

**AT THE NEXUS OF LAW AND ETHICS: A PROPOSED JUDICIAL STANDARD FOR  
COURT-ORDERED CESAREAN SECTIONS**

by

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# **AT THE NEXUS OF LAW AND ETHICS: A PROPOSED JUDICIAL STANDARD FOR COURT-ORDERED CESAREAN SECTIONS**

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Maternal-fetal conflicts, specifically court-ordered Cesarean sections, are explored from a legal and ethical perspective. An increase in technology, combined with the rise of bioethics, the respect for autonomy in medical decision-making, and the legal doctrine of informed consent have created an atmosphere in which conflicts may occur between the pregnant woman and her fetus. The scant legal precedent in this area does not provide a clear standard for evaluating cases in which a pregnant woman with a viable fetus refuses a recommended Cesarean section. The analysis first examines the clinical aspects of a Cesarean delivery, and then turns to a discussion of the legal precedent and the potentially analogous areas of law (i.e. abortion, parent-child relationships, and organ donation). In addition, there is an examination of the ethical and policy considerations, which weigh heavily in favor of honoring the pregnant woman's wishes over the perceived benefit for the fetus. Finally, a judicial standard is proposed which combines the legal and ethical analyses, and concludes that a court should virtually never override a competent patient's decision to refuse a Cesarean section.

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## INTRODUCTION

Health care marches forward. Practicing medicine today is vastly different from the way medicine was practiced decades ago. Even small changes are reflected from one day to the next, as new studies come out and technology creates new ways to perform procedures and new medicines to prescribe. Nonetheless, some changes bring unexpected side effects that challenge our morals, values, and views of what medicine should or should not be. Obstetrics is one such area in which several transformations in medicine have collided to create an unfortunate dilemma – known collectively as “maternal-fetal conflicts”.

Decades ago, the fetus growing inside of the pregnant woman was somewhat of a mystery because the doctor could only interact with the woman. Advancements in technology have opened the window to the womb to the point where physicians can monitor and test the fetus, perform surgery directly on the fetus, and view the fetus in surprisingly clear detail. As technology advanced, there was another gradual shift occurring in a different sphere of health care – bioethics. Medical paternalism was shifting to a patient-centered approach which valued autonomy in medical decision-making.

Law reflected these changes by recognizing that medical decision-making must contain informed consent by the patient. This recognition of patient autonomy meant that physicians must tell the patient about the risks and benefits of the proposed treatment, and the possible alternatives, including the option of doing nothing. Thus, the law of informed consent was a



further acknowledgment that patients have the right to accept or refuse treatment, which encapsulates our most basic notions of privacy and bodily integrity.

The combination of a dramatic increase in technology and a shift toward patient autonomy in medical decision-making has fueled the issue that this thesis will address – maternal-fetal conflicts, specifically those involving women who refuse a doctor-recommended Cesarean section (“C-section”). As one commentator has said, most women “would cut off their heads to save their babies”<sup>1</sup>, but there are others who will refuse a strongly recommended C-section for personal reasons, which can result in injury or death to the fetus and/or the pregnant woman. Physicians face a difficult balancing act when they perceive the woman’s wishes to be in conflict with fetal interests. The physician is thrown into a situation where it seems impossible to uphold the principles of beneficence and autonomy, and also try to honor their duty to both patients – the woman and the growing fetus. This creates enormous frustration and sometimes horrific consequences in this highly emotional environment, which, in turn, may lead to judicial involvement.

This thesis will examine the legal response to maternal-fetal conflicts involving forced C-sections. I will argue that a clear judicial standard is needed, and ultimately conclude that a competent woman should virtually never be compelled to have a C-section. Chapter 1 is devoted to the clinical aspects of C-sections: clinical indications, risks, and benefits. Chapter 1 will also look at the pregnant women’s perspective, which is an aspect that is frequently overlooked when discussing the legal and medical arguments surrounding forced C-sections.

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<sup>1</sup> Statement of Dr. Mitchell Golbus, Professor of Obstetrics, Gynecology and Reproductive Science, and Director of Reproductive Genetics Unit, Univ. of Cal. Medical Center, San Francisco, made at Planned Parenthood Conference on Human Fertility Regulation: Technological Frontiers and Their Implications, in New York City (Dec. 14, 1984).

Chapter 2 will delve into the judicial response to requests for court-ordered C-sections. There are several appellate cases on point, which will be analyzed in depth. In addition, there are some arguably analogous areas of law that are often cited in order to help physicians and judges conceptualize this unique problem, such as abortion, parent-child relationships, and organ donation.

Chapter 3 will propose the judicial standard, stating that judges should almost never override a competent patient's decision to refuse a C-section. This chapter will look at the many arguments made on both sides, and will examine the ethical and policy considerations, the constitutional rights issues, and the difference between moral and legal mandates. I will argue that the dangers of allowing law to condone the forced treatment of women are too great.

## 1.0 MEDICAL CONSIDERATIONS

There are two broad categories of maternal-fetal conflicts that are delineated in the literature: (1) substance abuse and lifestyle choices, and (2) medical decision-making. The former category encompasses conflicts that arise when pregnant women use drugs or alcohol during their pregnancies, or when their workplace environment contains harmful toxins or conditions that could endanger the fetus. This category is the subject of many articles and case law, but will not be the focus of this paper. Instead, the focus will be the second category – the medical decisions women make throughout their pregnancies. To narrow this category even further, this paper will specifically examine pregnant women with viable fetuses who refuse a doctor-recommended C-section.

An initial problem is in deciphering when a fetus is ‘viable’, as there is no bright line rule that provides a precise answer. The generally accepted ‘point of viability’ is approximately 23-24 weeks gestation.<sup>2</sup> There are two main reasons that only pregnant women with *viable* fetuses are the topic of this paper. First, physicians seek court orders to compel a C-section when the fetus is thought to benefit from a surgical delivery. This necessarily means that the fetus must be viable (i.e. able to live outside the womb) after a C-section.

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<sup>2</sup> D.K. JAMES, ET AL., HIGH RISK PREGNANCY MANAGEMENT OPTIONS 128-29 (3d ed. 2006).

Second, the state's interest in the fetus only becomes compelling at the point of viability.<sup>3</sup> Therefore, the woman's right to privacy (and corresponding right of bodily integrity) dictates that the woman can refuse medical treatment up until the point of viability. This constitutional argument stems from the abortion precedent, which will be discussed in Chapter 2. At this point, it is only used to illustrate why the framework for this paper will address pregnant women with *viable* fetuses.

## 1.1 THE CESAREAN SECTION PROCEDURE

A C-section is frequently said to be 'major surgery', but it is vital to understand just how 'major' and 'invasive' this surgery is – both physically and emotionally on the woman and the fetus. The description below is paraphrased from a popular pregnancy website giving medical information for the layperson:<sup>4</sup>

The woman will be given either general anesthesia or, more likely, will be given an epidural or spinal block. General anesthesia for a C-section is rare these days, but may be used in extreme emergency situations. The epidural or spinal block will numb the lower half of the woman's body so that she can be alert during the surgery. Extra medication may also be given through a catheter to make sure that the lower half of the woman's body stays numb throughout the procedure.

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<sup>3</sup> Roe v. Wade, 410 U.S. 113, 163 (1973).

<sup>4</sup> Giving Birth By Cesarean Section, <http://www.babycenter.com/refcap/160.html#4> (last visited Oct. 3, 2006).

A catheter will be inserted to drain urine before surgery, and an IV will be started. The top section of the woman's pubic hair will be shaved. After anesthesia is administered, a screen is raised above the woman's waist so that she does not have to see the incision being made.

The belly is swabbed with antiseptic, and the physician most likely will make a small, horizontal incision in the skin above the pubic bone. The physician will cut through the underlying tissue while working her way down to the uterus layer by layer. When the abdominal muscles are reached, the physician will separate them manually instead of cutting through them, which will expose what is underneath. When the uterus is reached, the physician will likely make a horizontal cut in the lower section of it (called a 'low-transverse' incision). The physician then reaches in and pulls out the baby. Afterwards, the placenta is delivered and the stitching process occurs. This usually takes about 30 minutes, and involves stitching layer by layer. The final skin layer may be closed with stitches or staples, and will be removed 3-4 days later.

After the surgery, the woman is taken to the recovery room and closely monitored for a few hours. If the baby is healthy, then he/she will be in the recovery room with the woman, where she can finally hold him/her. The woman can expect to stay 3-4 days in the hospital before going home.

## **1.2 CLINICAL INDICATIONS AND OUTCOMES**

As a general rule, a C-section delivery "is indicated any time delivery must be accomplished and when induction of labor, a trial of labor, additional labor, or vaginal delivery

of the fetus is deemed to be of greater risk to the mother or the fetus than abdominal delivery.”<sup>5</sup> The indications are usually lumped into four categories, which account for over 85% of C-section deliveries, and are as follows: (1) prior cesarean delivery, (2) dystocia, (3) fetal distress, and (4) breech presentation.<sup>6</sup> It is impossible to completely catalog all appropriate indications for C-section delivery.<sup>7</sup> In addition, each indication presents varying degrees of risk to the fetus and/or mother.

The level of certainty in each and every clinical indication is not absolute. Therefore, there are going to be variations across the profession as to how these cases should be managed. In addition, there is some uncertainty as to the diagnoses in many cases. For example, fetal distress is a common diagnosis that would indicate a C-section, but false positives are estimated at 18-80%.<sup>8</sup> Also, one physician notes that “[r]ecommendations to clinicians on how to use the fetal monitoring data are biased in support of cesarean delivery.”<sup>9</sup> This results in many unnecessary C-sections, but there is no way to know ahead of time whether it was unnecessary.<sup>10</sup> Electronic fetal monitoring (EFM) has increased the C-section rate by up to 40%, but it is well established that EFM has *not* reduced the risk of cerebral palsy or perinatal death, as compared to the previous method of intermittent fetal heart rate checks.<sup>11</sup>

As will be shown in Chapter 2, judges often rely very heavily on the statistical outcomes for certain diagnoses. But, as shown above, there is no uniform reaction to each situation and there are no guarantees of a particular outcome in any case.

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<sup>5</sup> MATERNAL-FETAL MEDICINE: PRINCIPLES AND PRACTICE 692 (Robert K. Creasy & Robert Resnik eds., 2004).

<sup>6</sup> F. GARY CUNNINGHAM, ET AL., WILLIAMS OBSTETRICS 591 (22d ed. 2005).

<sup>7</sup> *Id.*

<sup>8</sup> Carol A. Tauer, *Lives at Stake*, 73(7) HEALTH PROGRESS 18, 20 (1992) (citing Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 2014 (1986)).

<sup>9</sup> *Id.* at 23 (quoting Alan R. Fleischman, REPRODUCTIVE LAWS FOR THE 1990S 251 (Sherrill Cohen & Nadine Taub eds., 1989)).

<sup>10</sup> *Id.* at 23.

<sup>11</sup> F. GARY CUNNINGHAM, ET AL., *supra* note 6, at 591.

In 2002, the C-section rate was 26.1%, which was the highest ever recorded in the U.S.<sup>12</sup> There are additional risks to the woman and fetus from a C-section delivery, as opposed to a vaginal delivery. C-sections that are at issue in maternal-fetal conflicts are usually emergency in nature, which may involve patient anxiety, an incompletely emptied stomach, acute hemorrhage from a placental accident, and other conditions that pose greater challenges.<sup>13</sup> The maternal mortality rate for a C-section delivery with a live-birth outcome is 35.9 deaths per 100,000, while the rate for vaginal delivery is 9.2 per 100,000.<sup>14</sup>

Complications increase dramatically with a C-section compared to vaginal delivery. Women are nearly twice as likely to be rehospitalized in the 60 days following a C-section than after a vaginal delivery.<sup>15</sup> Serious intra-operative complications occur in approximately 2% of cesarean deliveries, including anesthesia accidents (e.g., problems with intubation, drug reactions, aspiration pneumonitis), hemorrhage, bowel or bladder injury, amniotic fluid embolism, and air embolism.<sup>16</sup> Urinary tract injuries are ten times more common in C-section deliveries than in operative vaginal deliveries.<sup>17</sup>

The postpartum maternal complications after a C-section include atelectasis (partial lung collapse), endomyometritis (infection of uterine tissues), urinary tract infection, abdominal wound problems (i.e. hematoma formation, rupture of the wound, infection, or necrotizing fasciitis (commonly known as flesh-eating bacteria)), thromboembolic disease, and bowel

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<sup>12</sup> F. GARY CUNNINGHAM, ET AL., *supra* note 6, at 590.

<sup>13</sup> MATERNAL-FETAL MEDICINE, *supra* note 5, at 690.

<sup>14</sup> Margaret A. Harper & Robert P. Byington, *Pregnancy-Related Death and Health Care Services*, 102 OBSTETRICS & GYNECOLOGY 273, 275 (2003). It is important to note that the C-section rate is likely affected by the fact that C-sections are usually recommended in cases where there are maternal or fetal complications.

<sup>15</sup> CUNNINGHAM, ET AL., *supra* note 6, at 592.

<sup>16</sup> MATERNAL-FETAL MEDICINE, *supra* note 5, at 690.

