Volume 70 | Number 1 Article 15

11-1-1991

# Forced Cesarean Sections: Do the Ends Justify the Means

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# COMMENT

## Forced Cesarean Sections: Do the Ends Justify the Means?

So many emotional issues surround court-ordered cesarean sections—pregnancy, motherhood, children, medical technology, bodily integrity, life, death, and impairment—that it is no wonder the practice has engendered so much debate and legal commentary. The subject arises in the rare situation when the attending physician decides that a surgical intervention such as a cesarean section is necessary, the woman refuses to consent, and the physician seeks a court order allowing the procedure despite her refusal.[1] A study published in the *New England Journal of Medicine* in 1987[2] found that fifteen court orders authorizing cesarean sections were sought in eleven states between 1980 and 1985.[3] Since that study was completed there have been other cases.[4]

Cesarean sections are relatively common and safe operations. The number of cesareans done in the United States has risen throughout this century as techniques have developed both for performing the surgery and for monitoring the fetus *in utero*.[5] Nevertheless, the risk of maternal morbidity is four times greater with cesarean sections than it is with vaginal deliveries.[6] There are a number of reasons why a physician might

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1. This patient-physician conflict typically arises during labor, but may surface earlier. *See, e.g., infra* text accompanying note 107. The reasons why a physician might decide a cesarean is more appropriate than vaginal delivery are varied. *See infra* notes 7-10 and accompanying text.

2. Veronica E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987) [hereinafter *New England Journal of Medicine Study*]. The researchers sent a questionnaire to 90 directors of maternal-fetal fellowship programs and directors of maternal-fetal medicine in obstetrics/gynecology residencies; the physicians represented 45 states and the District of Columbia (Alaska, Idaho, Montana, North Dakota, and Wyoming were not represented). The study asked the physicians to report incidents they knew of in which doctors had sought a court order to perform a cesarean section, an intrauterine transfusion, or a forced detention. *Id.* at 1192-93.

3. *Id.* at 1193.

4. *See, e.g., In re* A.C., 573 A.2d 1235 (D.C. 1990) (en banc); *In re* Madyun, Misc. No. 189-86 (D.C. July 26, 1986), *reprinted in A.C.*, 573 A.2d at 1260-63.

5. Janean A. Daniels, *National Health Law Program*, 21 CLEARINGHOUSE REV. 1064, 1064 (1988); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1958 (1986) (noting increase from 5% of deliveries in 1970 to 16.5% in 1980); *see also* NATIONAL INST. OF HEALTH, DEP'T OF HEALTH & HUMAN SERVICES, CESAREAN CHILDBIRTH REPORT OF A CONSENSUS DEVELOPMENT CONFERENCE 6 (1981) (Pub. No. 82-2067) [hereinafter CESAREAN CHILDBIRTH REPORT] (offering statistical analysis of use and risks of cesarean section births).

6. Daniels, *supra* note 5, at 1069 (citing CESAREAN CHILDBIRTH REPORT, *supra* note 5, at 255).

decide a cesarean is necessary. The cases reported in the *New England Journal of Medicine* study provide a sample: the cesarean was indicated because of fetal distress[7] in seven of the fifteen; previous cesarean[8] in three; and placenta previa[9] in two.[10] While most women consent to the surgery their physician recommends, some women refuse.[11] Two reasons often given for the woman's refusal to consent are religious beliefs[12] and concern for her own health.[13] Out of fear of future liability[14] or a belief that the woman has made a wrong, or even immoral, decision,[15] some hospitals will not accept the refusal and instead take the case to court.

The position of the judge called upon to hear such a case is an unenviable one. Most judges spend their time concerned with issues other than the state of fetal monitoring technology. There may not be time to give notice to all interested parties[16] or for other procedures that would enhance the court's decisionmaking ability.[17] Most important, the

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7. Fetal distress occurs when the fetal heart rate pattern is not synchronized with the uterine contraction pattern, possibly indicating oxygen deprivation. Rhoden, *supra* note 5, at 1957.

8. A previous cesarean was once an automatic justification for a cesarean section in all subsequent pregnancies due to the risk of rupture. Rupture now, however, occurs in less than one percent of cases. One study showed no maternal death from rupture over a 32-year period. Daniels, *supra* note 5, at 1069 (citing CESAREAN CHILDBIRTH REPORT, *supra* note 5, at 360).

