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RESEARCH ARTICLE

Refusal of Recommended Obstetric Care in a Pregnancy with Severe-Range Blood Pressure: A Four-Box Clinical Ethics Case Report

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Abstract. Background: A severe-range blood pressure reading during pregnancy warrants prompt assessment, while refusal of recommended obstetric care raises clinical and ethical challenges. This case report examines one such encounter using the Four-Box Method. Case Presentation: A 42-year-old woman (G3P2002) at a reported gestational age of 36 weeks and 1 day had one recorded blood pressure of 170/101 mmHg and breech fetal presentation during a community-based maternal health encounter. Referral for assessment and blood-pressure management was recommended, magnesium sulfate was considered if indicated, cesarean delivery was proposed, and permanent sterilization (MOW) was offered. The available records describe refusal of referral, further assessment, and proposed cesarean delivery; they do not establish that medication or MOW was individually refused. The patient and her husband were interviewed approximately two weeks later. Ethical Analysis: The patient expressed a preference for vaginal delivery, concern about infant health and fertility, and a perception of pressure during healthcare encounters. A structured capacity assessment and complete documentation of informed refusal were unavailable. Her account did not independently establish coercion. Diagnostic investigations and subsequent maternal and neonatal outcomes were incompletely documented or unavailable. Conclusion: This case emphasizes prompt clinical reassessment while respecting patient choice, separating obstetric treatment from permanent contraception, and distinguishing documented actions from recommendations for ethically defensible practice.

Keywords: Severe-Range Blood Pressure; Pregnancy; Informed Refusal; Patient Autonomy; Permanent Contraception; Four-Box Method.

INTRODUCTION

Hypertensive disorders of pregnancy are important contributors to maternal and perinatal morbidity and mortality worldwide (Duley, 2009; Garovic et al., 2022). Preeclampsia is estimated to complicate 2–8% of pregnancies worldwide; this estimate concerns preeclampsia overall rather than severe preeclampsia or all hypertensive disorders combined (American College of Obstetricians and Gynecologists [ACOG], 2020; Duley, 2009). The global burden of preeclampsia and eclampsia has also been documented through a systematic review demonstrating variation across geographical regions (Abalos et al., 2013). A systolic blood pressure of at least 160 mmHg or diastolic blood pressure of at least 110 mmHg is within the severe range and calls for timely confirmation and assessment (ACOG, 2020; Garovic et al., 2022; Magee et al., 2022). Classification of preeclampsia also requires attention to the patient's blood-pressure history, proteinuria, relevant maternal organ dysfunction, and other applicable diagnostic criteria (Chappell et al., 2021; Garovic et al., 2022). In primary-care and community settings where comprehensive assessment or emergency obstetric treatment is unavailable, the priority is to recognize potential danger, arrange prompt reassessment, and offer an appropriate referral pathway (Magee et al., 2022; Miller et al., 2016; National Institute for Health and Care Excellence, 2023).

Refusal of recommended care during pregnancy raises questions that extend beyond the clinical indication for intervention. Clinicians are obliged to explain the urgency, potential benefits, and risks of proposed management, yet a pregnant patient with adequate decision-making capacity retains authority to accept or decline specific interventions (ACOG, 2016). Providing appropriate maternal care therefore requires attention not only to the clinical necessity of interventions but also to their proportionality and the patient's preferences, consistent with the broader principles of evidence-based and respectful maternity care (Miller et al., 2016). Referral, antihypertensive treatment,

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seizure prophylaxis, the timing and mode of delivery, and permanent contraception represent distinct clinical decisions; refusal of one cannot be assumed to constitute refusal of all. In particular, permanent contraception requires voluntary, procedure-specific consent independent of any agreement to obstetric treatment (ACOG, 2024). The Four-Box Method offers a structured means of considering medical indications, patient preferences, quality of life, and contextual features without equating disagreement with incapacity (Jonsen et al., 2015).

Decision-making is also shaped by the patient's understanding of risk, experiences of healthcare communication, interpersonal relationships, and practical access to services. Research on person-centred maternity care has demonstrated the importance of effective communication, dignity, and respect for women's autonomy across different healthcare settings (Afulani et al., 2019; Shakibazadeh et al., 2018). Respect for autonomy therefore includes listening to the patient's reasons and values and considering how family members may support, but should not replace, her decisions (Entwistle et al., 2010). When healthcare encounters are perceived as pressuring, that perception deserves ethical attention, although it does not independently demonstrate that coercion occurred. Previous studies have highlighted concerns about mistreatment, inadequate communication, and limited participation in decision-making during maternity care, reinforcing the importance of examining women's reported experiences without assuming that such practices occurred in every individual case (Shakibazadeh et al., 2018; Vedam et al., 2019). Shared decision-making provides a framework for discussing clinically appropriate options and making space for patient preferences without treating agreement with the clinician as the required outcome (Elwyn et al., 2012). This approach is consistent with the broader understanding of maternal healthcare quality, which incorporates both the provision of evidence-based care and women's experiences of receiving care (Tunçalp et al., 2015).