<sup>17</sup> *Id.*

dysfunction.<sup>18</sup> Immediately after the baby is born, the woman will usually be given a dose of prophylactic antibiotics to attempt to avoid bacterial infections.<sup>19</sup> Taking into account all of the morbidities and the increased recovery time needed by the women, there is a twofold increase in costs for a C-section versus vaginal delivery.<sup>20</sup>

There are also long-term complications of C-section, which are more difficult to document, but include (1) C-section delivery in a subsequent pregnancy, (2) uterine rupture in a subsequent pregnancy, (3) placenta previa and placenta accrete in a subsequent pregnancy<sup>21</sup>, (4) ectopic pregnancy, (5) infertility, and (6) bowel obstructions resulting from intra-abdominal adhesions.<sup>22</sup>

Women are not the only ones affected – a recent study looked at neonatal mortality rates between vaginal and C-section deliveries in women with *no indicated medical risks* or complications. The results show that neonatal mortality rates are almost three times higher for C-section deliveries than vaginal births.<sup>23</sup> It is unclear how these results can be applied in the case of court-ordered C-sections, in which the woman *necessarily has* a medical complication which can endanger the fetus. However, it illustrates that C-section delivery alone (without other risk factors) poses a greater risk of death to the child than vaginal delivery. In addition to the risk of neonatal death, there are significant but uncommon complications to the fetus associated

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<sup>18</sup> *Id.*

<sup>19</sup> Harish M. Sehdev, *Cesarean Delivery*, Aug. 6, 2005, <http://www.emedicine.com/med/topic3283.htm#target2>.

<sup>20</sup> CUNNINGHAM ET AL., *supra* note 6, at 592.

<sup>21</sup> ‘Placenta previa’ is a condition in which the placenta is attached in such a way that it is blocking the birth canal. ‘Placenta accrete’ is a condition in which the placenta is firmly attached to the uterine wall. Both conditions are potentially life-threatening to the mother because they cause severe hemorrhaging.

<sup>22</sup> MATERNAL-FETAL MEDICINE, *supra* note 5, at 691.

<sup>23</sup> Marian F. MacDorman, et al., *Infant and Neonatal Mortality for Primary Cesarean and Vaginal Births to Women with “No Indicated Risk”, United States, 1998-2001 Birth Cohorts*, 33 BIRTH 175, 177 (2006).



with a C-section. These include fetal asphyxia, neonatal respiratory problems, and scalpel lacerations.<sup>24</sup>

In addition to the physical problems, there are some psychological problems linked to C-sections. One study interviewed women after having an emergency C-section, and revealed that a majority of the women experienced the C-section as a mental trauma.<sup>25</sup> Furthermore, one-third of the women experienced serious post-traumatic intrusive stress reactions.<sup>26</sup> Another emotional issue is that women often feel cheated out of a vaginal labor and birth.<sup>27</sup> One very popular pregnancy guidebook says that women should be prepared emotionally and intellectually for a C-section, which will help minimize the feeling of disappointment.<sup>28</sup> However, in the context of court-ordered emergency C-sections, the pregnant woman may be not only unprepared emotionally and intellectually, but also actively resist the surgery.

As will be seen in Chapter 2, judges very rarely discuss these complications in their opinions, but instead focus heavily on the proposed statistics of the life and death of the fetus without the recommended intervention. The health effects on the woman, the increased costs, and the long-term effects do not seem to factor into the judicial equation when these cases are heard.

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<sup>24</sup> MATERNAL-FETAL MEDICINE, *supra* note 5, at 691.

<sup>25</sup> Elsa Lena Ryding, Barbro Wijma, and Klaas Wijma, *Posttraumatic Stress Reactions after Emergency Cesarean Section*, 76 ACTA OBSTET. GYNECOL. SCAND. 856, 859 (1997).

<sup>26</sup> *Id.*

<sup>27</sup> HEIDI MURKOFF, ET AL., WHAT TO EXPECT WHEN YOU'RE EXPECTING 299 (3d ed. 2002).

<sup>28</sup> *Id.* at 378.

### 1.3 THE REACTION OF THE HEALTH CARE PROFESSION

Fortunately, the perceived need to get a court order for a C-section is a fairly infrequent problem. But, it is a problem that must be addressed in order for health care professionals to understand their options when such a situation presents itself. After the issue was brought to light in the mid-1980's and throughout the 1990's, there has been continued debate as to the proper course of action when a pregnant woman presents to the hospital and refuses a recommended C-section.

The American Medical Association (AMA) has weighed in with its own policy recommendations on the topic based on the legal and ethical background. This policy states that a pregnant woman should be encouraged to fulfill her moral responsibilities to her fetus, but a legal duty should not generally be imposed.<sup>29</sup> In addition, if the woman makes an informed refusal of a procedure which will benefit the fetus, the physician cannot be held morally responsible for the consequences of the woman's decision.<sup>30</sup> Physicians should not resort to the courts to impose their own personal value judgments on the pregnant woman.<sup>31</sup> Finally, the right to refuse medical treatment is not absolute. Therefore, it may be appropriate to seek a court order if an exceptional circumstance occurs in which the following three conditions are satisfied: (1) medical treatment poses an insignificant or no health risk to the woman, (2) it entails a minimal invasion of bodily integrity, and (3) it would clearly prevent substantial and irreversible harm to her fetus.<sup>32</sup>

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<sup>29</sup> Helene M. Cole, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2664 (1990).

<sup>30</sup> *Id.* at 2666.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

The American College of Obstetricians and Gynecologists (ACOG) has also weighed in on the topic with its own policy. It tends to echo the same sentiment as the AMA by saying that judicial intervention should generally be avoided.<sup>33</sup> ACOG also agrees that the right to refuse treatment is not absolute, and recommends judicial intervention if the following criteria are met: (1) a high probability of serious harm to the fetus, (2) high probability that the recommended treatment will prevent or substantially reduce this harm to the fetus, (3) there are no comparably less effective, less intrusive options, and (4) a high probability that the treatment benefits the pregnant woman, or that the risks are small.<sup>34</sup> These factors must be weighed against the fact that the woman is wronged (physically, psychologically, and spiritually), the patient loses trust in the health care system, and the other social costs associated with violating individual liberty.<sup>35</sup> Overall, however, the use of force is *not* justified, as this substantially increases the risk to the woman.<sup>36</sup>

Both the AMA and ACOG opinions try to encapsulate the legal and ethical issues in order to provide some guidance for physicians. However, both opinions seem to indicate that there is no clear legal standard; thus, physicians must try to weigh the probability of harm to the woman and fetus against the ethical and policy considerations. This may provide a satisfactory answer when physicians are trying to decide whether to seek judicial intervention, and may play a part in educating judges about the values and mind-set of the medical community. Nevertheless, the opinions cannot dictate how the law should be interpreted and applied. Both opinions are important to note at this time, however, because they illustrate medicine's 'official' reaction, even though this sentiment may not be echoed by every member of the profession.

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<sup>33</sup> AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, ETHICS IN OBSTETRICS AND GYNECOLOGY 36 (2d ed. 2004).

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

A parallel issue for health care professionals is the concern about tort liability in the event that the fetus is harmed because a C-section was not performed. Yet, there is little evidence that liability would attach if the physician obtained the informed consent of the woman to refuse the surgery. For example, a doctor was found 25% liable for a woman's death due to the fact that he negligently perforated her uterus during a procedure.<sup>37</sup> However, the deceased woman was 75% at fault because she refused the blood transfusion that would have prevented her death.<sup>38</sup> The court held that when a physician obtains the informed consent of the woman to refuse the surgery, he cannot be held liable to her for harm that results from honoring her refusal. However, if he intervenes and does so in a negligent manner that causes harm to the patient, he can be held liable for that portion of the injury caused by the negligence. That is, the doctor is not liable for honoring her wishes – but he is liable for the negligently performed operation. In a similar case, the court also found that the damages, resulting from the doctor's negligence after performing colorectal surgery, would be reduced because the patient did not consent to the blood transfusion that would have saved his life.<sup>39</sup> Ironically, it might be more accurate for the physician to worry that the woman will sue in the event that her wishes are not honored.<sup>40</sup>

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<sup>37</sup> Shorter v. Drury, 695 P.2d 116, 118-19 (Wash. 1985).

<sup>38</sup> *Id.*

<sup>39</sup> Corlett v. Caserta, 562 N.E.2d 257 (Ill. App. Ct. 1990).

<sup>40</sup> Pemberton et al. v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F.Supp.2d 1247, 1248 (N.D. Fla. 1999) (woman sued hospital and physicians for violating her substantive constitutional rights, right of procedural due process, committing negligence, and false imprisonment).

## 1.4 PREGNANT WOMAN'S PERSPECTIVE

Oddly, the viewpoint of the pregnant woman is sometimes lost in the shuffle as medicine and law endlessly debate this issue. Before the advent of technology that allowed us to see, manipulate, and test the fetus, there was great reliance on the pregnant woman's intuition as to what was happening within her body. As technology forges ahead, the intuition of women is seen as less reliable. One woman commented on her feelings toward the ultrasound picture of her own fetus, saying "[t]he free-floating fetus in the picture did not come close to my experience of pregnancy...a relationship that was at many times a unitary experience, a relationship I was having with my body, and at times a relationship of duality, in which I was as important to it as it was to me."<sup>41</sup> Technology has changed the way society views pregnancy, and thus can alter the relationship a woman has with her growing fetus – it is no longer an unseen mystery.

Pregnant women often find themselves under society's microscope during pregnancy. The Pregnancy Police, as one woman dubs it, are the strangers who approach pregnant women in public and who have all sorts of advice and horror stories, will rub the woman's belly (with or without her permission), and will take every opportunity to scold the woman about every small thing that could affect the baby.<sup>42</sup> This can foster a constant fear of "not doing pregnancy right".<sup>43</sup> One manifestation of this phenomenon is that one can go into any of the large bookstores and find an entire section with books about what women should do/feel/act about their pregnancies. This is not to suggest that this is a bad thing, but it has become a sought-after

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<sup>41</sup> April Cherry, *1999 Symposium Remarks: Maternal-Fetal Conflicts, the Social Construction of Maternal Deviance, and Some Thoughts About Love and Justice*, 8 TEX. J. WOMEN & L. 245, 247-8 (1999).

<sup>42</sup> VICKI IOVINE, *THE GIRLFRIENDS' GUIDE TO PREGNANCY* 63 (1995).

<sup>43</sup> *Id.* at 62.

resource for women in an age where technology is abundant and confusing, where they may see many different doctors throughout their pregnancy, and where they live in a society in which pregnancy is inextricably linked with medicine. Together, this creates an environment in which medicine is seen as the manager of pregnancy, and where women are expected to place complete trust and faith in the recommendations from their doctors.

The question still remains – why do women refuse a recommended C-section that could save their child’s life and even their own health and life as well? As will be seen in the cases discussed in Chapter 2, many of the reasons given are religious in nature. But, there lurks the suspicion that other reasons may motivate these decisions, including fear and distrust of medicine. Other reasons may include those that are not considered ‘appropriate’ or ‘good enough’ to risk the death or disability of the fetus. In the reported cases, religious reasons are given, which invoke first amendment freedom of religion concerns. Yet, other reasons sometimes seep through the cracks and become part of the record – for example, one woman and her husband cited her Muslim beliefs as the reason for refusing the C-section, but they also expressed their concern that the medical staff had not given the woman enough time for labor and prevented her from taking steps that may help the labor along (without resorting to a C-section).<sup>44</sup> Another case involved a pregnant woman who needed blood transfusions to save her own life after she had given birth.<sup>45</sup> She refused the transfusion for religious reasons (again invoking first amendment concerns), but later stated that she was also scared of getting blood tainted with the HIV/AIDS virus.<sup>46</sup> It is not my goal to examine the sufficiency of a woman’s

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<sup>44</sup> *In re Madyun*, Misc. No. 189-86 (D.C. Super. Ct. July 26, 1986).

<sup>45</sup> *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990)

<sup>46</sup> *Id.* at 79.

reasons for refusal of treatment, but it is important to note that what appears on the surface of the court opinions may not tell the entire story of the woman's fears, concerns, and motives.

The varying (and possibly hidden) reasons that women give for refusing treatment is an excellent indicator that health care professionals may need to dig deeper and employ different tactics when talking with and informing these women about medical interventions. Physicians need to ask themselves why the woman is refusing the surgery, because the answer may be quite useful in trying to convince her to submit to the surgery. "Obstetricians who deal with high-risk perinatal situations say the crucial factor is *how* the situation is explained to the pregnant woman."<sup>47</sup> There are a wide range of reasons behind these decisions – including fear of surgery, fear of the medical system, religious reasons, jeopardizing the chance of having future children, a cultural/ethnic opposition to a C-section (e.g., the Laotian Hmong), or a lack of understanding.<sup>48</sup> In many cases, it may obviate the perceived need for judicial involvement if the services of ethics consultants, social workers, and family members were utilized to create an open discussion with the woman and address the factors that are influencing her decision.

Overall, there is confusion and mystery surrounding the refusal of a C-section. It is clear that a C-section is a very invasive surgery, and is physically (and sometimes emotionally) demanding for the pregnant woman. Compounding the situation is the fact that women are expected to put their complete trust and faith in the doctor's hands, especially since technology seems to have surpassed the usefulness of the woman's intuition. Any deviation from this 'complete trust and faith' is seen as backward and morally questionable. Furthermore, ACOG

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<sup>47</sup> Carol A. Tauer, *Lives at Stake*, 73(7) HEALTH PROGRESS 18, 27 (1992).

<sup>48</sup> *Id.*

and the AMA have valiantly tried to establish guidance for these situations, but the end result is somewhat vague, due to the diverse nature of each case and the varying ways of interpreting the risks and benefits. Yet, it is impossible to place blame on any group in these situations. The number of reported legal cases is few, and, as will soon be seen, the law has therefore had little opportunity to provide as to the standards by which such decisions should be made.