9. Placenta previa occurs when the placenta has moved to block fetal access to the birth canal. The coverage can be partial or complete. STEDMAN'S MEDICAL DICTIONARY 1206 (25th ed. 1990).

10. *New England Journal of Medicine Study*, *supra* note 2, at 1193. Another term that may be used is "cephalopelvic disproportion," a general classification described as "a catch-all" and as "vague and nondiagnostic." Daniels, *supra* note 5, at 1070. Cephalopelvic disproportion refers to the size of the fetal head in relation to the maternal pelvis. STEDMAN'S MEDICAL DICTIONARY, *supra* note 9, at 278.

11. Rhoden, *supra* note 5, at 1959.

12. *See, e.g.*, *In re* Madyun, Misc. No. 189-86 (D.C. July 26, 1986), *reprinted in In re* A.C., 573 A.2d 1235, 1263 (D.C. 1990) (en banc); *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 86, 274 S.E.2d 457, 458 (1981) (per curiam).

13. Watson A. Bowes, Jr. & Brad Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OB. & GYN. 209, 209 (1981) (discussing case of a Colorado woman who feared surgery, in part because of her "morbid obesity").

14. Daniels, *supra* note 5, at 1064.

15. *See, e.g.*, Bowes & Selgestad, *supra* note 13, at 211.

16. *A.C.*, 573 A.2d at 1248 & n.17 (finding that patient's longtime treating physician did not receive notice of the court proceedings; would have testified against surgery). *A.C.* is the case of a District of Columbia woman who was 26.5 weeks pregnant and dying from cancer. The hospital doctor sought to perform a cesarean section because he felt that A.C.'s condition had so deteriorated that she could not support the child. *Id.* at 1238-39. For a more thorough discussion of *A.C.*, see *infra* notes 70-92 and accompanying text.

17. *A.C.*, 573 A.2d at 1248 & n.17 (finding that, in addition to her longtime physician not being notified, patient's appointed attorney could not meet with her and her medical records were missing); Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal*

time constraints involved when a woman is in active labor make careful study and reflection by the judge practically impossible: "In a matter of hours or even minutes, a judge must decide whether to mandate major surgery for a competent, unconsenting adult . . . or to uphold the woman's refusal, with its potentially tragic consequences for her baby."[18] As a result, precedent in this area is being established by orders handed down without the benefit of the time and reflection usually considered critical to the development of sound law.

It is impossible to slow labor in order to give a judge several weeks to think about an appropriate order; it is critical, therefore, that advocates present the arguments in advance. This Comment examines the legal arguments for and against the authorization of cesarean sections over the woman's refusal to consent and the ways that courts confronted with the problem have addressed these issues. It then considers whether court-ordered cesareans are good public policy. The Comment concludes that the courts should hear these cases but should not override the decision of a competent woman to forgo surgery her physician recommends, even if the woman is pregnant at the time of refusal.

The courts decide cesarean section cases based on a balancing of the interests involved. If no fundamental right is involved, then the court must simply balance the various interests of the patient, the hospital, and the state against each other.[19] If, however, the case involves a fundamental right protected by the Fourteenth Amendment's Due Process Clause,[20] the court must undertake a much closer review of the state's actions, subjecting them to strict scrutiny. Only if the state's interests are compelling and the means for achieving its goals are narrowly tailored to meet the desired ends will the state be permitted to infringe upon a fundamental right.[21] With cesarean sections, there is no less intrusive technique that will meet the physician's concerns and therefore no more

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*Rights*, 10 HARV. WOMEN'S L. J. 9, 48-49 (1987) (citing lack of notice, adequate representation, explicit standards of proof, and rights to timely appeal).

18. Rhoden, *supra* note 5, at 1952; *see also A.C.*, 573 A.2d at 1238 (three-hour hearing); *New England Journal of Medicine Study*, *supra* note 2, at 1193 ("Once a court order was deemed necessary, it took six or fewer hours to obtain it in 14 of 16 cases (88%). In three of these cases (19%), the court orders were actually obtained in an hour or less; at least one order was granted by telephone.").

19. For an example of a general weighing of interests, see *Winston v. Lee*, 470 U.S. 753, 761-62 (1985) (Supreme Court weighed individual's interests in privacy against society's interests in obtaining evidence and in accurate determinations of guilt and innocence in deciding the State could not surgically remove a bullet from defendant to use as evidence).

20. In order for this test to apply there must be not only a recognized fundamental right, but also state action. *See infra* notes 93-100 and accompanying text.

21. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2852 (1990); Roe v. Wade, 410 U.S 113, 155 (1973).

narrowly-tailored means. The balance thus focuses on the interests of the woman and the state. Determining the weight of an interest is a highly subjective undertaking. It is not, however, one a court must undertake without guidance. A number of legal analogies are available to help determine relative weight. Although none are exact, they are nevertheless helpful.

The logical starting point for examining a refusal to undergo surgery is the doctrine of informed consent. Before a physician may embark on a course of treatment, he must make his patient aware of the proposed intervention, any risks associated with it, the possible outcomes, any reasonable alternatives, and any future interventions that may become necessary once a treatment plan is begun.[22] It is then up to the patient to decide whether she wishes to proceed with or refuse the proposed treatment. By requiring the patient's informed consent, the law respects the patient's autonomy and secures for the patient the right to make the risk-benefit analysis inherent in medical decisionmaking.[23]

Informed consent has a strong basis in the common law, under which any touching without consent constitutes a battery.[24] Under modern law, informed consent is codified in many states and the failure to obtain it is considered negligence, rather than a battery.[25] Once a competent adult woman has decided to refuse medical treatment, the critical question becomes whether the state ever has a right to override her refusal, even if she is pregnant.[26]

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22. Nancy M. King, *Consent to Treatment*, in HEALTHCARE FACILITIES LAW § 7.1.3, at 463-68 (Anne Dellinger ed. 1991).

23. 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 17, 42-51 (1982); Rhoden, *supra* note 5, at 1970.

24. *Cruzan*, 110 S. Ct. at 2846; King, *supra* note 22, § 7.1, at 458.

25. Statutes differ from state to state. Most, however, define the standard of disclosure and causation. King, *supra* note 22, § 7.3, at 480-81 (comparing informed consent statutes); *see, e.g.*, N.C. GEN. STAT. § 90-21.13 (1990).

26. Although labor is a difficult process that may involve stress, anxiety, or pain, it is not a process that renders a woman presumptively incompetent to make a decision. Nevertheless, some commentators seem implicitly to argue that the pregnant woman should be treated as an incompetent. *See, e.g.*, Alice M. Noble-Allgire, *Court-Ordered Cesarean Sections: A Judicial Standard for Resolving the Conflict Between Fetal Interests and Maternal Rights*, 10 J. LEGAL MED. 211, 243 (1989) (citing the institutionalization and treatment against the will of the mentally incompetent as an example of a time when the state has a right to intervene).

Competency determinations are formal assessments by a psychiatrist or mental health professional, or, if absolutely necessary, by the treating physician. A competency evaluation need not take much time, especially since a psychiatrist probably will be available in a hospital without much delay. Competency evaluations already are undertaken by psychiatrists in a number of situations, including medical decisionmaking. *See generally* RUTH R. FADER & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 288-93 (1986) (presenting and evaluating different approaches to assessing competency); RALPH REISNER &

The court must therefore balance the woman's right to refuse against any interests asserted by the state. Courts and commentators have identified four state interests relevant to a competent decision to refuse treatment: "(1) the preservation of life; (2) the protection of dependent third parties; (3) the prevention of suicide; and (4) the preservation of the ethical integrity of the medical profession."[27] Neither prevention of suicide nor the preservation of ethical integrity is relevant when a woman refuses to consent to a cesarean section. Even if her health is also at risk, the woman refusing a cesarean is not trying to commit suicide,[28] and medical ethics do not require a physician to force unwanted treatment on a patient.[29] Thus, preservation of life and the protection of third parties are the state interests truly at issue.

It is well established that the state's interest in preservation of life is insufficient to justify overriding the refusal of a competent adult when only that patient's life is at risk; even if the refusal of the proposed treatment will result in death, the decision belongs to the patient.[30] Some courts have argued that the woman's health is also a factor to consider in deciding whether to order a cesarean, if she would benefit from the intervention.[31] Such an analysis contravenes the right to refuse treatment, even if the refusal would result in death. In the cesarean setting, however, there are not one, but two concerns at issue: the woman and the fetus. Is the state's interest in the potential life of the fetus sufficient to allow the court to override the decision of a competent pregnant adult?