The present report concerns a community-based maternal health encounter in Indonesia involving a 42-year-old woman at a reported gestational age of 36 weeks and 1 day, with one documented severe-range blood pressure measurement and breech presentation. Referral and further assessment were recommended; cesarean delivery was proposed, and permanent sterilization was also discussed. The patient subsequently described fears concerning delivery, fertility, and earlier healthcare interactions. Because serial blood-pressure values, laboratory investigations, and comprehensive fetal assessment were not available, the case does not support an independent reconstruction of a definitive diagnosis of preeclampsia with severe features. Rather than claiming a novel association or a resolved ethical conflict, this report aims to examine the documented clinical concerns and patient-reported experiences using the Four-Box Method, and to identify the implications for informed refusal, reproductive autonomy, and respectful referral communication in community-based obstetric care.

METHODS

Study Design and Case Context

This report presents a single clinical case with a descriptive clinical-ethics analysis informed by the Four-Box Method. The case concerns a 42-year-old woman (G3P2002) at a reported gestational age of 36 weeks and 1 day who was assessed in a community-based maternal health encounter in Kalisat District, Jember Regency, Indonesia, in March 2026. The ethical analysis focuses on the reported refusal of referral and obstetric recommendations alongside concerns about childbirth, future fertility, and healthcare communication. The report was organized with reference to the CARE case-report guidelines. It is intended to illustrate a context-specific clinical and ethical problem rather than estimate prevalence or establish causal relationships.

Data Sources and Interview Procedures

Information was drawn from the available Posyandu records, referral documentation, contemporaneous notes of the healthcare team, and retrospective interviews with the patient (ST) and her husband (AQ). The documentation was reviewed for the recorded maternal and fetal findings, proposed management, decisions reported during the encounter, and the availability of subsequent clinical information. The records accessible for this report did not provide serial blood-pressure measurements, quantitative proteinuria results, a complete blood count, liver or renal function tests, or a comprehensive fetal assessment beyond the reported presentation. Information not documented in these sources was treated as unknown rather than inferred.

Approximately two weeks after the initial encounter, a researcher who was not part of the treating clinical team interviewed the patient and her husband in a neutral setting selected by the participants. According to the study documentation, both participants provided written informed consent to the interviews and the use of de-identified quotations. The interviews were conducted in Indonesian; selected quotations were translated into English by the authors and checked against the original transcripts for consistency of meaning. Participation was described as voluntary, and participants were informed that their responses would not affect subsequent healthcare. The relevant ethics approval and consent-for-publication statement are provided in the Declarations section.

Clinical Assessment and Documentation Limits

The clinical description was restricted to findings and recommendations recorded in the available materials. The recorded blood pressure of 170/101 mmHg was considered a severe-range systolic measurement requiring prompt reassessment; it was not treated as proof that the complete diagnostic work-up for preeclampsia had been performed. The reported ultrasound-based gestational age and breech presentation were retained as documented, but the timing of the dating ultrasound and the full maternal and fetal evaluations were not established from the available report. Likewise, the distinction between interventions recommended, administered, and specifically declined was preserved throughout the analysis.

Four-Box Ethical Analysis

The clinical and interview information was organized deductively into four prespecified domains of the Four-Box Method (Jonsen et al., 2015): (1) medical indications, including recorded clinical findings, proposed interventions, and diagnostic uncertainty; (2) patient preferences, including expressed choices and available evidence of understanding or decision-making capacity; (3) quality of life, referring to the patient's anticipated consequences of childbirth, surgery, and loss of fertility; and (4) contextual

features, including family involvement, cultural interpretations, access barriers, and experiences of healthcare communication. For each domain, the reported evidence was distinguished from information that remained unavailable or unverified.

The analysis was descriptive and framework-guided rather than a claim of an independently validated inductive thematic analysis. Patient and family statements were interpreted as their reported experiences, not as independently verified accounts of healthcare professionals' actions or as proof of causation. No structured decision-making capacity assessment, formal quality-of-life measure, or longitudinal maternal-neonatal outcome assessment was documented. The four domains were subsequently considered together to identify ethical tensions; recommendations drawn from the wider literature are presented in the Discussion, not as interventions proven to have occurred. No statistical analysis was undertaken.

RESULTS OF STUDY

Case Presentation and Available Clinical Findings

In March 2026, a 42-year-old pregnant woman (G3P2002) attended a Posyandu encounter in Kalisat District, Jember Regency. Her reported gestational age was 36 weeks and 1 day on the basis of ultrasonography, and the fetus was described as being in breech presentation. A blood pressure of 170/101 mmHg was recorded. The available materials did not contain repeat or serial blood-pressure values, quantitative proteinuria findings, a complete blood count, liver or renal function results, or a formal fetal assessment beyond presentation. The recorded systolic pressure was within the severe range, but the available evidence did not permit independent reconstruction of the complete diagnostic classification.