## 2.0 LEGALLY SPEAKING

The legal precedents regarding court-ordered C-sections are sparse, at best. However, this does not signify that courts are not deciding these cases. In reality, there have been a significant number of documented attempts by physicians and hospitals to obtain a court order to force a woman to have a C-section<sup>49</sup>, but very few of these cases make it past the lower court level. Usually, the case is rendered factually moot before an appeal can be heard, because the pregnancy has already reached an outcome (varied as that may be). Appellate courts have heard some cases without commenting on the issue of standing<sup>50</sup> or by establishing standing in slightly different ways – one court pointed out that the state courts require guidance in this very serious area<sup>51</sup>, another wrote the opinion to assist others and to test the court’s decision with analysis of precedent<sup>52</sup>, while yet another wrote that what occurred was “capable of repetition, yet evading review”.<sup>53</sup> Interestingly, the appellate opinions in these cases are as varied as they are sparse – there is no clear standard to guide the judiciary, which consequently provides little direction for physicians, hospital administrators, and attorneys.

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<sup>49</sup> Charity Scott, *Resisting the Temptation to Turn Medical Recommendations Into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615, 618 n.13 (1994); Veronica E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987).

<sup>50</sup> *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).

<sup>51</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 330 (Ill. App. Ct. 1994).

<sup>52</sup> *In re A.C.*, 533 A.2d 611, 611 (D.C. 1987), *vacated*, 573 A.2d 1235 (D.C. 1990).

<sup>53</sup> *In re A.C.*, 573 A.2d 1235, 1242 (D.C. 1990) (quoting *Southern Pacific Terminal Co. v. ICC*, 219 U.S. 498, 515 (1911)).

This chapter will look at the nature of the legal rights invoked, and the precise reasoning of the cases on point. Interspersed within the discussion of the cases will be the identification and recognition of the considerations that will comprise Chapter 3. Lastly, Chapter 2 will examine analogous areas of law, such as abortion, parent-child relationships, and organ/tissue donation in an effort to find the appropriate comparisons and distinctions between those and court-ordered C-sections.

## 2.1 LEGAL RIGHTS

There are several constitutional rights potentially applicable in these situations. The right of privacy has been recognized by the Supreme Court within the fourteenth amendment's right of personal liberty and restrictions upon state action.<sup>54</sup> However, this is not an absolute right – the state may interfere if there is a compelling state interest. For example, courts have allowed states to intervene upon the sphere of privacy when parents refuse life-saving medical treatment for their children, or in cases of child abuse or neglect.<sup>55</sup>

Freedom of religion is guaranteed under the first amendment, but is also subject to state intervention in light of a compelling state interest.<sup>56</sup> For example, courts have intervened when parents refuse medical treatment for their children based on religious beliefs.<sup>57</sup> Freedom of religion is frequently invoked in compelled C-section cases because women assert religious reasons for their refusal of the surgery. Interestingly, judges rarely decide the C-section cases

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<sup>54</sup> *Roe v. Wade*, 410 U.S. 113, 153 (1973).

<sup>55</sup> *Prince v. Massachusetts*, 321 U.S. 158, 165-67 (1944).

<sup>56</sup> Alice M. Noble-Allgire, *Court-Ordered Cesarean Sections*, 10 J. LEGAL MED. 211, 225 (1989).

<sup>57</sup> *Id.*

from a first amendment standpoint, but instead focus on the right to bodily integrity and abortion precedent.

The right to bodily integrity was first recognized in the common law, and well-articulated by Justice Cardozo in 1914 – “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”<sup>58</sup> Consent is only the initial hurdle, because decision-making must also be *informed* – thus, informed consent developed as a way for the patient to understand and weigh the risks and benefits of the treatment, as well as promote the value of autonomy. The informed consent doctrine has undergone many twists and turns, but currently embodies the idea that physicians must discuss the following with the patient: (1) the diagnosis, (2) the proposed treatment, including the risks and benefits, and (3) the options (including the option of no medical treatment), with the risks and benefits.<sup>59</sup>

States have since recognized and reiterated that competent patients have the right to refuse or accept medical treatment.<sup>60</sup> Again, this right is not absolute and may be overridden in situations where one of the four state interests is compelling, which include: (1) the preservation of life, (2) the protection of the interests of innocent third parties, (3) the prevention of suicide, and (4) maintaining the ethical integrity of the medical profession.<sup>61</sup> Courts generally find that these state interests are not compelling enough to force competent adults to accept medical treatment, stemming from the ideal that people should be allowed to decide their own fate

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<sup>58</sup> *Schloendorff v. Soc’y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

<sup>59</sup> *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

<sup>60</sup> *Bouvia v. Superior Ct.*, 225 Cal.Rptr. 297 (App.1986).

<sup>61</sup> *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).

without judicial interference.<sup>62</sup> The application of the state interests will be explored later in this Chapter, and when outlining the judicial standard.

## 2.2 LEGAL PRECEDENT

### 2.2.1 Early Appellate Cases

One early appellate case of a court-ordered C-section was *Jefferson v. Griffin Spalding County Hosp. Auth. et al.*<sup>63</sup> Mrs. Jefferson was 39 weeks pregnant, and diagnosed with placenta previa, meaning that the placenta was completely blocking the birth canal.<sup>64</sup> This diagnosis was considered a clear indication for a C-section, because the doctors claimed that there was a 99% chance that the baby would die if delivered vaginally, and a 50% chance that the pregnant woman would die as well.<sup>65</sup> If, on the other hand, a C-section was performed, doctors estimated the chance of survival of both the woman and the child at almost 100%.<sup>66</sup> Mrs. Jefferson, however, refused the C-section due to her religious belief that the Lord has healed her body and that whatever happens to the child will be the Lord's will.<sup>67</sup>

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<sup>62</sup> ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 5-40 – 5-41 (3d. ed. 2006 Supp., 2006).

<sup>63</sup> *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).

<sup>64</sup> *Id.* at 458.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.* at 459.

The trial court looked at the issue of whether “the unborn child has any legal right to the protection of the Court”.<sup>68</sup> It equated Mrs. Jefferson’s decision to refuse a C-section with abortion of a viable fetus (which is a criminal offense in Georgia), and therefore the court deemed it appropriate to infringe upon the woman’s rights in order to give the child an opportunity to live.<sup>69</sup> Mrs. Jefferson was thus ordered to submit to a sonogram and C-section at Griffin-Spalding Hospital or another hospital of her choice.<sup>70</sup>

The case seems clear cut – the unborn child is almost guaranteed to die without a C-section (and the mother was in serious jeopardy as well), and would be almost guaranteed to live with a C-section. Yet, the outcome may be surprising – Mrs. Jefferson submitted to the ultrasound, which found that the placenta had moved, and a C-section was unnecessary.<sup>71</sup> She vaginally delivered a healthy baby soon afterward.<sup>72</sup>

The next two appellate cases occurred in the District of Columbia courts. The first was *In re Madyun*, which was effectively overruled by *In re A.C.* Mrs. Madyun’s pregnancy was at term when she presented to the hospital with her husband.<sup>73</sup> She wanted a natural delivery, but her labor was not progressing.<sup>74</sup> She refused to consent to the recommended C-section.<sup>75</sup> As a Muslim woman, her religion states that, in life and death situations, she has the right to decide whether to risk her health for the sake of the fetus.<sup>76</sup> Again, the court looked at the statistics as expounded by one of the physicians.<sup>77</sup> He estimated that the possibility of fetal sepsis was 50-

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<sup>68</sup> *Id.* at 458.

<sup>69</sup> *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 460 (Ga. 1981).

<sup>70</sup> *Id.* at 459-60.

<sup>71</sup> *Id.* at 461, n.1 (Hill, J., concurring).

<sup>72</sup> George J. Annas, *Forced Cesareans: The Most Unkindest Cut of All*, 12 HASTINGS CENTER REPORT 16, 16 (1982).

<sup>73</sup> *In re Madyun*, Misc. No. 189-86 (D.C. Super. Ct. July 26, 1986).

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

75%, judging by the length of her attempted labor.<sup>78</sup> No symptoms of fetal sepsis were currently apparent (except for Mrs. Madyun's slightly elevated temperature), but evidence of symptoms may not occur until the baby is already septic.<sup>79</sup>

The court recognized Mrs. Madyun's constitutional right to decline medical treatment, but found that the State (invoking the *parens patriae* power) can restrict parental control.<sup>80</sup> The court analogized to other cases in which the judiciary has overruled medical treatment decisions by parents for their already-born children.<sup>81</sup> The court found that unborn children are entitled to the same protection as already-born children because of the State's interest in protecting the potentiality of human life (i.e. abortion precedent).<sup>82</sup> The court found that her religious beliefs were sincere, but stated that the Madyuns were not doctors and did not understand the risks.<sup>83</sup> Therefore, the Hospital was ordered to take all medically-indicated steps (including a C-section) to preserve the life of the fetus.<sup>84</sup>

The case of *In re A.C.* presented a very novel and challenging set of facts for the court. A.C. was 27 years-old, and 26-weeks pregnant with her first child.<sup>85</sup> She had cancer when she was a teenager, but was in remission.<sup>86</sup> However, her cancer returned when she was pregnant, and doctors informed her that her condition was terminal.<sup>87</sup> She remained in the hospital, and seemed to indicate that she wanted to have the baby.<sup>88</sup> When her condition worsened, her

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<sup>78</sup> *Id.*

<sup>79</sup> *In re Madyun*, Misc. No. 189-86 (D.C. Super. Ct. July 26, 1986).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *In re A.C.*, 533 A.2d 611, 612 (D.C. 1987), *vacated*, 573 A.2d 1235 (D.C. 1990).

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

doctors wanted to get a court order so that they could perform a C-section.<sup>89</sup> The District of Columbia was permitted to intervene for the fetus as *parens patriae*.<sup>90</sup> The lower court judge granted the order.<sup>91</sup> One of the doctors tried to relay the decision to A.C., who was conscious at the time.<sup>92</sup> She mouthed the words “I don’t want it done. I don’t want it done.”<sup>93</sup> After hearing the new evidence, the lower court found that A.C.’s intent was still not clear – thus, a C-section could be performed.<sup>94</sup> After the C-section, the baby lived for only a few hours, and A.C. died two days later.<sup>95</sup>

The first opinion (which was later vacated) relied on the State’s compelling interest in protecting the potential for human life, stating that “[w]ith a viable fetus, a balancing of interests must replace the single interest of the mother . . .”<sup>96</sup> Even though there is a compelling state interest in viable fetuses, abortion can still be permitted after viability if the life or health of the mother is affected.<sup>97</sup> Interestingly, the court refused to apply this rule to A.C. because her good health was not being sacrificed to save the child’s life, even though her death was hastened by the C-section.<sup>98</sup> The court ultimately balanced the rights of A.C. against those of her fetus, and decided that the C-section would not “significantly” affect A.C.’s condition because she only had days left to live.<sup>99</sup> Thus, they upheld the trial court’s decision to subordinate A.C.’s right against bodily intrusion to the interests of the fetus.<sup>100</sup>

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<sup>89</sup> *Id.* at 613.

<sup>90</sup> *Id.* at 612.

<sup>91</sup> 533 A.2d 611, 613 (D.C. 1987), *vacated*, 573 A.2d 1235 (D.C. 1990).

<sup>92</sup> *Id.*

<sup>93</sup> *In re A.C.*, 573 A.2d 1235, 1241 (D.C. 1990).

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> 533 A.2d 611, 614 (D.C. 1987), *vacated*, 573 A.2d 1235 (D.C. 1990).

<sup>97</sup> *Id.*

<sup>98</sup> *Id.* at 617.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

The court seemed to be saying that because A.C. was going to die anyway, then the C-section would not be affecting her “good health” – a disturbing precedent to set because it implies that the right to privacy and bodily integrity are somehow less important for people who are not considered to be in “good health” (as defined by the court and/or physicians). This slippery slope argument could be considered too alarmist, but the basic quandary is whether a balancing approach is appropriate in these situations – should we cast the woman and fetus as rivals, trying to edge each other out for whose life and health should reign supreme?

### **2.2.2 *In re A.C.* – The Second Time Around**

Three years later, the second opinion by the District of Columbia Court of Appeals for *In re A.C.* tried to answer that very question. In addition, the court addressed some of the policy considerations that had not been discussed in prior opinions. The two “profoundly difficult and complex issues” that the court answered were as follows: (1) who has the right to decide the course of medical treatment for a near-death patient who is pregnant with a viable fetus, and (2) how must a decision be made if the patient cannot make it for herself.<sup>101</sup> The court found that in virtually all cases, the patient must decide what is to be done for herself and the fetus.<sup>102</sup> The answer to the second question is that if the patient is incompetent and unable to give informed consent, then the decision must be reached through the substituted judgment procedure.<sup>103</sup> In reaching these answers, the court took an intense look at analogous areas of law, and policy

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<sup>101</sup> *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990).

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*



considerations, and thus finally provided guidance for the future by wrestling with the arguments on both sides, a task that had not been done sufficiently by courts in the past.