Four bodies of law relate to this question: those controlling child neglect, child treatment, rescue, and abortion. Child abuse and neglect laws are often cited as a basis for state intervention.[32] There are, how-

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CHRISTOPHER SLOBOGIN, LAW AND THE MENTAL HEALTH SYSTEM 807-22 (1990) (same). No competency evaluation was done in *In re* A.C., 573 A.2d. 1235 (D.C. 1990) (en banc), *see id.* at 1247; *see also New England Journal of Medicine Study, supra* note 2, at 1193 (commenting that of 21 reported cases, the woman's competency was evaluated in only 3).

27. Rhoden, *supra* note 5, at 1971; *see also A.C.*, 573 A.2d at 1246 (identifying these four interests); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977) (same); DAVID W. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 10:12, at 248 (1981) (same); Noble-Allgire, *supra* note 26, at 227 (same).

28. *See A.C.*, 573 A.2d at 1246 n.12. *But cf. Cruzan*, 110 S. Ct. at 2859 (Scalia, J., concurring) (arguing that failure to take steps to preserve life is suicide; state may forcibly intervene).

29. *A.C.*, 573 A.2d at 1246 n.13; Rhoden, *supra* note 5, at 1971-72.

30. *See, e.g., In re* Osborne, 294 A.2d 372, 375 (D.C. 1972) (upholding patient's refusal on religious grounds to consent to blood transfusion deemed necessary to save his life); Lane v. Candura, 6 Mass. App. Ct. 377, 384-85, 376 N.E.2d 1232, 1235-36 (1978) (upholding patient's refusal to have legs amputated to prevent spread of gangrene); *In re* Quackenbush, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (1978) (same).

31. *See, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 86, 274 S.E.2d 457, 458 (1981) (per curiam).

32. *See, e.g., id.* at 87, 274 S.E.2d at 459; Bowes & Selgestad, *supra* note 13, at 212.

ever, at least two problems with the argument that the State's recognized authority to intervene in parents' actions that are abusive and neglectful of their children justifies forcing unwilling women to undergo cesarean sections. First, many states have statutes setting forth standards and procedures for court intervention and assumption of custody or control of minors.[33] It is not at all clear that fetuses are meant to be included within the definition of juveniles in these statutes.[34] Nevertheless, courts have been willing to exercise jurisdiction over fetuses using these laws. For example, in *Jefferson v. Griffin Spalding County Hospital Authority*[35] the hospital sought a court order to operate on a woman with a complete placenta previa who refused to consent to surgery.[36] The Georgia Department of Human Resources intervened, seeking not only the court order, but also temporary custody of the fetus as a child without proper parental care.[37] The trial court granted custody of the fetus to the Department and gave it "full authority to make all decisions, including giving consent to the surgical delivery."[38] This order was upheld on appeal per curiam, although one concurring opinion questioned the assumption of jurisdiction by the juvenile court[39] and another seemed to rest on the general balancing test between the rights of the woman and fetus, not on the court's ability to award custody.[40]

A second inadequacy of relying on child abuse and neglect laws is the implicit equation of refusing medical treatment with abuse. A woman should not be considered a negligent or abusive parent solely because she refuses to consent to treatment she does not consider appropriate.

Closely related to the questions of abuse and neglect and to statutory child neglect law is the body of law authorizing the court to intervene and order medical treatment for children over their parents' objections. Many religious persons, such as Christian Scientists and Jehovah's Witnesses, do not believe in accepting certain medical treat-

33. *See, e.g.*, N.C. GEN. STAT. § 7A-517(20) (Supp. 1990) (defining juvenile as a person under 18). In defining over whom a juvenile court may assume jurisdiction over and for whom it may make decisions about custody or medical treatment, many states rely on a similar age-based formula. *See, e.g.*, ALA. CODE § 12-15-1(3), (18) (Supp. 1990); GA. CODE ANN. § 15-11-5 (1990); KY. REV. STAT. ANN. § 199-011 (1991).

34. Daniels, *supra* note 5, at 1066; *see also* Rhoden, *supra* note 5, at 1963 (contending that the jurisdiction argument cannot be relied on because it is too "narrow and legalistic").

35. 247 Ga. 86, 274 S.E.2d 457 (1981).

36. *Id.* at 86, 274 S.E.2d at 458.

37. *Id.* at 87, 274 S.E.2d at 459.

38. *Id.* at 88, 274 S.E.2d at 459.

39. *Id.* at 92, 274 S.E.2d at 461-62 (Smith, J., concurring).