Recommended Management and Documented Actions

Referral to a higher-level health facility (FKRTL) was recommended for further maternal and fetal evaluation and blood-pressure management, including consideration of magnesium sulfate if clinically indicated and evaluation of the timing and mode of delivery. The clinical narrative reports that cesarean delivery was recommended in the context of breech presentation and severe-range blood pressure. However, detailed obstetric findings supporting the proposed mode of delivery were not available for independent assessment. Permanent sterilization (Metode Operasi Wanita [MOW]) was also offered during the course of obstetric counseling. The documentation does not establish that acceptance of cesarean delivery was explicitly made conditional on acceptance of MOW.

The available case narrative records the patient's refusal of referral, further assessment, and the proposed cesarean delivery. Neither magnesium sulfate nor antihypertensive treatment was documented as administered at the initial primary-care encounter. The available information does not establish whether these medications were offered as separate options, were available for administration at that site, or were explicitly refused individually. A discussion involving the patient and her husband was subsequently described, with the stated aim of exploring concerns and communicating risks. The precise dates and sequence of the reported specialist consultation and repeated home visits could not be reconstructed from the available clinical documentation.

Patient Preferences and Perceived Clinical Risk

During the interview, the patient explained that she wished to deliver vaginally, as she had during her two previous births. She associated the onset of labor with contractions or other symptoms and did not consider her condition an emergency in their absence:

"Doctor, I'm not having any abdominal pain yet, I'm not experiencing any contractions, and I haven't had any spotting. Why are you insisting on delivering the baby now? I want to give birth when I start having abdominal pain, and I want to deliver normally, just like I did with my other children." (ST)

She also described taking blood-pressure medication in response to symptoms rather than according to a clearly documented regular treatment regimen:

"I only take my blood pressure medication when I feel dizzy, Doctor. I usually just go to the mantri, get an injection, and feel better right away. They also give me some pills." (ST)

The medication name, dosage, prescribed regimen, and qualifications of the provider referred to as mantri were not established in the available material. The patient communicated a clear preference for vaginal delivery, but no structured assessment of understanding, appreciation, reasoning, and communication of choice was documented. Accordingly, the interview cannot establish either adequate decision-making capacity for each specific intervention or incapacity; disagreement with clinicians' recommendations alone is not evidence of incapacity.

Anticipated Quality-of-Life and Reproductive Concerns

The patient expressed concern about possible harm to her baby from delivery before the time she considered appropriate. She also described fears about postoperative complications and the permanent loss of fertility associated with MOW:

"The baby isn't fully developed yet, and I'm afraid they'll be prone to illnesses as they grow up if they're born now." (ST)

These statements describe the patient's anticipated consequences of early delivery, surgery, and permanent contraception; they do not constitute a formal measurement of quality of life. The available interviews did not establish whether she understood cesarean delivery and MOW as separate procedures requiring separate decisions, or whether she believed that accepting one would entail accepting the other.

Contextual Factors and Reported Healthcare Experiences

The patient referred to the Javanese calendar when describing her estimate of gestational age, to childbirth practices in her social environment when explaining her preference for vaginal birth, and to difficulties accessing healthcare services:

"I calculate my pregnancy using the Javanese calendar, Doctor. By my calculation, I'm only eight months pregnant, so I'm afraid the baby isn't fully developed enough to be born now." (ST)

"All the women around here have given birth normally, Doc, so I think it should be fine. There's no need for surgery." (ST)

"The health centre is far from my home, Doc. I also don't really understand how BPJS works because the village administration handles it for me." (ST)

The patient and her husband retrospectively described distress associated with repeated home visits and a specialist consultation that took place without the husband's prior knowledge. The patient's account included the following statements:

"I was suddenly taken on the back of a motorbike to the hospital without having the chance to tell my husband. Once I got there, the obstetrician immediately told me to undergo a caesarean section and sterilisation." (ST)

"It felt as though they were constantly chasing me and forcing me to do it, Doc." (ST)

These quotations document how the patient recalled and interpreted the encounters; they do not independently establish that coercion occurred. The treating clinicians' contemporaneous accounts of the communication process were not available. It was also not documented whether the patient had requested her husband's presence during the earlier specialist consultation. The reported distance to services and uncertainty regarding BPJS were treated as patient-reported access concerns rather than independently verified barriers or established causes of refusal.

Available Sequence and Follow-up

The report establishes an initial clinical encounter in March 2026, recommendations for referral and further management, subsequent descriptions of family discussion and healthcare encounters, and research interviews conducted approximately two weeks after the initial encounter. The precise order and dates of all reported home visits and specialist consultations could not be verified from the available clinical documentation. The later research interviews should not be interpreted as evidence that clinical follow-up or treatment was completed. No reliable longitudinal record of maternal status, delivery, neonatal outcomes, or a subsequent change in the patient's treatment decision was available.