First, the court looked at the supposed rights of the fetus, in particular the argument that a woman has an enhanced duty to assure the welfare of the fetus because she has chosen to bring the child into the world.<sup>104</sup> The court looked warily at such an argument, and did not deny that fetal rights and interests are involved, but said that “[s]urely...a fetus cannot have rights in this respect superior to those of a person who has already been born.”<sup>105</sup> Second, the practical considerations were troublesome to the court – namely that if a woman refuses to submit to the court-ordered C-section, then enforcement could only be accomplished through physical force.<sup>106</sup>

In addition, the court is also troubled by the possibility that trust could erode in the doctor-patient relationship if women are worried that their treatment decisions will not be honored.<sup>107</sup> Finally, the court worries about due process concerns because these cases tend to occur under enormous time constraints, which make it difficult or impossible for the woman and her counsel to prepare adequately for trial.<sup>108</sup>

The court equates this case with a competent person’s right to accept or refuse medical treatment.<sup>109</sup> Judge Terry strongly reiterates that this is not about abortion – A.C. chose to become pregnant, and wanted to bear her child as close to term as possible. Therefore, the issue “is not whether A.C. (or any woman) should have a child but, rather, who should decide how that

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<sup>104</sup> *Id.* at 1244.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* at 1244., n. 8.

<sup>107</sup> *In re A.C.*, 573 A.2d 1235, 1248 (D.C. 1990).

<sup>108</sup> *Id.*

<sup>109</sup> *Id.* at 1247.

child should be delivered.”<sup>110</sup> Once couched in that framework, the court looks at the four compelling state interests that are analyzed in other treatment refusal cases – preserving life, preventing suicide, maintaining the ethical integrity of the medical profession, and protecting innocent third parties.<sup>111</sup> The court is not able to tell whether A.C. was competent; therefore, the trial court should not have weighed the interests of A.C. against those of the fetus, because A.C.’s interests were not known and were not deciphered through the substituted judgment procedure either.<sup>112</sup> If, after using the substituted judgment standard, there is still not enough information to discern the woman’s wishes, then it would be proper for the court to look at what most persons would do in a similar situation – which would allow the court to weigh the factors for both the woman and the fetus.<sup>113</sup>

Ultimately, the patient’s wishes, once they are ascertained, must be followed in virtually all cases.<sup>114</sup> However, the court is hesitant to make a bright line rule. Instead, it states that “[w]e do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient’s wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional . . . [t]his is not such a case.”<sup>115</sup>

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<sup>110</sup> *Id.* at 1245, n. 9.

<sup>111</sup> *Id.* at 1246.

<sup>112</sup> *Id.* at 1247.

<sup>113</sup> *In re A.C.*, 573 A.2d 1235, 1251 (D.C. 1990) (the court lists some of the factors, such as: the mother’s prognosis, the viability of the fetus, the probable result of treatment or non-treatment for both mother and fetus, and the mother’s likely interest in avoiding impairment for her child together with her own instincts for survival).

<sup>114</sup> *Id.* at 1252.

<sup>115</sup> *Id.*

### 2.2.3 Polar Opposites: *Baby Boy Doe* and *Pemberton*

There are only two reported appellate cases that arose after the D.C. Court's attempt to make a rule – both cite *In re A.C.*, but manage to arrive at completely opposite conclusions. The first, *In re Baby Boy Doe (a fetus) v. Mother Doe*, involved a woman who was 36.5 weeks pregnant, competent, and refused a C-section for religious reasons.<sup>116</sup> It was determined that her viable fetus was receiving insufficient oxygen due to a problem with the placenta – thus it was recommended that she should have a C-section for the benefit of the fetus.<sup>117</sup> Due to her “abiding faith in God’s healing powers”, Doe decided to wait for natural childbirth.<sup>118</sup>

The lower court made initial findings that the chances of the unborn child surviving natural childbirth were close to zero (due to the medical complications), and if the child were to somehow survive the natural childbirth, he would be mentally handicapped.<sup>119</sup> The chances that the child would survive a C-section are close to 100%, and the mother’s chance of death is 1 in 10,000 (maternal mortality for vaginal birth is between 1 in 20,000 to 1 in 50,000).<sup>120</sup> Finding no cases on point in Illinois, the trial court did *not* order the C-section because the state failed to demonstrate any statutory or case law that would justify this intrusive procedure on a competent person.<sup>121</sup> Interestingly, in the meantime, Doe vaginally delivered an “apparently healthy, although somewhat underweight, baby boy” approximately two and a half weeks later.<sup>122</sup>

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<sup>116</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 327 (Ill. App. Ct. 1994).

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.* at 327-28.

<sup>120</sup> *Id.* at 328.

<sup>121</sup> *Id.* at 329.

<sup>122</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 329 (Ill. App. Ct. 1994).

The Appellate Court of Illinois affirmed the decision of the trial court.<sup>123</sup> They boldly stated that Illinois courts should not balance the rights of the viable unborn fetus against the right of a competent woman to choose the medical care she deemed appropriate (based partly on her religious views) – the “woman’s competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus.”<sup>124</sup>

The court relied on the right of competent individuals to accept or refuse medical treatment. But, they also examined the Illinois case of *Stallman v. Youngquist*, which recognizes the idea that a woman’s constitutional rights are not diminished during pregnancy.<sup>125</sup> The court argues that “[t]he potential impact upon the fetus is not *legally* relevant; to the contrary, the *Stallman* court explicitly rejected the view that the woman’s rights can be subordinated to fetal rights.”<sup>126</sup>

The court also delved into a discussion of abortion law, stating that the state has a compelling interest in the potential life of a viable fetus such that the state can prohibit post-viability abortions except when the life or health of the woman is at stake.<sup>127</sup> The comparisons to abortion precedent will be discussed in much further detail later in this Chapter. But, it is important to note that the Illinois court does not agree with the argument that *Roe v. Wade* bestows “rights” unto the fetus.<sup>128</sup> In addition, the court states that any degree of increased risk to the mother’s life or health, in order to aid the fetus, is unacceptable according to the U.S.

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<sup>123</sup> *Id.* at 335.

<sup>124</sup> *Id.* at 330.

<sup>125</sup> *Stallman v. Youngquist*, 531 N.E.2d 355 (Ill. 1988) (holding that a child cannot bring a tort action against his mother for harm done during pregnancy).

<sup>126</sup> 632 N.E.2d at 332 (emphasis added).

<sup>127</sup> *Id.* at 334.

<sup>128</sup> *Id.*

Supreme Court.<sup>129</sup> Therefore, since a C-section presents higher maternal morbidity and mortality – when recommended for the sole purpose of benefiting the fetus – it is unconstitutional to order this invasive procedure for the pregnant woman against her wishes.<sup>130</sup>

Finally, the court looks at the four state interests identified in treatment refusal cases, and finds that they are not compelling enough to override Doe’s objection.<sup>131</sup> Therefore, the trial court was correct not to enter an order for a C-section.

The most recent appellate C-section case occurred in Florida in 1999, and was heard in federal court, as opposed to all of the cases discussed above which were heard in state courts.<sup>132</sup> Mrs. Pemberton had already delivered a baby by C-section, and was now pregnant again.<sup>133</sup> She did not believe that a C-section was necessary, and thus sought to avoid the surgery during this pregnancy.<sup>134</sup> She was unable to find a doctor to deliver her next baby vaginally (due to the risk of uterine rupture), and thus arranged for a home delivery with a midwife.<sup>135</sup> During labor, she became dehydrated, and presented at the hospital for an IV.<sup>136</sup> She and her husband told the doctors that she did not want a C-section, and then left the hospital against medical advice.<sup>137</sup> The hospital convened an “expert team”, contacted a judge, and held a hearing without Mrs. Pemberton present.<sup>138</sup> The judge ordered her to return to the hospital – which was accomplished by sending a police officer to her house and bringing her by ambulance against her will.<sup>139</sup> The

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<sup>129</sup> *Id.* at 333 (citing *Thornburgh v. Am. Coll. Of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986)).

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at 334.

<sup>132</sup> *Pemberton et al. v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F.Supp.2d 1247 (N.D. Fla. 1999).

<sup>133</sup> *Id.* at 1249.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Pemberton et al. v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F.Supp.2d 1247, 1250 (N.D. Fla. 1999).

<sup>139</sup> *Id.*

hearing was then continued with Mrs. Pemberton present, and the judge ordered a C-section.<sup>140</sup> She was forced to submit to the C-section, which resulted in the birth of a healthy baby boy.<sup>141</sup> She brought suit in federal court alleging a violation of her constitutional rights, common law negligence, and false imprisonment (arising from the forced return to the hospital by ambulance).<sup>142</sup>

The court engages in a balancing test (the very kind which the A.C. court explicitly rejected), and found that the state's interest in the fetus outweighed the woman's constitutional rights.<sup>143</sup> The court lambasts Mrs. Pemberton's belief that the risk of vaginal delivery was not appreciable.<sup>144</sup> According to some doctors, the risk of uterine rupture during a vaginal delivery was approximately 4-6%, while another doctor placed the risk around 2-2.2% and that the risk that the baby would die *if there was a rupture* was 50%.<sup>145</sup> The court found that the risk was unacceptably high, and likened the situation to one in which an airline told passengers that there was a 4-6% risk of a fatal plane crash – no one would likely board the plane.<sup>146</sup> The court found that this situation was the “rare and truly exceptional case” that was left open by the A.C. court.<sup>147</sup> Thus, the C-section was ordered and performed against her will.

As evidenced by the discussion of the five reported appellate cases, there is no discernable standard that can provide guidance for judges, which in turn provides little advice for action in the hospital setting. While *In re A.C.* went a long way to try to establish some

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<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* at 1249.

<sup>143</sup> *Id.* at 1251-52.

<sup>144</sup> Pemberton et al. v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F.Supp.2d 1247, 1252 (N.D. Fla. 1999).

<sup>145</sup> *Id.* at 1253.

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 1254, n. 18.

guidance, the results from other courts demonstrate palpable confusion about how to interpret the facts and use the analogous areas of law in each case. *Jefferson*, *Madyun*, and *Pemberton* use various balancing tests to weigh the interests of the pregnant woman against the interests of the fetus and the state. There appears to be no clear evidentiary standard in any case. The medical statistics are frequently unclear, and courts seem to be ‘winging it’ when trying to figure out the true risks and benefits. Courts are also not sure whether to treat unborn children in the same fashion as already-born children (when invoking the state’s *parens patriae* power).

There is a sense that judges, due to the lack of precedent, make up their minds as to whether or not they want to intervene to potentially save the fetus, and then unconvincingly string arguments together from other areas of law to support the outcome. As seen in the strikingly different outcomes of the cases, the courts were basically looking at the same set of facts but attacking the issue in markedly different ways. The *Baby Boy Doe* and *A.C.* courts looked at the issue of who has the right to decide how the child will be born, and decided that the competent woman is the decision-maker. The *Jefferson* and *Pemberton* courts viewed the issue from the abortion perspective of whether the woman can be compelled to bear a child she does not want. They found that the state’s interest in the fetus outweighed the woman’s interest in choosing the method of birth. The *Madyun* and *Jefferson* courts also drew from child neglect law, and found that the woman cannot be allowed to endanger her child by her medical decision. Very similar fact patterns were presented, yet courts were not able to universally identify the issue at stake.

The one thing that everyone can agree upon is that this is a frustrating and dreadful issue that pits doctors against patients, and women against their unborn children. The outcome will never please everyone – similar to the abortion debate – because there will always be a

divergence of opinion as to when life truly begins, how far the right to bodily integrity extends, and whether medicine and law should intrude upon this highly personal part of life.

Furthermore, this distressing area of law is not frequently brought out into the open, as very few cases are reported and even fewer reach the appellate level. The real worry is not who ‘wins’ at the appellate court level, as the arguments are heard and the opinions issued after the women have given birth. Instead, the real concern is whether the appellate precedent is clear and strong enough that hospitals and trial judges will know how to deal with these issues when the situation is tangible and exigent.

There are several themes running through the C-section cases which highlight the inherent difficulties with this issue. Courts struggle with the legal analogies that are used as conceptualization tools, and as a way to establish fetal rights – including abortion precedent, parent-child duties, and organ/tissue donation. Depending on how the issue is presented, courts seem to identify different areas of law as analogous to the facts at hand. The remainder of this Chapter will be devoted to looking at these areas of law and the arguments on both sides.

First, however, there is a need to address the idea that fetal rights can be inferred from tort or criminal liability for fetal harm. State law is varied – some states do not allow a child to sue its own mother for prenatal injuries<sup>148</sup>, while others have suggested that this may be allowed.<sup>149</sup> For the purposes of my argument, it is not necessary to delve into the various state laws on the topic because my aim is to identify what the standard should be when courts are presented with a refusal of a recommended C-section. One prominent commentator, Nancy K. Rhoden, has stated, “the fact that tort or criminal liability may be imposed on *completed* conduct

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<sup>148</sup> Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988) (holding that a child cannot bring a tort action against her own mother for harm done during the pregnancy).

<sup>149</sup> Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980) (holding that a child’s mother bears the same liability for negligent conduct which results in prenatal injury as would a third person).



does not mean that any steps, no matter how extreme, are permissible to *prevent* such conduct, especially when individuals' constitutional rights are implicated."<sup>150</sup> Furthermore, "our society does not imprison people simply because they are likely to commit a crime, even though they can unquestionably be punished afterward."<sup>151</sup> Therefore, even if women could be criminally punished or liable in tort for prenatal harm to the child, it does not logically follow that a state could restrict the woman's conduct to prevent such harm.<sup>152</sup>

## 2.3 ABORTION

The U.S. Supreme Court's decision in *Roe v. Wade* is consistently invoked as a basis for fetal rights or fetal interests.<sup>153</sup> Without *Roe* and the long line of other abortion cases, it is difficult to decipher the nature of the state's interest in fetuses. The Court held that a fetus is not considered a "person", as used in the fourteenth amendment.<sup>154</sup> In addition, the state's interest in the "potentiality of human life" does not become compelling until after viability, as that is the point when the fetus has a chance of meaningful survival outside of the womb.<sup>155</sup> Therefore, states may prohibit abortion after the point of viability (which, as stated in Chapter 1, is a fuzzy

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<sup>150</sup> Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1966 (1986).