40. *Id.* at 90, 274 S.E.2d at 460 (Hill, J., concurring).

ment.[41] The parents' right to refuse treatment in exercise of their religion, however, is insufficient to prevent the state's intervention to order treatment for their children.[42] It should be clear, though, that court-ordered treatment for a child and a forced cesarean are not comparable. The parent who refuses treatment for the child in the usual situation has no interest in physical integrity at stake. As there is no personal risk involved, there is no interest analogous to the pregnant woman's interest in not undergoing surgery without her consent.

Commentators often cite *Prince v. Massachusetts*[43] in support of state intervention: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children."[44] *Prince*, however, was not a case involving any risk to the parent; in fact it is not even a case about health care. Rather, it involved an appeal from the conviction of an eight-year-old girl for selling *The Watchtower*, a publication of the Jehovah's Witnesses, in violation of laws restricting selling by children. The girl's aunt, her guardian, had given her the magazines and argued that the conviction violated the girl's First Amendment right to freedom of religion.[45] The aunt could assert no interest similar to bodily integrity. Because balancing tests are only analogous when the rights in both cases are roughly equal, *Prince* has little to add to the forced cesarean debate.[46]

Professor Nancy Rhoden has provided a twist on an example that illustrates this critical difference. The example is that of Dr. Norman Fost: " '[I]f a father were denying medical care to his child and also blocking access to him . . . one would be justified in pushing the father aside to treat the child.' "[47] Few people would disagree with this state-

41. Jehovah's Witnesses refuse to accept blood transfusions because they believe doing so violates Biblical prohibitions against blood consumption. RELIGIONS OF AMERICA: FERMENT AND FAITH IN AN AGE OF CRISIS 139 (Leo C. Rosten ed. 1975); *see also Leviticus* 17:10 ("If any man . . . eats any blood, I will set my face against that person who eats blood, and will cut him off from among his people."); *Acts* 15:20 ("abstain . . . from blood").

42. LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 14-13, at 1267-68 & n.99 (2d ed. 1988) (discussing court's ability to order treatment not only when the child's life is threatened, but also in cases in which refusal to treat can result in significant impairment); Rhoden, *supra* note 5, at 1960-61 (same).

43. 321 U.S. 158 (1944).

44. *Id.* at 170; *see also* Noble-Allgire, *supra* note 26, at 236 (citing *Prince*).

45. *Prince*, 321 U.S. at 159-61.

46. In a later case, the Supreme Court relied on *Prince* to uphold a lower court decision authorizing blood transfusions for minor Jehovah's Witnesses whose parents objected. Jehovah's Witnesses v. King County Hosp., 390 U.S. 598 (1968) (per curiam), *aff'g* 278 F. Supp. 488 (W.D. Wash. 1967).

47. Rhoden, *supra* note 5, at 1967 & n.105 (quoting Dr. Norman Fost, Address at the Hastings Center Conference on Abortion and Scientific Change at Hastings-on-Hudson, New York (May 24, 1985)).

ment, but it is not fully relevant to what is at issue with forced cesareans. As Professor Rhoden points out: "A more accurate analogy would be if the recalcitrant father were very obese and securely wedged in the door, and gaining access to the sick child to provide treatment required cutting through the father."[48] While this example may seem unlikely to occur in real life, it does point out the critical part of the balance left out in Dr. Fost's example.

Another body of law relevant to the balance of interests in the cesarean setting is that of rescue. Generally stated, no one is required to go to the aid of another absent a special relationship, such as that between parent and child.[49] Even when a special relationship, and therefore a duty to aid, exists, there is no duty if the rescuer would risk her personal safety in the process.[50] That a potential rescuer has no legal duty does not mean she has no moral duty, nor does it mean that society cannot expect parents to undergo personal risk to help their children. It means only that the courts will not intervene and *require* the parent to provide the health-risking assistance.[51]

Organ donations by a living donor offer an apt analogy. The living donor receives no physical benefit, only the psychological benefit of hav-

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48. *Id.* at 1968.

49. *In re* A.C., 573 A.2d 1235, 1244 (D.C. 1990) (en banc); Rhoden, *supra* note 5, at 1976; Jay Silver, *The Duty to Rescue: A Reexamination and Proposal*, 26 WM. & MARY L. REV. 423, 425 (1985).

50. TRIBE, *supra* note 42, § 15-10, at 1354; Rhoden, *supra* note 5, at 1977.

51. One commentator points out that there is a common-law cause of action when one prevents others from providing assistance. Noble-Allgire, *supra* note 26, at 235. She argues that the woman is standing in the way of aid for the fetus and is therefore liable. *Id.* This analysis suffers from the same error as the analogy to denial of treatment for children: it does not take into account the serious invasion of the woman's body and her interest in not undergoing it against her will.

