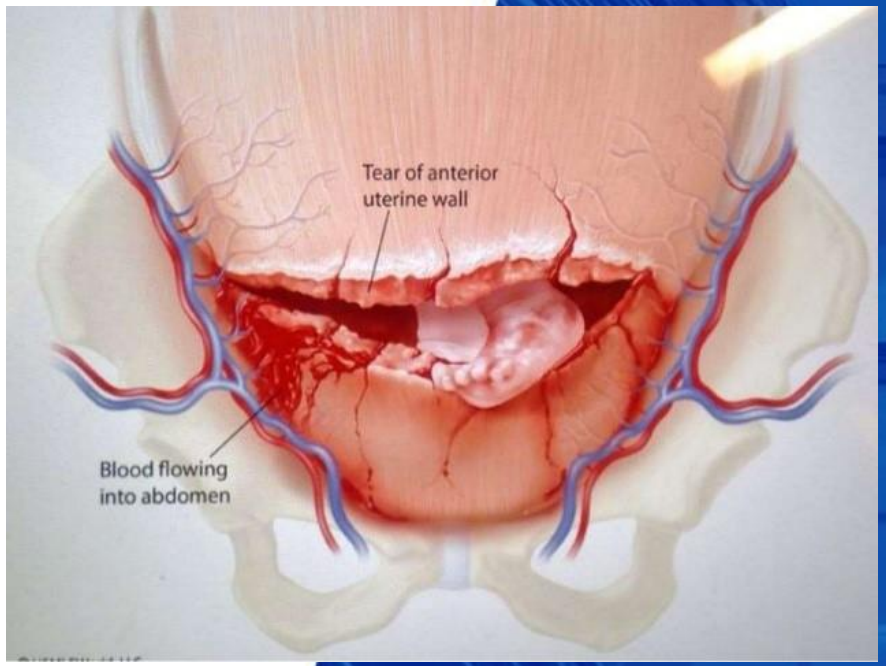
# Respecting Autonomy at the Edge of Risk: Cesarean Refusal Following Prior Uterine Rupture

- Background
  - Uterine Rupture
    - Incidence
      - Spontaneous <0.1%
      - H/o 1 cesarean section 0.2-0.9% (low transverse incision)
      - H/o 2 cesarean sections 2-3.9%
    - Distorts contractile fibers of the uterus, subsequent contractions can lead to uterine rupture, hemorrhage, maternal/neonatal death
    - Recommendation for delivery with prior uterine rupture is scheduled cesarean section at 36 weeks

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# The Case

- 39 y/o G5P4004 Swahili speaking patient from Tanzania presented to high-risk obstetrics clinic desiring a VBAC. H/o CS x4 with uterine rupture in G3 and G4 after TOLAC
    - G1:2012 Cesarean section for non-reassuring fetal heart tones
    - G2: 2016 rLTCS complicated by 3.5cm uterine dehiscence and iatrogenic cystotomy
    - G3: 2021 TOLAC with terminal brady and uterine rupture -->emergent rLTCS
    - G4: 2023 TOLAC with nipple stimulation and Cook balloon followed by amniotomy --> rLTCS after failed operative delivery, uterine rupture noted in operative report. Of note, patient refused neuraxial anesthesia and CS performed under general.
  - Patient declined scheduled rLTCS due to belief “everything would be ok”
  - Ethics committee consulted – CS could not be performed without consent of patient or husband if patient incapacitated even for fetal distress
  - Presented in labor at 41w5d and progressed to 10cm.
  - After 36 minutes of pushing in the OR with no fetal descent, she agreed to cesarean section. A 7cm cystotomy was incidentally made upon entry into abdomen. A uterine window was noted with no overt rupture.

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# Teaching points

- Ethical conflict
  - Automony – patient's wishes
  - Nonmaleficience – Do no harm, but what happens when this in conflict with autonomy?
  - Beneficence – Attempting to prevent harm, but again in conflict with patient autonomy
- Understanding cultural differences and exploring patient's past experiences can provide insight into current thoughts and behaviors
- Identify health care employees in your institution who originate from the same country/area that a patient is from or someone who speaks the patient’s native language.
  - In person interpreting can build stronger patient trust in the health care system
- Consider involving trusted elders/leaders in the patient’s community or religious affiliation.
- Cesarean sections (in Kansas) cannot be performed to save the fetus if a mom explicitly declines cesarean section, even if she becomes incapacitated.
  - Know your institution’s policies.
  - Get ethics and risk management at your institution involved early

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