RECIPE Small Group Discussions: Case 7 Video
(Video length 2:26)

OVERVIEW
This case involves a 23-year-old refugee who arrives in labor with a compromised fetus documented by fetal heart rate monitoring. She refuses a cesarean section because of her fear of dying and her family’s desire not to intervene. Multiple religious, ethical and cultural issues underlie this scene so the case is relevant for use in undergraduate and graduate medical education. The video highlights a situation involving a patient’s refusal of an abortion, culture and state laws but is presented to allow faculty the opportunity to discuss other issues not uncommon to the reproductive clinic. This video also allows future healthcare providers to address personal biases, such as caring for culturally diverse patients, that should not influence patient interactions. The physician’s handling of the situation is also portrayed to allow discussion of professionally managing patient encounters and not as a model to follow. Students need to be conscious of how to professionally handle these sensitive situations so we encourage faculty to view this facilitator guide as suggestive but not all encompassing.

Learning Objectives
At the end of the session, the student should be able to:

1. Explore varying viewpoints patients have concerning cesarean section.
2. Discuss the religious and cultural beliefs pertaining to cesarean section.
3. Discuss the physician’s role when a patient refuses or stops treatment in a clinic/hospital.
4. Develop strategies for managing a patient’s preferences regarding cesarean section in the clinic.

Facts to Initiate Discussion
- Research comparing Somali immigrants living in Washington State to US-born black and white women during 1993 and 2001 found Somali women were more likely to experience fetal distress and failed induction of labor requiring cesarean deliveries (Johnson, Reed, Hitti and Batra, 2005).
- Religious and cultural considerations are important to consider in cesarean deliveries. Cesarean sections are known to be refused by Hmong women based on cultural beliefs and may be perceived as mutilation by some Arab cultures (Deshpande and Oxford, 2012).

Critical Points (Every Student Needs to Hear)
- ACOG does not recommend the use of coercion when a pregnant woman refuses recommended medical treatment (ACOG Committee Opinion, June 2016). The pursuit of court ordered intervention is also discouraged. If a pregnant woman is capable of making medical decisions, the physician may accept her refusal of treatment or surgical intervention.
- Prior to labor, physicians can formulate a birth plan with patients that offers the opportunity to discuss delivery situations and possible reasons for a cesarean delivery. Birth plans do not prevent unwanted interventions but allow for preemptive discussion about wishes, and thus minimize the need of extended discussion during delivery when time may be critically important (Deshpande and Oxford, 2012).
- American Medical Association’s Policy of Provision of Life-Sustaining Treatment states, “Patients can refuse treatments even when such refusal is likely to result in death” (American Medical Association, 1995-2016).
- Performing any medical intervention without obtaining informed consent of a woman can be deemed criminal medical battery (Deshpande and Oxford, 2012).
**Questions to Ask**

- How should the healthcare team proceed?
- What members of the healthcare team would be essential to this case?
- Who are the appropriate decision-makers in this situation?
- Can you as a professional healthcare provider go against the patient’s wishes in order to save them both? How would you defend your decision?

- What steps should the physician take when working with the patient and her family?
- How would you proceed if you are morally conflicted about the patient’s decision?
- The team members are in moral distress at the thought that both the patient and the unborn child may die. What should happen next?

**Concluding the Session**

- Communicating with patients about a birth plan prior to delivery provides an opportunity to discuss all aspects of the birth, specifically when a cesarean delivery may be necessary. Fears surrounding the childbirth experience should also be discussed prior to delivery. Immigrants may have cultural beliefs that differ from the provider. These differences should be explored prior to delivery.

- When a woman refuses to have a cesarean delivery despite having a medical need the provider may be required to respect her decision, even if her life or the fetus’ life is at risk.

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**Background Information**

- Meta-analyses found higher cesarean rates for immigrant women from Sub-Sahara Africa, Somalia and South Asia (Merry, Small, Blondel and Gagnon, 2013). Immigrant women from North Africa (Maghreb), West Asia (Middle East) and Latin America had an increased risk for emergency cesarean births.

- According to one study, Somalian refugee women fear cesarean deliveries, but most would have a cesarean delivery if their provider recommended it was in their best interest (Ameresekere, Berg, Frederick, Vragovic, Saia and Raj, 2011). Communication about cesarean delivery can improve the childbirth experience for these women.

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