<sup>151</sup> *Id.*

<sup>152</sup> *Id.* at 1966-67.

<sup>153</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>154</sup> *Id.* at 158.

<sup>155</sup> *Id.* at 163.

point).<sup>156</sup> However, states must still permit post-viability abortions if the life or health of the mother is at stake.<sup>157</sup>

There are two schools of thought as to the state's interest in the fetus. To reiterate, states can prohibit abortion of viable fetuses unless the health or life of the mother is at stake. Therefore, one side argues that abortion precedent instructs us that a pregnant woman's rights can be overridden after the point of viability because it is at that point that the state's interest in the fetus becomes compelling. This approach equates refusal of a C-section with abortion. This idea has merit, on first glance, but it assumes that the state's compelling interest in viable fetuses – in order to prevent elective abortions – also “licenses a similar override of the woman's interests in all other contexts.”<sup>158</sup>

This leads to the second school of thought, echoed by the Illinois Supreme Court in *Baby Boy Doe* – “[t]he fact that the state may prohibit post-viability pregnancy terminations does not translate into the proposition that the state may intrude upon the woman's right to remain free from unwanted physical invasion of her person when she chooses to carry her pregnancy to term.”<sup>159</sup> The rights invoked are *different*. Just as the Supreme Court stated that the right to abortion was distinct from the other rights under the aegis of ‘privacy’ (i.e. procreation, marriage, family relationships, etc.)<sup>160</sup>, the right of bodily integrity which we hold to be a fundamental tenet of American law is also distinct. The A.C. court endorsed this viewpoint by saying that “this case is not about abortion”, and that the “issue presented in this case is not

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<sup>156</sup> *Id.* at 163-64.

<sup>157</sup> *Id.*

<sup>158</sup> Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 32 (1987) (citing John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 437 (1983)).

<sup>159</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994).

<sup>160</sup> *Roe v. Wade*, 410 U.S. 113, 159 (1973).

whether A.C. (or any woman) should have a child but, rather, who should decide how that child should be delivered.”<sup>161</sup>

This is an important difference that distinguishes the outcome from the rights invoked. In an abortion case, the right at stake is the right to terminate a pregnancy for which the woman has given consent, and which will result in the intentional destruction of the fetus. In a court-ordered C-section case, the right at stake is the right to bodily integrity (to accept or refuse medical treatment), and for which the pregnant woman has not given consent to invade her body – which may or may not result in harm to the fetus. The outcome *may* be the same, but the rights invoked are distinct. This school of thought takes the maternal-fetal conflicts *outside* the realm of abortion, and focuses simply on the right of a competent adult to accept or refuse medical treatment. As said previously, the right to refuse treatment is still not absolute, but must be evaluated in light of the four state interests (preservation of life, prevention of suicide, protection of innocent third parties, and maintaining the ethical integrity of the medical profession).

The discussion thus far has only focused on the Supreme Court’s words concerning the state’s interest in the fetus. Yet, after this landmark decision, the Court has continued to refine and interpret its words as other state statutes and specific abortion practices have been challenged. The ‘health and life of the mother’ is one such factor that plays a part in this debate. In *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, the Court looked at a Pennsylvania statute which required post-viability abortions – that are performed to ensure the life or health of the mother – to be done in such a way as to give the fetus the best chance for survival.<sup>162</sup> The Supreme Court affirmed the lower court ruling that the Pennsylvania statute was “unconstitutional because it required a “trade-off” between the woman’s health and fetal

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<sup>161</sup> *In re A.C.*, 573 A.2d 1235, 1245, n. 9 (D.C. 1990).

<sup>162</sup> *Thornburgh v. Am. Coll. Of Obstetricians and Gynecologists*, 476 U.S. 747, 768 (1986).

survival, and failed to require that maternal health be the physician's paramount consideration."<sup>163</sup>

In applying this "no trade-off" rule to the compelled C-section cases, there are two propositions to keep in mind. First, the maternal morbidity and mortality for a C-section is greater than for vaginal delivery. Second, many C-sections are performed solely for the benefit of the fetus. The logical conclusion is that for many of the recommended C-sections, the physician is favoring the life of the fetus over the life of the woman. Granted, the woman is extremely likely to desire this type of intervention (recall that most women would "cut off their heads to save their babies"<sup>164</sup>). But, in the case where a woman does not wish to have the C-section, a court order requiring the surgery would be an unconstitutional trade-off between the woman's health/life for the sake of the fetus's life/health.

On the other hand, in the case where the C-section is actually less risky for the fetus *and* the woman, it would seem that the "health of the woman" argument fails. However, this outcome is troubling because the woman's health risk would now be the triggering factor as to whether she can be compelled to have a C-section. This is illogical in light of the fact that in any other medical situation, the woman would be permitted to choose a procedure of higher risk to her own body in order to help the fetus.

I believe that the second school of thought is the more accurate way to conceptualize the maternal-fetal conflict, because these situations involve distinct rights – the right to abortion only addresses the *active* termination of a pregnancy, while the right of bodily integrity addresses a competent adult's right to be free from unwanted medical treatment. American law treats

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<sup>163</sup> *Id.* at 768-69.

<sup>164</sup> Statement of Dr. Mitchell Golbus, *supra* note 1.

affirmative acts very differently from omissions to act.<sup>165</sup> The Supreme Court has not attempted to weigh these rights against each other; therefore, it is illogical to assume that *Roe*'s holding applies in contexts outside abortion, and predictions cannot be made as to their relative weights in the maternal-fetal context. It is clear that the two schools of thought will likely not reach a consensus any time soon. Thus, other areas of law prove to be better analogies when trying to conceptualize the problem and identify the interests at stake.

## 2.4 PARENT-CHILD RELATIONSHIPS: CHILD NEGLECT

Courts have pointed to child neglect law to justify ordering the C-section upon a non-consenting woman. In fact, the *Jefferson* court found that the fetus was a neglected child under the Juvenile Code, and thus was able to exercise the state's *parens patriae* power in order to compel treatment of the woman.<sup>166</sup> As with abortion law, this argument is misplaced and confuses the right to bodily integrity with the fundamental right of childrearing. The analogy also equates already-born children with fetuses – a leap that is not intuitively obvious.

Parents generally are empowered to make medical treatment decisions for their children, arising from the recognized fundamental right to raise a child as they see fit.<sup>167</sup> Yet again, this right is not absolute. States have a recognized *parens patriae* power to intervene in cases of

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<sup>165</sup> Charity Scott, *Resisting the Temptation to Turn Medical Recommendations Into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615, 653 (1994) (citing PROSSER AND KEETON ON TORTS § 56 (5<sup>th</sup> ed. 1984) (discussing deeply-rooted distinction in tort law between “active misconduct working positive injury to others and passive inaction or a failure to take steps to protect them from harm”)).

<sup>166</sup> *Jefferson v. Griffin Spalding County Hosp. Auth. et al.*, 274 S.E.2d 457, 459 (Ga. 1981).

<sup>167</sup> *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

child neglect – which entitles intervention in some cases when parents refuse medical treatment for their children.<sup>168</sup>

In one landmark case, *Newmark v. Williams*, the state tried to intervene to force cancer treatment upon a 3-year old, whose parents refused to consent on his behalf because of their Christian Scientist beliefs.<sup>169</sup> The state was required to prove by clear and convincing evidence that intervening in the parent-child relationship was necessary to ensure the health or safety the child.<sup>170</sup> The court concluded that the parents' decision should be honored because the treatment was highly invasive, painful, involved terrible temporary and permanent side effects, had an unacceptably low chance of success, and a high risk that the treatment would cause the child's death.<sup>171</sup> In such cases, the state's interest in protecting minors is weighed against the parents' fundamental right of childrearing, and the court may use a balancing test to determine whether the state's interest should prevail over the parents'. Applied to forced C-section cases, the state's interest in protecting the potentiality of human life should be weighed against the right to bodily integrity, and the court should use a balancing test to determine whether to allow the state to compel the C-section.

However, there are two vital differences between child neglect cases and C-section cases. First, there is an essential disparity between overriding a parental decision compared to cutting open a parent to treat the child. Second, this equates already-born children with fetuses. Let us assume for the moment that fetuses are equal to already-born children. If this is the case, then logically the fetus would possess the right to life-saving treatment which is being denied by its mother. Yet, here is where the first difference is critical – the physician would not be simply

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<sup>168</sup> *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

<sup>169</sup> 588 A.2d 1108, 1109 (Del. 1990).

<sup>170</sup> *Id.* at 1110.

<sup>171</sup> *Id.* at 1120.

overriding the parent and treating the child, but instead would be cutting open the parent to treat the child. Thus, the right of bodily integrity is implicated in the C-section context, but it is not in the child neglect context. This highlights the unique nature of the maternal-fetal conflicts, because we cannot help the fetus without physically invading the woman. The nature of the applicable rights are simply different. Thus, child neglect is not an accurate analogy to use when determining whether to compel a C-section.

## 2.5 ORGAN/TISSUE DONATION

The law surrounding compelled organ and tissue donation presents the strongest analogy for the compelled C-section situation because this is only context where one person's body is used for the sake of another. A foundational tenet of American law is that we do not require the invasion of one person to save another. A mother cannot be compelled to undergo surgery or donate an organ to save her already-born child.<sup>172</sup> So the question remains – why would it be required for pregnant women?

In *McFall v. Shimp*, a court was presented with a heart-breaking set of facts: McFall sued his cousin, Shimp, to compel him to submit to a bone marrow test to determine if he was a suitable candidate to donate bone marrow that could save McFall's life.<sup>173</sup> Shimp's bone marrow was McFall's last chance at survival because he was the only possible match for a donor.<sup>174</sup> Yet, Shimp would not consent to the procedure.<sup>175</sup> Judge Flaherty found Shimp's

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<sup>172</sup> Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision is it Anyway?*, 41 RUTGERS L. REV. 591, 594-95 (1989).

<sup>173</sup> *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 90 (1978).

<sup>174</sup> *Id.*

actions “morally indefensible”, but the decision was not hard – a court cannot compel one person to undergo treatment for the sake of another.<sup>176</sup> To rule otherwise would defy the fundamental tenets of bodily integrity and freedom, and cause an extreme reevaluation of how far society is willing to allow medicine and technology to alter our very basic values. “Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another.”<sup>177</sup>

One argument advanced by fetal rights advocates is that the pregnant woman stands in a special relationship to the fetus – that by her decision to forgo an abortion and carry the child to term, she has ‘waived’ her rights and now has an enhanced duty to rescue the fetus from harm.<sup>178</sup> This argument could lead down a very slippery slope, as it would require the pregnant woman to do everything possible to ensure the health and mind of the child. Advocates for this perspective realize that this would also require a sharp departure from our current policy of organ/tissue donation. If a mother can be compelled to undergo surgery to save the fetus, then a parent could also be compelled to undergo surgery to save a living child. This also highlights the problem between moral and legal obligations – “...in this very private and bodily sphere, the issue of moral obligations, even very compelling ones, must be kept distinct from the issue of legal coercion of individuals to meet their moral obligations.”<sup>179</sup> Ideally, parents would do anything to save their child, even if that meant undergoing major surgery. But, to legally mandate that they fulfill their moral obligation is a perilous policy to set, and would require an overhaul of our current policy of purely altruistic organ donation.

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<sup>175</sup> *Id.*

<sup>176</sup> *Id.* at 91.

<sup>177</sup> *Id.*

<sup>178</sup> Eike-Henner W. Kluge, *When Caesarian Section Operations Imposed by a Court are Justified*, 14 J. Med. Ethics 206, 206 (1988); John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 438 (1983).

<sup>179</sup> Rhoden, *supra* note 150 at 1980.



The real conceptual difficulty with the maternal-fetal unit is the spatial proximity of the two patients.<sup>180</sup> Whether one agrees with the idea that the fetus is a person or not, or whether the woman and fetus are one entity or two separate entities, it is impossible to forget the fact that the fetus is located inside the woman. In any other organ/tissue donation or rescue situation, the two people are spatially separate, which curiously alters the perspective, even though it still involves the same life-and-death struggle. It is hard to articulate, but the maternal-fetal unit evokes a different emotional response than the organ donation cases. When a judge is called into the hospital in an emergency situation, it may be difficult to analogize the maternal-fetal context from a person-person organ donation context. If viewed as a question of compelled treatment or organ donation, though, it is apparent that in no other situation does the court *compel* treatment of one person to save another. Value judgments – about the individual woman, the woman’s reason for refusal, the moral duty of pregnant women to their fetuses, or the place of women in society – should not dictate a different outcome than in other treatment refusal cases.

The result of utilizing the organ donation analogy is that fetal rights must be subordinate to maternal rights, dreadful as the results may be at times. Thus, the cases should ‘default’ to the treatment refusal context, and a court must examine the four state interests that have been recognized in such cases. The prevention of suicide is not applicable here because the pregnant woman’s life is likely not jeopardized. Even if her life were in danger, courts have declined to hold that treatment refusals are tantamount to suicide.<sup>181</sup>

The state’s interest in preserving the woman’s life is also not compelling enough to overcome a competent adult’s decision to refuse treatment. Again, the woman’s life is not in grave danger in the majority of C-section cases. If she were not pregnant, then the court would

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<sup>180</sup> *Id.* at 1979.