Synthesis of the Four Ethical Domains

Table 1 summarizes the documented findings and interview accounts in each Four-Box domain. The table separates case evidence from uncertainties and identifies the issue requiring ethical consideration. It does not assume that the recommended actions were implemented or that the reported ethical conflict was resolved.

Table 1. Four-Box Ethical Analysis of Documented Case Evidence, Information Gaps, and Ethical Considerations in the Refusal of Recommended Obstetric Care.

Domain	Case evidence	Information not established	Issue for ethical analysis
Medical indications	Single recorded BP of 170/101 mmHg; reported gestational age 36 weeks + 1 day; breech presentation; referral and obstetric assessment recommended.	Serial BP values, proteinuria, organ-function investigations, full fetal assessment, and definitive rationale for the mode of delivery.	Urgency of reassessment and referral despite incomplete diagnostic documentation.
Patient preferences	Expressed preference for vaginal birth; concern about early delivery and surgery; refusal of referral and further examination reported.	Formal capacity assessment; details of information communicated; explicit response to each medication or procedure.	Distinguishing expressed refusal from informed refusal and from decision-making capacity.
Quality of life	Anticipated infant-health concerns, postoperative fears, and concern about permanent loss of fertility.	Formal quality-of-life assessment; whether the patient believed cesarean delivery and MOW were inseparable; later maternal-neonatal outcomes.	Respecting values concerning childbirth and reproductive choices without assuming a measured outcome.
Contextual features	Reported use of the Javanese calendar, social expectations, BPJS/access concerns, family experiences, and perceived pressure.	Treating clinicians' contemporaneous perspectives; precise sequence of encounters; independent verification of barriers; whether husband's involvement was requested.	Interpreting reported experiences while preserving autonomy and avoiding unsupported findings of coercion.

DISCUSSION

The present case illustrates the clinical and ethical challenges associated with the refusal of recommended obstetric interventions in a high-risk pregnancy. At 36 weeks and 1 day of gestation, the patient had a recorded blood pressure of 170/101 mmHg, which meets the systolic threshold for severe hypertension during pregnancy. According to the International Society for the Study of Hypertension in Pregnancy (ISSHP), severe hypertension requires prompt confirmation, urgent clinical assessment, and appropriate antihypertensive management in a monitored setting (Magee et al., 2022). Similarly, the American College of Obstetricians and Gynecologists (ACOG, 2019) emphasizes the urgency of treatment for confirmed acute-onset severe hypertension during pregnancy, while the National Institute for Health and Care Excellence (NICE, 2023) recommends hospital assessment and appropriate monitoring when severe hypertension is identified. Although the recorded blood pressure indicates a potentially serious maternal condition, the available documentation does not include repeated blood pressure measurements, proteinuria assessment, maternal organ-function tests, or comprehensive fetal evaluation. These limitations prevent a reliable reconstruction of the complete diagnostic assessment and therefore restrict the certainty with which the patient's hypertensive disorder can be classified.

Importantly, diagnostic uncertainty should not be interpreted as an absence of clinical urgency. A severe-range

blood pressure measurement warrants timely reassessment even when the patient reports no subjective symptoms. In this case, the patient did not perceive an emergency because she was not experiencing contractions, abdominal pain, or vaginal bleeding. However, these symptoms are not reliable indicators of the presence or severity of hypertensive complications. The clinical concern therefore arises from the recorded severe-range blood pressure rather than from a fully documented diagnosis of preeclampsia with severe features. This distinction is essential because it allows the clinical recommendations to be evaluated according to the evidence actually available, without overstating diagnostic certainty (ACOG, 2019; Magee et al., 2022; NICE, 2023).

The recommended interventions also require consideration according to their respective clinical purposes. Referral to a higher-level facility was intended to facilitate further assessment and management, while antihypertensive treatment and magnesium sulfate serve different therapeutic functions. The former addresses elevated blood pressure, whereas the latter is used for seizure prevention or treatment when clinically indicated. The preventive benefits of magnesium sulfate in women with preeclampsia have been demonstrated in the Magpie Trial, although its indication in an individual patient must be assessed according to the clinical findings (Magpie Trial Collaborative Group, 2002). The report states that neither treatment was administered at the initial facility, but the available information does not establish whether each intervention was offered separately, could have been provided at that facility, or was specifically refused. Similarly, the recommendation for cesarean delivery was associated with breech presentation and severe-range hypertension; however, the incomplete maternal and fetal assessments prevent an independent determination of the full obstetric rationale for that recommendation. These distinctions are important because refusal of referral, medication, operative delivery, and permanent contraception should not automatically be interpreted as refusal of a single, indivisible treatment package.

