sufficient time to process the information about the proposed procedure in her own time;
2. it would be a more controlled and structured process so that CA would be aware of the stages involved and more likely to avert undue stress;
3. it would eliminate potential emergency interventions and consequences which could be less tolerable for her;
4. it would allow her to undergo adequate physical and psychological preparation specific for the birth;
5. it would reduce the potential of undue physical restraint to enable care to take place, an action that could have a lasting dramatic effect on her;
6. it would not require continuous foetal monitoring;
7. it would afford hospital-based caregivers the opportunity to plan appropriately and specifically for any potential complication;
8. it would allow other caregivers to plan adequately untimely provision of care for both CA and the baby.

The drawbacks of an elective Caesarean section included:

1. the thought of having a major surgery could be daunting for her and its impact on her would be impossible to assess;
2. it would in her case require a general anaesthetic and possibly some degree of restraint during that process;
3. CA would be more likely to experience post-delivery pain, although that could be managed adequately;
4. it may make it more difficult for her to bond with the baby;
5. it would create yet another scar on her abdomen which could lead to an adverse psychological effect;
6. it may take her longer to recover physically than from a vaginal delivery.

The benefits of vaginal delivery:

1. a potential shorter stay in hospital;
2. no abdominal scar;

3. it may make it easier for her to bond with the baby;
4. a quicker recovery would be more likely;
5. she would require less physical support; and
6. it would involve less pain relief after the birth.

The disadvantages of vaginal delivery:

1. it would require regular foetal monitoring which she was likely to refuse;
2. as a result, there was the potential for poor foetal outcome, with a possible adverse impact on CA;
3. there was an increased risk of potential injury to CA and others due to her possible non-compliance with medical intervention;
4. as labour is a prolonged process associated with escalating levels of pain, there was a risk of significant and lasting psychological impact on her which might compound her pre-existing post- traumatic stress disorder;
5. vaginal delivery is associated with perineal and vaginal injuries and it was difficult to assess how she would respond to such complications;
6. it was likely that this would involve significant restraint and therefore associated physical and psychological trauma;
7. there was a greater risk of an unplanned delivery at home;
8. as CA was more likely to decline vaginal examinations during labour, it would be difficult to assess progress and institute appropriate intervention;
9. due to her reluctance to comply with medical interventions, it would be difficult to manage a potential post-part haemorrhage which might put her life at risk.

Mr G and his colleague therefore concluded that, based on the above risk assessment and taking into account her history of non-compliance and lack of capacity to consent to surgical intervention, an **elective Caesarean section would be the safest, least traumatic and most appropriate mode of delivery**. The recognised potential drawback for the proposed abdominal surgery could be mitigated in part by cooperation between the obstetrician and psychiatrist, coupled with an appropriate and adequate support structure in the immediate and long-term after delivery.

In oral evidence, Mr G added that, when a mother has undergone FGM, there is a risk that vaginal labour may lead to a tear and blood loss, although this risk was greater in cases of type 3 FGM than type 1. Given CA's antipathy towards medical examination, assessing and treating this heightened risk of a tear would be more difficult than usual. Mr G observed that a substantial proportion of deliveries – just over one in four vaginal deliveries – lead to an emergency Caesarean section. Statistically, therefore, there was a significant risk that a vaginal delivery in CA's case would lead to such an emergency.

In his report, Dr I concluded that the option of a vaginal delivery was unrealistic due to CA's refusal to allow the midwife to carry out repeated vaginal examinations to monitor the progress of her labour; her refusal to talk through various options for pain relief; her refusal to allow administration of any necessary injectable medication if required; her anticipation that the baby would just "pop out"; her lack of realisation that the experience of first delivery may be long and often painful; her reluctance to comply with instructions and the

consequent risk of lack of cooperation, for example when instructed to push, leading to an uncoordinated or chaotic labour process. He therefore concluded that CA was not adequately prepared to go through the process of natural birth and that, if she was allowed to proceed with that of mode of delivery, it was likely to end with an emergency Caesarean section. In his opinion, this would be the least desirable option and the most risky for both mother and baby. It would be practically difficult to assemble the multi- professional team of her choice for a natural birth out of hours, or in the likely event of an emergency Caesarean section. Dr I also formed the opinion that CA was unlikely to understand the rationale for a Caesarean section in an emergency due to her heightened anxiety and was therefore unlikely to cooperate. This in turn was likely to lead to delay, putting both baby and mother at unnecessary and avoidable risk.

Dr I therefore concurred with the opinion of the multi-professional team that a planned Caesarean section was the safest option. This would not only allow assembling a team of familiar faces but also would reduce the risk of uncertainties and chaos. He was aware that CA may require a degree of restraint for the administration of injectable medication, but the alternative options of a natural birth and/or an emergency Caesarean section also likely to require a degree of restraint. Restraint was therefore in all probability unavoidable whichever option was preferred.

Best interests conclusion: (taken directly from the judgement)

The court must, of course, pay careful attention to CA's expressed wishes and feelings and her experience of trauma in the past which is a significant cause, of her deep-seated aversion to medical procedures. But looking at the evidence overall, it is manifestly clear that the balance comes down decisively in favour of a planned Caesarean section. I accept the analysis set out in the balance sheet provided by Mr G and his colleague. I accept the further evidence of Mr G that there is a substantial risk that an attempted vaginal delivery would lead to an emergency Caesarean section. I accept the evidence of Dr I that an emergency Caesarean section would cause the greatest degree of psychological damage to CA, and that a planned Caesarean section is likely to lead to the least psychological damage of the options in this case.

I further concluded, having regard to evidence provided by the consultant anaesthetist Dr K, that the Caesarean section should be carried out while CA was under a general anaesthetic, as opposed to regional anaesthetic.

The judge made an order incorporating:

1. a declaration that CA lacked the capacity to conduct the proceedings and make decisions about medical treatment;
2. a declaration that it was lawful and in her best interest undergo a Caesarean section at the Trust's hospital on or around 17 November 2016;
3. a declaration that it was lawful and in her best interests that restraint as set out in the Trust's control and restraint plan be used as necessary to enable the treatment to be carried out; (4) a declaration that arrangements for her care and treatment

were lawful and proportionate notwithstanding that they entail the deprivation of her liberty, and

4. an order that at all times before, during and after the birth, the Trust should take all and every reasonable step to minimise distress to CA and to preserve her dignity.

Postscript:

On 17th November, I was very pleased to learn that CA had given birth to a baby boy after a successful planned Caesarean section during which minimal restraint was required to hold her hand to administer intravenous sedation. The baby had in fact been in the breech position prior to delivery. Subsequent blood tests revealed that CA was significantly anaemic and she was provided with a 2.5 litre blood transfusion.