<sup>181</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994); Rhoden, *supra* note 150 at 1971.

very likely honor her decision to refuse life-saving treatment because our judicial system examines the interest “as it impacts upon the preservation of life of the maker of the decision.”<sup>182</sup>

The state’s interest in protecting innocent third parties has only been applied in situations in which the person’s medical decision will result in an abandonment of dependent children.<sup>183</sup> One could argue that a fetus should count as an innocent third party. However, these state interests are balanced against the woman’s right to make treatment decisions for her own life and health. Protection of the fetus’ interest in having a mother would only come into play if the mother’s life were in jeopardy, which is not usually the case in C-section cases. If the woman’s life was in severe jeopardy (i.e. in cases of placenta previa or gross cephalopelvic disproportion), then it could be argued that the fetus’ interest in having a mother should outweigh her right to refuse treatment. Making this argument would be a difficult uphill battle due to the invasiveness of the surgery, and the fact that courts have not found this interest to be compelling for less invasive procedures (i.e. blood transfusions).<sup>184</sup>

The final state interest – maintaining the ethical integrity of the medical profession – is also not likely to overcome the woman’s right to refuse treatment. Courts have stated that the medical profession cannot “maintain their ethics at the expense of an individual whose body is at issue and have refused to allow this asserted state interest to override a competent person’s right to refuse medical treatment.”<sup>185</sup> Some may argue that the ethical duties are enhanced when a fetus is involved. On the other hand, coercing pregnant women with court orders is also an unethical practice. Regardless of what physicians believe their ethical system requires, it is still

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<sup>182</sup> 632 N.E.2d at 334.

<sup>183</sup> *In re Dubreuil*, 629 So.2d 819 (1993) (court found that the state’s interest protecting the dependent children from abandonment was not compelling enough to override the woman’s constitutional right to refuse a blood transfusion).

<sup>184</sup> *Id.*

<sup>185</sup> Scott, *supra* note 165 at 649 (citing *Bouvia v. Superior Ct.*, 225 Cal. Rptr. 297, 305 (Ct. App. 1986)).

not clear that the court should find this interest to be compelling enough to override the bodily integrity right of the woman – “this is too important and complex a societal issue to be decided on the basis of doctors’ views of their professional obligations.”<sup>186</sup> The court should not allow physicians to make this decision that affects an essential and cherished right. Again, due to the high degree of invasiveness and the strong constitutional rights invoked, it is unlikely that a court would find that this interest is compelling enough.

It seems clear, on first glance, that the woman’s right to refuse treatment should be upheld in virtually all situations. Yet, judging by the attitude of some courts, these compelling state interests could be interpreted in broader ways that would factor the fetus into the equation and allow the state to compel treatment. In addition, courts may still cling to abortion analogies or child neglect law, as these have provided an analysis (albeit imprecise) for ruling in favor of the fetus. Therefore, further examination is necessary to identify the other factors that play into my proposed judicial standard – namely, ethical and policy considerations.

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<sup>186</sup> Rhoden, *supra* note 150 at 1972.

### **3.0 ETHICAL CHALLENGES AND THE JUDICIAL STANDARD**

The previous Chapter plants the seedlings of a judicial standard by examining the cases on point and distinguishing the analogous areas of law from those that are not as precise. Pure legal analysis can only go so far, though, because (a) there is not enough precedent from which to synthesize a clear standard, and more importantly (b) forced treatment of pregnant women implicates policy and ethical considerations that cannot and should not be ignored. These considerations provide a richer picture of the effect of court-ordered C-sections, thus providing a stronger argument for why courts should virtually never order this invasive surgery on a non-consenting pregnant woman.

#### **3.1 AUTONOMY VS. BENEFICENCE: ENEMIES OR HIDDEN ALLIES?**

Autonomy and beneficence are regarded as two of the foundational principles of biomedical ethics, and have been alluded to throughout the discussion thus far. Respecting patients' autonomous action is seen as a bedrock principle for medical decision-making and remains a theme in any context where a patient's decision is called into question. Autonomous action is viewed as that which is done intentionally, with a substantial degree of understanding

and freedom from controlling influences.<sup>187</sup> The principle of respect for autonomy reflects medicine's move away from paternalism and toward a patient-centered approach to medical treatment. "To respect an autonomous agent is, at a minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs...[s]uch respect involves respectful *action*, not merely a respectful *attitude*."<sup>188</sup> The judiciary must recognize that, by granting these orders, it may be endorsing a model in which autonomy is not honored, and physicians are encouraged to give lip service to the principle of autonomy by running to the judge.

Both the *Madyun* and *Pemberton* courts echoed paternalistic attitudes by rejecting the woman's right to make an autonomous decision and saying that they were making irrational, dumb decisions. The *Madyuns* were told that they were not trained physicians, and that "to ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents...is something that the Court cannot do."<sup>189</sup> Similarly, the *Pemberton* court likened the choice to refuse a C-section to a possible plane crash, stating "if an airline told prospective passengers there was a four to six percent chance of a fatal crash, nobody would board the plane."<sup>190</sup> What the court ignores, however, is that they were taking away Mrs. *Pemberton's* choice to board that plane – a choice that any other competent individual would have.

What could be so important that courts and physicians feel justified in blatantly disrespecting the autonomy of patients? Thus enters the principle of beneficence, which is the idea that physicians should take positive steps to help their patients.<sup>191</sup> Of course, it is easy to

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<sup>187</sup> TOM L. BEAUCHAMP AND JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 59 (5<sup>th</sup> ed. 2001).

<sup>188</sup> *Id.* at 63.

<sup>189</sup> *In re Madyun*, Misc. No. 189-86 (D.C. Super. Ct. July 26, 1986).

<sup>190</sup> *Pemberton et al. v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F.Supp.2d 1247, 1253 (N.D. Fla. 1999).

<sup>191</sup> BEAUCHAMP AND CHILDRESS, *supra* note 187 at 165.

appreciate the medical point of view – a fairly routine surgery, though invasive, has the great potential to eliminate the death or disability of an unborn child, and may even save the woman’s life or health as well. This paints a very uplifting picture of what technology can do, and presents an option to which the vast majority of women would quickly consent in order to help themselves and their fetuses.

When a woman does not want this intervention, that pesky principle of autonomy is seen as competing with beneficence. Beauchamp and Childress attempt to find common ground by saying that “beneficence provides the primary goal and rationale of medicine and health care, whereas respect for autonomy...sets moral limits on the professional’s actions in pursuit of this goal.”<sup>192</sup> Health care has evolved from its roots in paternalism, and their formulation recognizes the laudable goal of medicine while at the same time recognizing the limitations that must accompany this evolution. Autonomy and beneficence should not be seen as competing principles, particularly if one accepts the idea that the fetus is not a patient in the traditional sense. By respecting the woman’s autonomy and allowing her to make the ultimate decision, the physician is also fulfilling the duty of beneficence because he/she is effectuating the woman’s well-being and her meaning of health. This is vital in our society where technology changes the way medicine is practiced every day.

Dr. Lisa Harris argues that by examining only the principles of autonomy and beneficence in maternal-fetal conflicts, we risk only coming up with objective solutions that do not account for the particular circumstances of the woman.<sup>193</sup> Yet, in these situations, we cannot

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<sup>192</sup> *Id.* at 177.

<sup>193</sup> Lisa H. Harris, *Rethinking Maternal-Fetal Conflict: Gender and Equality in Perinatal Ethics*, 96 *OBSTETRICS & GYNECOLOGY* 786, 788 (2000).

ignore the other substantive issues that affect women.<sup>194</sup> An alternative model, such as care-based ethics, broadens the scope by including social factors into the decision-making equation – such as sex, race, and social inequalities.<sup>195</sup> Instead of focusing on the conflict between two seemingly innocent and deserving parties, the clinician would focus on “important social and family relationships, contexts or constraints that might come to bear on a pregnant women’s decision making, such as her need to care for other children at home or to continue working to support other family members...and attempt to provide relief in those areas.”<sup>196</sup> This is a way to conceptualize the ‘conflict’ instead of labeling the woman’s choice as deviant. Consequently, when looking at the conflict through a wider lens, which addresses the woman’s social, cultural, economical, and emotional matters, then “fetal well-being is achieved when maternal well-being is achieved.”<sup>197</sup> While this method will not solve every dilemma, it furthers our understanding of the woman’s decision, and provides a more-inclusive framework in which to view the relationship between autonomy and beneficence.

Overall, these fundamental bioethical struggles are at the heart of maternal-fetal conflicts. Using purely principle-based ethics creates much tension between autonomy and beneficence in practice. The right of bodily integrity and privacy belie the notion that a doctor should be legally authorized to do what he/she wishes as long as it benefits the patient. Instead, alternative models, such as care-based ethics, are not as constricting, and may be able to fill in some of the gaps in our current way of viewing the issue. This is especially important in light of the fact that we are looking at a very specific population – pregnant women – which possess characteristics that may benefit from an ethical system that takes a broader view of the issues. Certainly, it is

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<sup>194</sup> *Id.*

<sup>195</sup> *Id.*

<sup>196</sup> *Id* at 789.

<sup>197</sup> *Id.*

difficult to persuade people to follow one ethical system or another – as they all have some merit. Therefore, it is useful to recognize this tension and forge ahead to other considerations raised by compelled treatment. Autonomy and beneficence provide the background and starting point for the tension, which is why both principles are woven throughout the remaining ethical and policy considerations.

### **3.2 THE DOCTOR-PATIENT RELATIONSHIP: VANISHED TRUST**

According to a survey by the Pfizer Medical Humanities Initiative presented to the World Medical Association, U.S. doctor-patient relationships ranked second overall in importance (behind family relationships), far exceeding spiritual relationships, financial relationships, and coworker relationships.<sup>198</sup> Patients place their lives and health in the hands of doctors and must believe that the doctor will respect this trust relationship – especially given that the doctor-patient relationship is viewed as possessing an unequal power balance. The doctor is in a position of higher power due to his/her medical knowledge and expertise, while the patient is seen as occupying the lower power position because of her need for this medical knowledge.

Trust is a necessary element that is supposed to facilitate an environment of free-flowing information, frank discussions, and revelation of very private matters. Yet, as our medical system becomes more and more specialized, it becomes increasingly difficult to have a close relationship with one doctor because a patient may see many different health care professionals

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<sup>198</sup> Mike Magee, Relationship-Based Health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. A Comparative Study of Patient and Physician Perceptions Worldwide, Presentation at World Medical Association. (Sept. 11, 2003) (The method of data collection was a random telephone survey to patients (over 21 years of age) and physicians (in general practice for 5+ years)).



throughout one medical episode. Nevertheless, medicine relies on trust in the doctor-patient relationship in order to make sure that diagnoses are correct, plans of care are followed, and further care is rendered. Pregnancy requires a very open discussion about all facets of life – everything from drugs, alcohol, and domestic abuse to seatbelts, Jacuzzis, and vitamins. It is also involves a great deal of physical vulnerability, as there are many tests and frequent check-ups required in prenatal care. Throughout 40 weeks of poking, prodding, and getting a play-by-play of the woman’s most private area, it is crucial that the doctor maintain the trust of the woman, or run the risk of jeopardizing the honest communication and the regular visits during prenatal care.

Further tension arises when a maternal-fetal conflict occurs due to the fact that the doctor perceives both the woman and the fetus as patients. ACOG recommends that the “[r]ole of the obstetrician should be one of an informed educator and counselor, weighing the risks and benefits to both patients as well as realizing that tests, judgments, and decisions are fallible.”<sup>199</sup> In the vast majority of pregnancies, the woman would do anything to help her growing fetus. Therefore, it seems entirely normal and practical for a doctor to view the fetus as a patient as well. However, there is an inherent limitation to how far the doctor’s role can go. If the woman wants an abortion (prior to viability), the doctor is legally permitted to terminate the pregnancy.<sup>200</sup> In some circumstances, the physician would recommend an abortion in order to preserve the life or health of the mother. Logically, a doctor’s relationship to the fetus is inherently different from the relationship with the pregnant woman. While the doctor should perform the role of informed educator and counselor to benefit both patients, it cannot be said that the fetal patient should override the doctor’s loyalty to the living female patient. To allow

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<sup>199</sup> AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, ETHICS IN OBSTETRICS AND GYNECOLOGY 36 (2d ed. 2004).

<sup>200</sup> Roe v. Wade, 410 U.S. 113, 163 (1973).

such a scenario would create a conflict of interest that would result in a breach of fiduciary duty to the woman. It would also create an atmosphere in which the woman is pregnant with a growing adversary.

If a physician seeks judicial intervention and the court grants an order to compel a C-section upon a non-consenting pregnant woman, there are three possible consequences for the doctor-patient relationship: (1) confidentiality and trust in the doctor is destroyed for the individual woman, (2) trust in medicine and trust in the doctor is negatively affected in the larger population, and (3) paternalism regains strength in the obstetrical context. First, by resorting to the public courts, the doctor blatantly disobeys the confidentiality rule that is supposed to protect the patient's private information and allow her to feel safe in divulging her very private matters. In addition, the woman may be unlikely to trust medicine in the future if she understands that doctors can override her informed decisions by resorting to the court.