Evidence regarding the timing of delivery in preeclampsia further emphasizes the importance of individualized decision-making. The CRADLE-4 randomized controlled trial compared planned delivery with expectant management among women with late-preterm preeclampsia in India and Zambia. Although the primary composite maternal outcome did not differ significantly between groups, planned delivery was associated with reductions in severe maternal hypertension and stillbirth (Beardmore-Gray et al., 2023). These findings support consideration of planned delivery in appropriately selected patients but do not establish that cesarean delivery is required for every patient with preeclampsia after 34 weeks of gestation. The timing and mode of delivery must be evaluated separately, considering gestational age, fetal presentation, maternal and fetal condition, and available obstetric expertise. Guidance on breech presentation similarly emphasizes individualized assessment and counseling regarding the benefits and risks of available delivery options (Impey et al., 2017). Because the present case lacks several essential diagnostic and fetal assessment findings, the appropriateness of the specific recommendation for cesarean delivery cannot be conclusively evaluated from the available records.

The patient's refusal was accompanied by a perception of pregnancy-related risk that differed from the clinical concerns expressed by healthcare professionals. Her previous experiences of vaginal childbirth, the absence of symptoms she associated with an obstetric emergency, and her concerns regarding early delivery contributed to the reasoning she described during the interview. Similar differences between clinical knowledge and patients' interpretations of hypertensive disorders have been reported in qualitative research. Tamma et al. (2023), for example, identified misconceptions and gaps in knowledge concerning hypertension during pregnancy among affected women in Ghana. Furthermore, a systematic qualitative review by Downe et al. (2018) highlighted the importance of women's expectations, beliefs, and personal values in shaping their experiences and preferences during childbirth. Nevertheless, findings from other populations cannot establish the causes of refusal in the present case. The patient's statements should therefore be understood as reported explanations for her preferences rather than as evidence of causal relationships.

An important ethical distinction concerns the relationship between misunderstanding medical information and impaired decision-making capacity. The patient's preference for vaginal delivery, concerns about surgery, and reliance on previous childbirth experiences do not independently demonstrate that she lacked the capacity to make medical decisions. Decision-making capacity is generally assessed through four abilities: understanding relevant information, appreciating its implications for one's own circumstances, reasoning about available options and their consequences, and communicating a choice (Appelbaum, 2007). In the present case, the patient was able to communicate her preferences consistently. However, the available documentation does not establish whether her understanding, appreciation, and reasoning were assessed systematically. Consequently, the evidence is insufficient to confirm either that she possessed all the abilities required for the specific decisions concerned or that her capacity was impaired.

The concept of informed refusal is particularly relevant because a patient's disagreement with medical recommendations does not itself constitute evidence of incapacity. ACOG (2016) emphasizes that a pregnant patient with decision-making capacity retains the right to refuse recommended medical treatment, including interventions intended to protect maternal or fetal well-being. An ethically valid refusal requires more than documentation that a patient declined a procedure. The decision-making process should include understandable information regarding the clinical condition, potential benefits and harms of the proposed intervention, reasonable alternatives, and possible consequences of declining treatment. Patients should also have opportunities to ask questions and communicate their concerns without coercion. These requirements are consistent with ACOG's subsequent guidance on informed consent and shared decision-making, which emphasizes the integration of clinical evidence with patients' values and preferences (ACOG, 2021).

In this context, shared decision-making provides a practical approach to supporting informed choices. Elwyn et al. (2012) describe a model that emphasizes introducing available choices, explaining options, and supporting patients in considering what matters most to them. Strategies such as checking comprehension through teach-back may also help clinicians identify misunderstandings and adjust their explanations. A systematic review by Talevski et al. (2020) found that teach-back can support patient understanding and communication, although implementation methods and reported outcomes varied across studies. However, such strategies should not be used to pressure patients toward a predetermined decision. In the present case, the documentation does not establish whether a structured assessment of understanding or a

formal informed-refusal discussion was completed. These approaches should therefore be presented as recommendations for ethically defensible practice rather than interventions demonstrated to have been successfully implemented.

A particularly important feature of this case is the concurrent recommendation of cesarean delivery and permanent sterilization, locally described as Metode Operasi Wanita (MOW). Although both procedures may be discussed during obstetric care, they involve fundamentally different decisions. Cesarean delivery concerns the management of childbirth, whereas permanent sterilization affects the patient's future reproductive capacity. Consent to one intervention does not constitute consent to the other. Evidence-based contraceptive counseling should emphasize informed choice, effective communication, and respect for individual reproductive preferences (Dehlendorf et al., 2014).