A related "interest" that courts have occasionally used to justify forcing treatment on a competent, refusing adult is the presence of minor children. Because there is a societal interest in having children provided for, the argument goes, the parent should not be able to refuse treatment if she has dependents. *See, e.g.*, United States v. George, 239 F. Supp. 752, 753-54 (D. Conn. 1965) (authorizing blood transfusions when patient had four young children). *But cf. In re* Farrell, 108 N.J. 335, 349, 529 A.2d 404, 411 (1987) (holding that the right of competent, terminally ill wife to withdraw life-sustaining respirator outweighed state's interest in preserving life). Even when the patient is allowed to make her own decision, however, courts may have considered the dependent party factor. *See* Wons v. Public Health Trust, 500 So. 2d 679, 687-88 (Fla. Dist. Ct. App. 1987) (allowing competent adult to refuse blood transfusions on basis of religious beliefs when refusal would not result in abandonment of her children). This interest seems little more than a rationalization because reference to either rescue law or the right of a competent patient to refuse medical treatment even if the refusal will result in death are in direct contradiction. Moreover, as Professor Rhoden points out, the State does not prevent parents with young children from engaging in other activities that may leave their children orphans, from skydiving to serving in the United States Army. Rhoden, *supra* note 5, at 1974-75.

ing helped preserve the life of another, and, as in the cesarean setting, major surgery is required.[52] The courts do not order a refusing adult to submit to organ donation for the benefit of another.[53] *McFall v. Shimp*[54] provides a classic example. In *McFall* the patient's cousin, the only suitable donor,[55] refused to undergo a bone marrow transplant operation. The court declined to order him to do so, even though without the transplant the patient would die.[56] When a court orders a cesarean section, it requires the woman to rescue the fetus at her own risk, a decision unprecedented in other areas of law.

The organ donation analogy is appropriate only if the state's interest is similar to that involved in the forced cesarean situation. Fetal rights advocates argue that the fetus has a number of rights recognized at law that must be added into the balance. A cause of action for wrongful injury *in utero,* and the inheritance right of a fetus born alive after the testator's death, for example, are cited as evidence of legal recognition of fetal rights.[57] In addition, these advocates point to *Roe v. Wade*[58] as having established that the State's interest in the potential life of the fetus is compelling, and is strong enough to override the woman's refusal to submit to treatment:

> [w]ith respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. . . . If the

52. Blood transfusions are not an adequate comparison with "the much more invasive, risky, and painful cesarean sections and intrauterine procedures at issue today." *New England Journal of Medicine Study*, *supra* note 2, at 1195. For this reason, Raleigh Fitken-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 423-24, 201 A.2d 537, 538, *cert. denied*, 377 U.S. 985 (1964), in which a court ordered a blood transfusion over the objections of a 32-week-pregnant Jehovah's Witness, is not particularly helpful in the forced cesarean setting. Nevertheless, this case occasionally is cited as support of a court's power to order a cesarean section. *See, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 89, 274 S.E.2d 457, 460 (1981); Bowes & Selgestad, *supra* note 13, at 212.

53. In Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969), the court applied substituted judgment and allowed a guardian to consent to the donation of an incompetent patient's kidney for the benefit of his brother. *Id.* at 148-49. This case clearly is not the same as a court-ordered donation by a competent patient over his nonconsent. *See also In re* Guardianship of Pescinski, 67 Wis. 2d 4, 7-8, 226 N.W.2d 180, 181-82 (1975) (court refused to follow *Strunk* and instead applied the "best interests" test and refused to allow a guardian to consent to a kidney transplant). In applying the substituted judgment test, a court will try to determine what the patient would decide for herself if competent. In applying the best interests test, the court focuses solely on what is best for the patient.

54. 10 Pa. D. & C.3d 90 (1978).

55. *Id.* at 90.

56. *Id.* at 91-92 ("For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence.").

57. Noble-Allgire, *supra* note 26, at 217-19.

58. 410 U.S. 113 (1973).

> state is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.[59]

*Roe* does not, however, support the proposition that the state has a sufficient interest in fetal life to justify overriding the woman's refusal to consent to major surgery. A state interest once found sufficient to override another interest does not thereby become a talisman before which all interests must fall.