Even more alarming is the second consequence, which is the effect upon the larger population of women, but also including patients in every medical situation. Obstetricians rely on their patients to tell them everything about their pregnancies – including the difficult topics of drugs, alcohol, smoking, and domestic abuse. They also must rely on the women to present to the hospital for prenatal care. While physicians think that they are protecting the fetus (and maybe the woman too) by resorting to the courts to compel a C-section, they may in fact be stifling that very goal by destroying the aura of trust and confidentiality in the doctor-patient relationship. In fact, the physician has “helped transform himself or herself into an agent of the state's authority.”<sup>201</sup> Thus, the court is endorsing a defective model of the doctor-patient relationship by granting an order to override a patient's decision. If women believe that their

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<sup>201</sup> George Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213, 1214 (1987).

wishes will not be honored and that their physicians are acting on the state's behalf instead of theirs, then they may be much less likely to seek prenatal care. Consequently, it is not only wise to respect the wishes of pregnant women for their own sakes, but also in order to improve the well-being of many fetuses as well.

Gone are the days (supposedly) that paternalism was the driving force in the doctor-patient relationship. However, the third consequence is worrisome because obstetrical care is a vulnerable area where paternalism has the ability to rear its ugly head. If we value the informed consent doctrine as a way to provide information and work through decisions with patients, then medicine cannot turn its back when the decision made is not in line with preconceived values. Even more importantly, judges should not endorse a model that disregards the patient's right to make an informed decision. Law, medicine, and bioethics have repeatedly affirmed medicine's commitment to autonomy and informed consent, and consistently rejected paternalism as an appropriate approach to patient care. Pregnancy should not affect this. The alternative is to isolate pregnant women in a category where their autonomy is respected less than other competent adults. I am not suggesting that physicians should step back completely and blindly accept the woman's choice. In fact, their role must be one of education, information, facilitation, and persuasion (without resorting to coercion). Courts must also realize their role in the bigger picture, and be extremely careful that their actions do not foster a defective model of the doctor-patient relationship.

### 3.3 THE USE OF PHYSICAL FORCE ON PREGNANT WOMEN

In 1984, in Chicago, a Nigerian woman expecting triplets was hospitalized for the final period of her pregnancy. The woman and her husband steadfastly reiterated their unwillingness to consent to the Caesarean section that doctors regarded as necessary for a safe multiple birth. As the woman's due date approached, doctors and hospital legal counsel obtained a court order granting the hospital administrator temporary custody of the triplets and authorizing a Caesarean section as soon as the woman went into labor. Although this plan was known to all the residents, it was never presented to the patient. She was not given the opportunity to seek care elsewhere. Confronted with the doctor's intentions, the woman and her husband became irate. The husband was asked to leave, refused, and was forcibly removed from the hospital by seven security officers. The woman became combative and was placed in full leathers, a term that refers to leather wrist and ankle cuffs that are attached to the four corners of the bed to prevent the patient from moving. Despite her restraints, the woman continued to scream for help and bit through her intravenous tubing in an attempt to get free. Some days later, the hospital newsletter published a photograph of the woman and her three children, making no mention of the violent melee attending the birth.<sup>202</sup>

The purely legal and medical aspects of court-ordered C-sections blur the practical reality that physical force is lurking every time a judge signs such an order. Yet, the blame for the violence is diffused due to the nature of system, such that no one group feels the need to take responsibility for it.<sup>203</sup> The doctors do not want to commit a battery by treating the woman against her will, so they summon hospital legal counsel for guidance as to how they can lawfully proceed. Hospital legal counsel does not have the ability to ultimately make that call, so they draw up a complaint and proposed order and hand it off to a judge. The judge may not ever set foot in the hospital, may not ever meet with the woman, and must make a hasty decision after

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<sup>202</sup> Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 9-10 (1987).

<sup>203</sup> Annas, *supra* note 201 at 1213.

being presented with frightening statistics saying that the baby will die or be severely handicapped without the surgery. Most importantly, it is highly unlikely that the judge would be present when the order is carried out – thus hiding the harsh reality. The doctors, with signed order in hand, feel that the law has given the ‘ok’ sign, and that they are required to follow the order.

This is not to suggest that physicians enjoy or agree with physically forcing the woman to submit to surgery, but it sheds light on the problem of enforcement. A C-section is a highly invasive surgery that requires a great amount of preparation, and a great deal of cooperation by the woman to follow post-surgery care. Courts have recognized the problem – “[t]he state opposes the use of force...[t]hus we have been asked to issue an order that no one expects to be carried out”<sup>204</sup> – yet, the orders are still entered by lower courts. ACOG has also recognized the problem by stating that the use of force is not justified because it substantially increases the risk to the woman.<sup>205</sup> Yet, physicians still seek these orders. Orders continue to be entered because judges and doctors are likely hoping that the woman will submit to the surgery without the need for force, and will appreciate their efforts after the fact. This type of “deferred consent” is simply an “anticipated outcome that reassures health professionals that they are acting in the patient’s best interests”<sup>206</sup> – which does not respect the autonomy of the woman, and ignores the legal mandate of truly informed consent.

The use of physical force is a practical reality that cannot be ignored. It is bad policy for the courts to enter orders that the state has no intention of carrying out if met with physical resistance from the woman. It is also bad policy to allow a pregnant woman to endure physical

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<sup>204</sup> *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326, 335 (Ill. App. Ct. 1994).

<sup>205</sup> AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *ETHICS IN OBSTETRICS AND GYNECOLOGY* 36 (2d ed. 2004).

<sup>206</sup> BEAUCHAMP AND CHILDRESS, *supra* note 187, at 68.

violence sanctioned by our judicial system and performed by our medical system - “[s]uch actions would surely give one pause in a civilized society, especially when [the woman] had done no wrong.”<sup>207</sup>

### 3.4 CONCERNS OF JUSTICE

In 1987, Kolder, et al. conducted the first large scale empirical study of court-ordered obstetrical interventions, by surveying maternal-fetal medicine programs throughout the country.<sup>208</sup> Her results were surprising and alarming: in cases where court orders were sought, they were granted 86% of the time – 81% of the women involved were black, Asian, or Hispanic, 44% were unmarried, and 24% did not speak English as their primary language.<sup>209</sup> These statistics represent all court-ordered obstetrical interventions, not just C-section cases. The C-section court order statistics were as follows: 15 court orders were sought – 47% were black Americans, 33% were African or Asian, 20% were white Americans; 50% were unmarried and 27% did not speak English as their primary language.<sup>210</sup> The statistics speak for themselves, and bring attention to idea that various types of discrimination may be lurking behind the supposed beneficence-based medical judgments.

A more recent study, published in 2003, revisited Kolder’s study to see how physician perceptions and attitudes had changed over the years (though the sample size was much

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<sup>207</sup> *In re A.C.*, 573 A.2d 1235, 1244, n. 8 (D.C. 1990).

<sup>208</sup> Veronica E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987) (the survey response rate was 83%, and included responses from 45 states and the District of Columbia).

<sup>209</sup> *Id.* at 1193.

<sup>210</sup> *Id.*

smaller).<sup>211</sup> The results were surprising – the number of requests for court orders seems to have declined over the years since the Kolder study. While Kolder found that 47% of respondents agreed that the woman should be required to undergo life-saving treatment for the sake of their fetuses, only 4% agreed with this statement in the 2003 study.<sup>212</sup> However, in the 2003 study, of the nine cases in which the woman’s wishes were overridden – six of those were C-section cases.<sup>213</sup> This could be an encouraging development because it shows that hospitals and physicians may be altering their perspectives, and treating women in the same way as other competent adults. The authors, however, were still quite concerned that the study reflected the disparity between expressed attitudes and actual behavior, meaning that clinicians were giving the ‘politically correct’ answer, rather than expressing their true feelings and actions.<sup>214</sup>

Concerns about the fairness and justice are always worrisome, especially when empirical data indicates that discrimination is a reality, not a hypothetical. Poor, uninsured women often do not have a primary care physician, and must present for care at an emergency room filled with doctors with whom they have no history or personal connection.<sup>215</sup> In addition, “prior incidents of racism might lead women of color to take a more oppositional stance to the judgments of their doctors than most white middle-class women.”<sup>216</sup> These are just some of the factors that may lead to a disproportionate number of court orders for racial minorities and lower socio-economic groups. Certainly these women are entitled to the same rights as all women, yet because of the

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<sup>211</sup> Sarah F. Adams, Mary B. Mahowald & Janet Gallagher, *Refusal of Treatment During Pregnancy*, 30 CLIN. PERINATOL. 127, 134 (2003) (the survey response rate was 70%, and included responses from 27 states and the District of Columbia. This sample size was smaller than the Kolder study).

<sup>212</sup> *Id.* at 135.

<sup>213</sup> *Id.* at 134.

<sup>214</sup> *Id.* at 137.

<sup>215</sup> Harris, *supra* note 193, at 788.

<sup>216</sup> *Id.* at 788-89 (quoting Dorothy E. Roberts, *Reconstructing the Patient: Starting with Women of Color*, FEMINISM AND BIOETHICS – BEYOND REPRODUCTION (SM Wolf ed. 1996)).

nature of the health care system, they may find that their rights are challenged more frequently than others. These unjust consequences cannot be overlooked or forgotten.

### 3.5 DUE PROCESS

Obtaining bedside court orders under exigent circumstances necessarily invokes due process concerns. In the 2003 study, cited above, all but one of the court orders were obtained within minutes to hours after the request.<sup>217</sup> Kolder found that in 88% of the cases, the court order was granted within six or fewer hours.<sup>218</sup>

It is impossible to read the C-section cases without getting the feeling that the woman's rights were doomed from the beginning. Mrs. Jefferson was not even present for the emergency hearing in which an order was entered to require her to submit to the C-section.<sup>219</sup> The judge came to the hospital where A.C. was staying, and yet never once entered her room or attempted to contact the physician who had been caring for her for years.<sup>220</sup> Mrs. Pemberton was not given notice that the hospital had convened a hearing – a particularly flagrant due process violation – which resulted in an order that required her to be forcefully brought to the hospital by ambulance with a police escort to continue the hearing.<sup>221</sup> The *Pemberton* court also noted that the trial court order contained an exaggeration of the medical testimony – that death of the fetus was a certainty – but, in reality, there was a substantial and unacceptable risk of death, not a

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<sup>217</sup> Adams et al., *supra* note 211, at 134.

<sup>218</sup> Kolder et al., *supra* note 208, at 1193.

<sup>219</sup> Jefferson v. Griffin Spalding County Hosp. Auth. et al., 274 S.E.2d 457, 458 (Ga. 1981)

<sup>220</sup> *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990).

<sup>221</sup> Pemberton et al. v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F.Supp.2d 1247, 1250 (N.D. Fla. 1999).



certainty.<sup>222</sup> This calls into question the veracity of the evidence presented at these quickly-assembled hearings – in which there is little time to reflect on the testimony and even less time to gather medical testimony for the patient’s case.

Imagine the tremendously difficult position that judges find themselves in when they are hovering over a fully pregnant woman, with doctors pleading to save the life and health of an unborn child. The impulse to help an innocent child would be overwhelming, especially in light of the exigent circumstances, the lack of precedent, and the fact that the decision may result in the death or impairment of a child. Yet,

“[t]he judge, even when he is free, is still not wholly free. He is not to innovate at pleasure. He is not a knight-errant, roaming at will in pursuit of his own ideal of beauty or of goodness. He is to draw his inspiration from consecrated principles. He is not to yield to spasmodic sentiment, to vague and unregulated benevolence.”<sup>223</sup>

George Annas suggests that the delivery room is “not conducive to such reflection, and judges probably do not belong there at all in such circumstances.”<sup>224</sup>

Of particular concern is that even though the women can appeal the decision and try to challenge the alleged due process violations and constitutional rights issues, their stake in the outcome is no longer remediable – the C-section has already been performed, and they were denied their right to make the medical decision. This illustrates why the due process concerns are so vital at the trial court level, when the woman still has an imminent stake in the outcome. Nevertheless, it seems virtually impossible to adequately respect the due process rights of the woman in these fast-paced circumstances. Thus, judges should be extremely wary of such

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<sup>222</sup> *Id.*

<sup>223</sup> Annas, *supra* note 72, at 17 (quoting Application of the President and Dir. of Georgetown Coll., 331 F.2d 1010, 1017 (D.C. Cir. 1964) (Burger, J., dissenting)).

<sup>224</sup> *Id.* at 17.

hearings, and consider the larger issues before condoning compelled treatment on such shaky due process grounds.

### **3.6 PREGNANT WOMEN: MEANS TO AN END?**

A utilitarian might look at maternal-fetal conflicts and say that overriding the woman's decision to refuse a C-section is less harmful than the possible outcomes for the fetus – therefore, the woman's right to refuse should be overridden to produce greater utility. Yet, this equation only focuses on the individual woman and her fetus, and ignores the greater implications for all citizens. As stated previously, compelling women to have C-sections not only destroys the woman's trust in her doctor, but can also produce and reinforce distrust in the medical system in the minds of other pregnant women. The overall utility is negatively affected because women may not seek prenatal care and may not be as forthcoming with their obstetricians, thus jeopardizing the health and safety of themselves and their fetuses.

This is not the only significant consequence. By allowing courts to compel C-sections, we run the risk of treating women as a means to an end – a mere fetal container. If the woman makes a choice that displays altruism toward the fetus, then her autonomous choice is given judicial protection. But, when a pregnant woman makes a choice that reflects her own personal needs, wants, and values – then the court may strip away her right to make an autonomous decision.