ACOG's Committee Statement on permanent contraception emphasizes that counseling should protect reproductive autonomy, support voluntary decision-making, and avoid coercion or practices that limit meaningful reproductive choice (ACOG, 2024). In the present case, the patient's concern that sterilization would permanently eliminate her fertility represents a relevant expression of her reproductive values. It is therefore essential to distinguish her concerns about surgery from her concerns about permanent contraception, rather than treating them as a single objection to medical intervention. Such an approach is also consistent with patient-centered contraceptive counseling that recognizes the importance of individual preferences and the quality of clinician–patient communication (Dehlendorf et al., 2014).

Presenting cesarean delivery and sterilization during the same clinical encounter may create uncertainty about whether acceptance of one procedure is conditional upon acceptance of the other, particularly when the patient perceives the consultation as urgent or pressuring. However, the available interview findings do not establish whether the patient explicitly understood the two procedures as inseparable or whether healthcare professionals presented them in that manner. Such an interpretation must therefore remain a possibility rather than a confirmed explanation for her refusal.

Nevertheless, this uncertainty identifies an important ethical lesson. Counseling regarding permanent contraception should clearly distinguish the indications, anticipated consequences, benefits, risks, and alternatives of sterilization from those of obstetric intervention. The patient's consent must be voluntary and specific to the procedure concerned. An urgent obstetric condition should not be used as justification for pressuring a patient to accept a permanent reproductive decision. International guidance on eliminating forced, coercive, and otherwise involuntary sterilization similarly emphasizes that decisions about sterilization must be based on full, free, and informed consent (ACOG, 2024; World Health Organization [WHO], 2014). In this case, maintaining a clear separation between obstetric management and contraception counseling may have been important for preserving the patient's perception of control over her reproductive choices, although the effect of such an approach cannot be established retrospectively.

The patient's and her husband's accounts also demonstrate the importance of interpersonal relationships in clinical decision-making. Both described discomfort associated with repeated home visits and a specialist consultation that the patient experienced as unexpected and pressuring. These statements provide insight into how the healthcare process was perceived by the family. However, because contemporaneous accounts from the treating healthcare professionals are unavailable, the findings cannot establish that objectively coercive practices occurred. The distinction between perceived coercion and verified coercion is essential to avoid drawing conclusions beyond the available evidence. Previous work on disrespect and abuse in maternal healthcare has emphasized the importance of distinguishing women's experiences and interpretations from the assessment of professional practices and institutional processes (Freedman et al., 2014).

From an ethical perspective, clinicians may appropriately provide strong recommendations when an intervention is medically urgent, but directive counseling must be distinguished from coercion. ACOG (2016) recognizes that clinicians can actively recommend treatments while continuing to respect a decisionally capable pregnant patient's right to refuse them. Recommendations become ethically problematic when accompanied by threats, manipulation, force, or other forms of inappropriate pressure. The present case therefore raises an important question about how repeated efforts to prevent maternal harm may be experienced by patients who perceive that their concerns have not been adequately heard. Although the intentions of the healthcare professionals cannot be established from the available data, the reported experiences highlight the need to consider not only the clinical appropriateness of recommendations but also how those recommendations are communicated (Freedman et al., 2014).

The involvement of the patient's husband requires equally careful consideration. The husband's absence from the initial specialist consultation does not, by itself, establish inadequate care or a violation of the patient's rights. An adult patient with decision-making capacity remains the primary decision-maker regarding her medical treatment. Nevertheless, family involvement may facilitate understanding and emotional support when it reflects the patient's own preferences. Research on women's childbirth experiences also supports the importance of recognizing individual expectations and the relationships that women consider meaningful during maternity care (Downe et al., 2018).

This interpretation is consistent with the concept of relational autonomy, which recognizes that individual decisions are made within social relationships and may be supported or constrained by interpersonal interactions (Entwistle et al., 2010). In the present case, involvement of the husband could be ethically appropriate if requested or authorized by the patient, but his preferences should not replace her own. The relevant consideration is therefore not whether the husband was present, but whether the patient had a meaningful opportunity to determine whom she wished to involve in the decision-making process.

The patient's perception of pressure also has implications for respectful maternal care. Bohren et al. (2015) identified multiple forms of mistreatment experienced by women during childbirth, including difficulties related to communication, autonomy, and dignity. Freedman et al. (2014) further emphasized the importance of understanding disrespect and abuse in maternity care through women's experiences, professional practices, and health-system accountability. More recently, WHO (2025) emphasized person-centered care that protects dignity, supports informed choices, and seeks to prevent mistreatment in maternal and newborn health services. These sources provide a relevant framework for interpreting the ethical significance of the patient's

experience, although they do not constitute evidence that mistreatment occurred in this particular case.

An ethically appropriate response requires communication that is clinically clear, respectful, and responsive to the patient's concerns. The urgency of maternal risk does not eliminate the need for dialogue, nor does respect for autonomy require clinicians to withhold important medical recommendations. Rather, both responsibilities should inform how healthcare professionals continue to engage with patients who decline recommended interventions. This approach is consistent with the principles of informed consent and shared decision-making in obstetric and gynecological care (ACOG, 2021).