One commentator asks, “[w]hy can’t a woman make a choice vis-à-vis herself and her fetus that might have a bad outcome?...[i]n other words, why can’t women make mistakes?”<sup>225</sup> When the question is posed in this manner, it highlights the problem of medicine and law trying to manage, control, and “medicalize” pregnancy to the extent that the process of having a child is no longer in the private realm. “[W]omen are expected to donate themselves in the form of time, energy, and body, particularly as mothers.”<sup>226</sup> A woman is labeled as deviant if she does not behave in these stereotypical ways, and “risks placing [herself] outside of the law’s protection, for the force of law continues to be used to ensure women’s compliance with female social norms.”<sup>227</sup>

When looking at the overall picture, it is difficult to ignore that pregnant women are being treated differently from all other competent adults when their medical decisions are judicially overridden. Judges and physicians do not seem to have malevolent intentions – in fact, they see their role as one of saving an innocent life. But, there lurks unintended consequences of treating women as lesser citizens. Justice Brennan’s dissent in the landmark treatment refusal case of *Cruzan v. Director, Missouri Dept. of Health* was not addressing maternal-fetal conflicts, but eloquently articulated the danger of trampling the liberty interest, saying

“[i]t is not apparent why a State could not choose to remove one of her kidneys without consent on the ground that society would be better off if the recipient of that kidney were saved from renal poisoning...indeed, why could the State not perform medical experiments on her body, experiments that might save countless lives, and would cause her no greater burden than she already bears...”<sup>228</sup>

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<sup>225</sup> Cherry, *supra* note 41, at 252.

<sup>226</sup> April L. Cherry, *Roe’s Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 741 (2004).

<sup>227</sup> *Id.*

<sup>228</sup> 497 U.S. 261, 313, n. 13 (1990) (Brennan, J., dissenting).

If women are treated differently than other competent adults, the slippery slope argument comes sharply into focus. If we are willing to compel a procedure as invasive as a C-section, where does it end? Less invasive procedures would seem easy, and other comparable surgeries might also be deemed the norm. Justice Brennan's words reflect the notion that there is something greater at stake than simply the desire to avoid pain and suffering. Treating women as fetal containers, in which we can compel them to undergo unwanted medical procedures for the sake of a perceived greater good, is not an ethically or legally defensible goal.

### **3.7 MORAL AND LEGAL IMPERATIVES**

It is hard to analyze maternal-fetal conflicts without getting the overwhelming feeling that something is not right – that the women in these cases are just not deciding correctly. I imagine that if I were the friend or family member of one of these women, I would strongly encourage her to make the 'right' choice, and would probably have the impulse to shake some sense into her. This is a reaction based solely on a moral viewpoint – that a person has a moral duty to help the unborn child come into the world with a sound mind and body. It is comforting to think that law always reflects and upholds moral duties, but there must necessarily be a distinction between a moral imperative and a legal imperative in some areas of law.

Justice Holmes' word of caution over 100 years ago ring true in this instance: “[The Constitution] is made for people of fundamentally differing views, and the accident of our finding certain opinions natural and familiar or novel and even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution

of the United States”.<sup>229</sup> People will likely always differ on the questions of whether it should be legally acceptable for a pregnant woman to jeopardize the fetus by refusing treatment, whether the fetus is a patient imbued with the same rights as the pregnant woman, or whether the fetus is a person. Yet, the Constitution has been interpreted as not providing the fetus with the same rights under the fourteenth amendment as an already-born person.<sup>230</sup> Also, the interests of the state in the “potentiality of human life” have not been equated with the C-section cases by the Supreme Court. Therefore, this is an area where a legal mandate should not follow from a moral mandate. The dangers of allowing this to happen have been shown throughout the Chapter thus far. Most notably, the precedent established by doing so would seem to condone many other less invasive procedures (such as blood transfusions) and similarly invasive treatments (such as fetal surgery) to be legally thrust upon pregnant women without consent.

Morality and legality should not be seen as opposing forces in maternal-fetal conflicts, however. Instead, we should recognize that fundamental bioethical principles – autonomy, beneficence, and justice – are actually furthered by honoring the woman’s wishes, even though we may not morally agree with the woman’s decision. If we truly aim to uphold these principles and find value in their use in medicine, then we cannot pick and choose when to apply and respect them.

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<sup>229</sup> *Lochner v. New York*, 198 U.S. 45, 76 (1905) (Holmes, J., dissenting).

<sup>230</sup> *Roe v. Wade*, 114 U.S. 113, 158 (1973).

## THE JUDICIAL STANDARD

The first step is to determine the competency of the woman (Figure 1, Box 1). As seen in the *A.C.* case, this is a crucial step in order to determine whether the woman can make an autonomous decision and give informed consent. If she lacks competency, the court must determine her wishes based upon the substituted judgment standard. However, if her wishes are not ascertainable through this method, the best interests standard can be employed by the court.

This first step may seem like the easy part, but it is often overlooked in exigent circumstances. Patients are presumed in law to be competent, but decision-making ability is often called into question when the patient makes a decision that most people in similar circumstances ordinarily do not make or that is not in line with her own previously manifested values. Because of the presumption of competency, doctors do not need to check every pregnant woman for competency, but when consideration is being given to obtaining a judicial order for a C-section, it may be a wise first step. The Kolder study found that, in cases where a court order was sought, maternal competency was established by a psychiatrist in only 15% of the cases, and not investigated in the rest.<sup>231</sup> I am not suggesting that pregnant women are incompetent, but it would seem that a competency test would be a sensible step that, (a) would not automatically ruin the trust relationship, (b) would not involve the doctor as an agent of the state, and (c) would not involve any physical force exerted upon the woman. Furthermore, if the woman was truly

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<sup>231</sup> Kolder et al., *supra* note 208, at 1193.

incompetent, it could save her life and the life of her fetus by ensuring that she is able to make an autonomous decision.

The second step (Figure 1, Box 2), as established throughout Chapter 2, reflects the notion that abortion precedent does *not* dictate that the state's interest in the "potentiality of human life" should be balanced against the woman's right to privacy and bodily integrity – there is no guidance from the Supreme Court as to whether or how the two distinct rights could be weighed against each other. Therefore, it is inappropriate to employ a balancing test when deciding the C-section cases involving competent women. In addition, ethical considerations counsel *against* the use of a balancing test because it would: (a) create an adversarial relationship between the pregnant woman and fetus, (b) foster a system in which discrimination and value judgments produce unjust results, and (c) treat the woman as merely a means to an end – a fetal container.

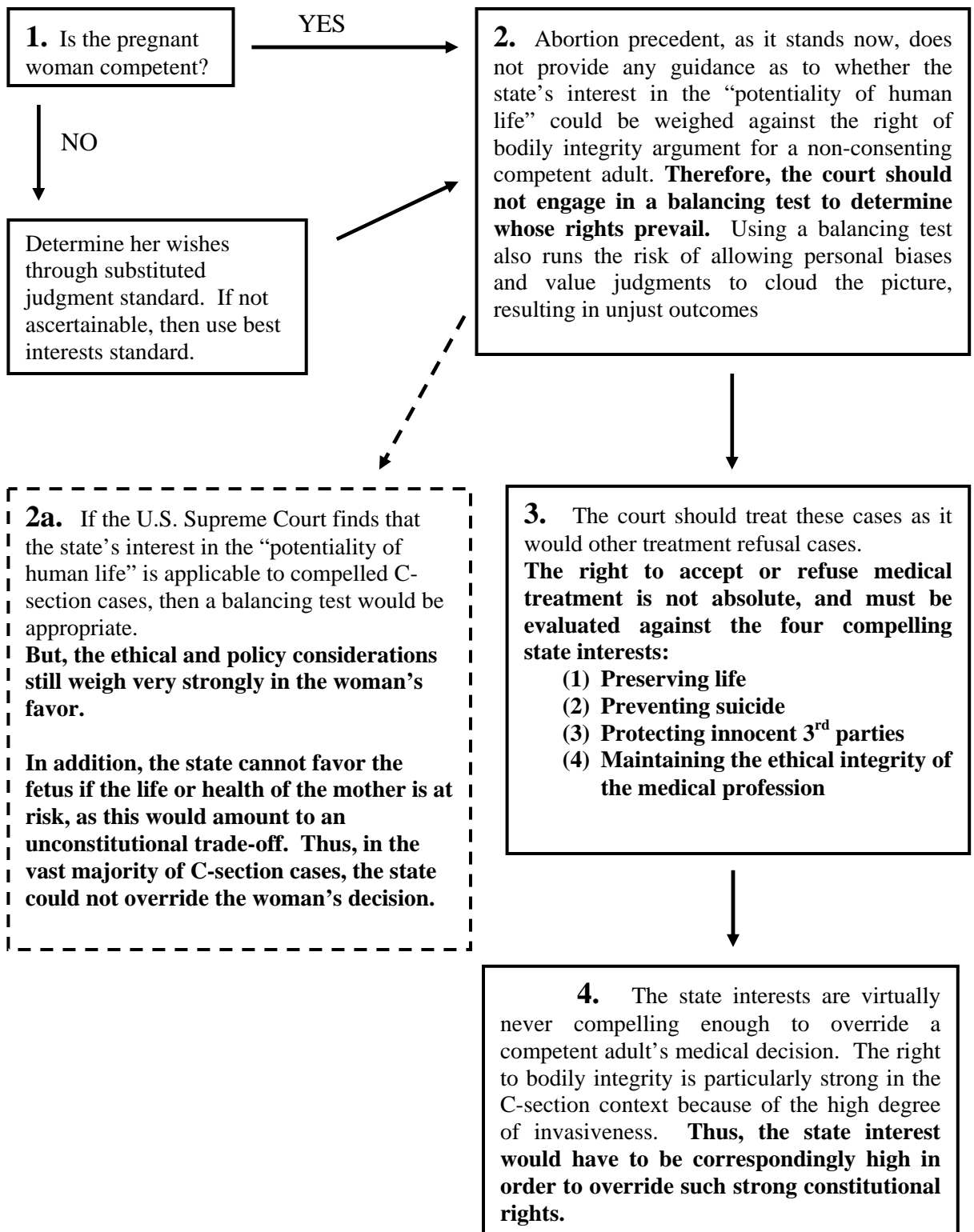


Figure 1: Proposed Judicial Standard



However, if the Supreme Court were to find that the state interest in the “potentiality of human life” is appropriately weighed against the woman’s right to bodily integrity (Figure 1, Box 2a), a balancing approach would become allowable – which would balance the woman’s right to privacy and bodily integrity against the state’s interest in the viable fetus. Nonetheless, the ethical and policy considerations should virtually always tip the balance in the woman’s favor, most notably the following:

- a. The use of physical force upon the woman to accomplish the C-section puts her health and life in jeopardy, and could harm the fetus as well. It also sets an unnerving precedent for the treatment of women during pregnancy.
- b. If the court orders an extremely invasive procedure such as a C-section – where would we draw the line? As technology marches forward, new fetal surgeries and interventions will be discovered, as well as other less invasive means to help the fetus. If the court feels justified in allowing the state’s interest in the fetus to override in C-section cases, it would seem very easy to slide down the slippery slope to both less invasive procedures and equally or more invasive fetal surgeries. Technology should not dictate rights.
- c. The due process concerns are insurmountable. Thus, the proceedings in these cases do not extend the same legal rights to pregnant women that are afforded to all other citizens when similar rights are sought to be restricted or denied.

It is also worth noting that if abortion precedent is deemed applicable to C-section cases, it is unconstitutional to require any trade-off of the mother’s life and health in order to favor the fetus.<sup>232</sup> Thus, in the vast majority of cases – where the C-section is only recommended to aid

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<sup>232</sup> Thornburgh v. Am. College of Obstetricians and Gynecologists, 476 U.S. 747, 768 (1986).

the fetus – the state could not compel the woman to submit to a C-section that is riskier to her life and health than a vaginal delivery.

Returning to the current state of the law, the next step would be to recognize that the compelled organ donation context provides the best analogy for the C-section cases (Figure 1, Box 3). Using this analogy allows the court to view the issue as other treatment refusal cases. The right to refuse treatment would be balanced against the four recognized state interests. At first glance, this would appear to refute my claim that a balancing test is inappropriate. However, when the four state interests are balanced against the woman's constitutional rights, the balance is *not* between the fetus and mother (as it would be if the woman's rights were balanced against the state's interest in the potentiality of human life). I am seeking to avoid balancing the woman against the fetus, as this is a very value-laden exercise that can produce widely varying interpretations in state courts – how can one truly decide who is more deserving? Instead, the issue should be approached from the following angle: who gets to decide if treatment is administered? Competent adults are granted that right, and if judicially challenged, must be balanced against the four state interests.

The next step is to do just that – examine the four state interests in treatment refusal cases (Figure 1, Box 4). These interests were analyzed at the end of Chapter 2. To reiterate, it is highly unlikely that courts could find that any of these interests could outweigh the woman's overarching right to decide what is done to her body. However, courts may find that the preservation of life or the protection of innocent third parties is an unexplored area for maternal-fetal conflicts. These interests would have to be extraordinarily compelling in order to overcome the high degree of invasiveness and the ethical and policy considerations outlined throughout this Chapter. Thus, courts should virtually never override a competent woman's decision to refuse a

C-section. The threshold is set remarkably high in order that courts do not trample the liberty rights of any citizens.

## **CONCLUSION**

This examination of the law and ethics surrounding court-ordered C-sections highlights the inherent dilemmas that plague this topic. My aim has been to provide insight into the struggles, and argue for a comprehensive judicial precedent that embodies respect for the individual, and upholds the tenets upon which our legal system was built. My proposed standard argues that courts should virtually never override a competent woman's right to refuse a C-section. It is my hope that the debate will continue, that law will eventually reach a thorough standard, and that women will find that medicine and law honor their wishes just as they should those of any other competent individual.

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