The contextual features of this case extend beyond interpersonal communication. The patient described using the Javanese calendar to estimate gestational age and referred to previous childbirth experiences and local expectations of vaginal delivery when explaining her preferences. These statements illustrate the role of personal and sociocultural meanings in perceptions of pregnancy and childbirth. However, they should not be interpreted as evidence that Javanese cultural beliefs generally cause refusal of obstetric care. The findings concern the interpretation reported by one patient and cannot establish broader cultural patterns. The importance of understanding women's values and expectations in maternity care has also been emphasized in qualitative evidence synthesis (Downe et al., 2018).

These observations suggest that effective counseling should begin by understanding how the patient interprets her condition before introducing biomedical explanations. Differences between traditional and clinical interpretations of gestational age can be addressed through respectful discussion of the available examination findings. Such communication may support comprehension without dismissing the patient's experiences or cultural frame of reference. The aim should be to make clinical information understandable and relevant to the patient's concerns rather than to characterize her beliefs as inherently incompatible with appropriate medical care (Downe et al., 2018; Elwyn et al., 2012).

Healthcare access represents another important contextual consideration. The patient reported difficulty reaching the health center and limited understanding of procedures associated with Indonesia's national health insurance system, BPJS. These reported barriers raise questions related to the principle of justice, particularly whether patients have sufficient information and practical support to access recommended care. Although the available data do not establish that financial or geographical barriers were the principal reasons for refusing referral, such barriers may constrain the alternatives that patients perceive as realistically available. Previous research has identified geographical accessibility, socioeconomic conditions, and healthcare-related factors as important determinants of maternal healthcare utilization across different settings (Gabrysch & Campbell, 2009).

Within the Four-Box Method, consideration of contextual features should therefore extend beyond individual beliefs to include healthcare accessibility, referral arrangements, and the information required to navigate available services (Jonsen et al., 2015). In this case, explaining referral procedures, clarifying relevant insurance arrangements, and identifying feasible pathways to further assessment would represent ethically appropriate responses to the reported concerns. However, the case documentation does not establish which of these measures were implemented or whether they affected the patient's subsequent decisions. The broader literature supports the relevance of identifying practical barriers to accessing maternal healthcare while recognizing that these barriers may operate differently across populations and healthcare systems (Gabrysch & Campbell, 2009).

Integrating the four domains of the Four-Box Method demonstrates that the ethical challenge cannot be reduced to a simple choice between protecting maternal safety and respecting patient autonomy. The medical indications domain identifies a clinically urgent severe-range blood pressure measurement requiring prompt reassessment and appropriate management, while acknowledging important limitations in diagnostic documentation. The patient preferences domain highlights the patient's desire for vaginal delivery, concerns regarding medical interventions, and the absence of a structured capacity assessment. The quality-of-life domain draws attention to her expectations regarding childbirth, infant health, and future fertility. Finally, the contextual features domain identifies reported cultural beliefs, family relationships, healthcare access barriers, and experiences of perceived pressure (Jonsen et al., 2015).

Taken together, these domains suggest that ethically defensible care requires both the communication of clinically appropriate recommendations and the protection of meaningful patient choice. The first priority is to explain the clinical concern and the potential consequences of delaying evaluation in terms the patient can understand. Each proposed intervention should then be discussed separately, including the option of referral and further assessment without presuming consent to cesarean delivery or permanent sterilization. Where there are genuine concerns regarding decision-making capacity, an assessment should focus on the patient's ability to understand, appreciate, reason about, and communicate a decision, rather than on whether the patient agrees with the clinician's recommendation (ACOG, 2016, 2021; Appelbaum, 2007).

If a patient with adequate decision-making capacity continues to decline recommended care after an appropriate discussion, the refusal should be respected and documented. Clinicians should continue to offer clinically appropriate assessment, monitoring, referral, and management alternatives when feasible, while maintaining opportunities for the patient to reconsider without coercion. Family involvement should be guided by the patient's preferences, and practical barriers to accessing care should be addressed wherever possible. This approach is consistent with shared decision-making principles and the ethical obligations underlying respectful maternal healthcare (ACOG, 2016, 2021; Elwyn et al., 2012; WHO, 2025).

It is important to distinguish these recommendations from the actions documented in the present case. The available records describe recommendations for referral and obstetric intervention, followed by discussions involving the patient and her husband. They do not establish that a structured capacity assessment, a comprehensive informed-refusal process, or the full range of alternative management strategies described above was implemented. Furthermore, subsequent maternal and neonatal outcomes could not be ascertained. Consequently, this report cannot demonstrate that the ethical conflict was successfully resolved or that any particular communication strategy improved clinical outcomes.

The principal contribution of this case lies in illustrating how urgent clinical recommendations, reproductive preferences, experiences of healthcare communication, and barriers to service access may converge in a single decision-making encounter. It also highlights why counseling about

permanent contraception should remain distinct from counseling about urgent obstetric interventions. Rather than establishing a general explanation for treatment refusal, the case offers a context-specific basis for considering how clinicians can communicate serious maternal risk while preserving reproductive autonomy and a respectful therapeutic relationship.

Strengths and Limitations

An important strength of this report is its integration of clinical documentation with the perspectives of both the patient and her husband. The Four-Box Method provides a structured framework for considering medical indications alongside patient preferences, quality-of-life concerns, and contextual influences. The primary-care setting also offers a relevant perspective on the ethical challenges that may arise before patients reach facilities capable of comprehensive obstetric assessment and management.

Nevertheless, several limitations substantially restrict the interpretation of the findings. First, the absence of repeated blood pressure measurements, proteinuria assessment, maternal laboratory investigations, and comprehensive fetal evaluation limits diagnostic certainty and prevents independent verification of the full rationale for the recommended interventions. Second, the lack of longitudinal clinical records and maternal–neonatal outcome data prevents evaluation of the subsequent clinical course and the consequences of the patient's decisions. Third, the absence of a structured decision-making capacity assessment limits conclusions regarding the adequacy of the informed-refusal process.

Fourth, the interview findings reflect retrospective accounts from the patient and her husband, which may be affected by recall and interpretation. Although the interviews provide valuable insights into their experiences, the absence of contemporaneous perspectives from the treating healthcare professionals limits the ability to reconstruct the complete communication process or establish whether coercive practices occurred. Fifth, the analysis concerns a single case and therefore does not permit statistical generalization or causal attribution regarding the factors associated with refusal.

These limitations underscore the need for cautious interpretation. The case should be regarded as an illustration of clinical and ethical complexity rather than evidence of the effectiveness of a particular approach or the occurrence of a verified ethical violation. Its value lies in identifying considerations that may improve the quality of clinical reasoning, informed-refusal documentation, and respectful communication in comparable high-risk obstetric encounters.

CONCLUSION

Refusal of recommended obstetric interventions in the setting of severe hypertension in pregnancy constitutes an ethical issue that engages medical indications, patient preferences, quality of life, and contextual factors. Analysis with the Four-Box Method shows that the patient's decision was shaped by risk perception grounded in prior experience, cultural beliefs, family dynamics, and perceptions of healthcare interactions. Strong medical indications for prompt evaluation existed, yet decision-making capacity and the adequacy of the informed-refusal process could not be comprehensively assessed from the available data. Permanent sterilization requires separate, voluntary consent distinct from consent to cesarean delivery. Respect for patient autonomy remains an essential component of ethical maternal healthcare, including when the patient's decision differs from medical recommendations. Ethically defensible practice therefore includes empathetic communication, structured capacity assessment when indicated, clear separation of obstetric and sterilization decisions, documentation of informed refusal, and continued non-coercive offers of monitoring and referral without claiming that the ethical conflict in this particular case was resolved.

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DECLARATIONS

Ethics Approval and Consent to Participate

Ethical approval for this study was obtained from the Health Research Ethics Commission of Universitas Jember (Approval No. 3762/UN25.8/KEPK/DL/2026, dated February 27, 2026). The confidentiality of the patient and their family was maintained by using initials and omitting information that could lead to individual identification. Clinical documentation was accessed with institutional permission under the same ethics approval. Interviews were conducted after the clinical encounter as part of the approved research protocol.

Consent for Publication

Written informed consent for publication of this case report and accompanying interview quotations was obtained from the patient. The manuscript does not include information intended to identify the patient or their family. The requirements for publication of clinical information and interview findings have been addressed in accordance with the journal's policy and the applicable ethics approval.

Availability of Data and Materials

The data supporting this study consist of clinical documentation and verbatim interview transcripts. These data are not publicly available due to confidentiality and ethical considerations concerning the participants' privacy. De-identified excerpts relevant to the analysis are presented within the manuscript.

Conflicts of Interest

The authors declare that they have no competing interests. None of the authors was involved in the direct clinical care of the patient described in this report

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Grammarly was used to support English-language editing. OpenAI ChatGPT was used to assist with substantive restructuring and drafting of the manuscript. The authors are responsible for verifying all clinical information,

interview quotations, references, interpretations, and final wording against the original documentation and source publications before submission.

Authors' Contributions

Arsyzilma Hakiim was responsible for data collection, conceptualization, and preparation of the initial manuscript draft. Eny Nurmaida coordinated the allocation of tasks among the authors and contributed to the Discussion section. Yohanes Sudarmanto contributed to the Discussion section and provided consultation on the study concept. Yoviena Kusuma Terichtia Tamaranny was responsible for conceptual refinement, critical review, manuscript finalization, translation, and English-language editing. All authors reviewed and approved the final version of the manuscript.

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ADDITIONAL INFORMATION

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