In the abortion context, the United States Supreme Court weighed the woman's right to privacy against the state's interest in potential life and found that in the third trimester the State may regulate abortion, even to the extent of prohibiting it in all cases in which the life or health of the mother is not threatened.[60] But a critical difference separates the level of intervention between regulation of abortion and authorization of surgery, even if it is done to aid maternal health.[61] Finally, *Roe* itself makes clear that a fetus is not treated as a person with full constitutional rights.[62]

The Supreme Court also has held that maternal health may not be risked to benefit fetal health. In *Thornburgh v. American College of Obstetricians & Gynecologists*[63] the Court struck down a Pennsylvania statute that would have required a physician performing a post-viability abortion to use the abortion technique " 'that . . . would provide the best opportunity for the unborn child to be aborted alive unless,' in the physician's good-faith judgment, that technique 'would present a significantly greater medical risk to the life or health of the pregnant woman.' "[64] The Court found the statute unconstitutional because requiring such a "trade-off" is impermissible.[65] Therefore, even if the State could argue that it has a compelling interest in fetal life sufficient to require a woman

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59. *Id.* at 163-64.

60. *Id.*

61. Daniels, *supra* note 5, at 1066; Rhoden, *supra* note 5, at 1965. One commentator has suggested that paternal interests in the fetus should override the woman's refusal so long as her right to have an abortion is not infringed upon. *See* Kevin M. Apollo, Note, *The Biological Father's Right to Require a Pregnant Woman to Undergo Medical Treatment Necessary to Sustain Fetal Life*, 94 DICK. L. REV. 199, 214, 219, 224 (1989). This discussion barely addresses, however, the woman's significant interest in autonomy and bodily integrity, and cannot be considered a proper balancing of the interests involved.

62. "[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn." *Roe*, 410 U.S. at 158.

63. 476 U.S. 747 (1986).

64. *Id.* at 768.

65. *Id.*; *see also* Colautti v. Franklin, 439 U.S. 379, 400-01 (1979) (striking down an earlier version of the Pennsylvania statute on similar grounds).

to undergo major surgery against her will (and it seems reasonably certain that it does not), the State still would be unable to require the woman to undergo the increased risks of surgical delivery because it is impermissible to trade away her health to benefit the fetus.

Trial and appellate level courts have considered some, or all, of these doctrines when deciding whether to authorize a cesarean. The two appellate courts that have considered the issue, however, have come to very different conclusions. In *Jefferson v. Griffin Spalding County Hospital Authority*[66] the trial court cited *Roe* for the proposition that "[a] viable unborn child has the right under the U.S. Constitution to the protection of the State."[67] The trial court issued an order giving the Georgia Department of Human Resources custody of the fetus and the ability to consent to a forced cesarean for the woman: "Because the life of the defendant and of the unborn child are, at the moment, inseparable . . . it [is] appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live."[68] The trial court spoke only of the "wishes" of the woman, not of her informed consent. It did not consider her competency, nor did it address rescue law. The Georgia Supreme Court upheld the trial court's order per curiam, and therefore accepted the trial court's balancing of the woman's religious rights, the risk of surgery, and the child's right to live, as well as the trial court's finding that the interests of the fetus were sufficient to override the woman's refusal to consent.[69]

A recent District of Columbia Court of Appeals case, *In re A.C.*,[70] is perhaps the most publicized of the forced cesarean cases. A.C. had cancer years before the case arose. While her cancer was in remission, she married and became pregnant. During the course of her pregnancy, her cancer reappeared.[71] A.C. and her physicians discussed whether the physicians should attempt a cesarean section at twenty-eight weeks if she became too ill to carry the baby to term. A.C. consented to this surgery.[72] Unfortunately, the physicians decided that a cesarean was necessary at 26.5 weeks, an eventuality A.C. and her physicians had not discussed. The hospital sought a court order advising it what to do.[73]

66. 247 Ga. 86, 274 S.E.2d 457 (1981). For further discussion of *Jefferson*, see *supra* text accompanying notes 35-40.

67. *Jefferson*, 247 Ga. at 87, 274 S.E.2d at 458.

68. *Id.*; *see* discussion of child abuse law, *supra* notes 32-40 and accompanying text.

69. *Jefferson*, 247 Ga. at 90, 274 S.E.2d at 460 (Hill, J., concurring).

70. 573 A.2d 1235 (D.C. 1990) (en banc).

71. *Id.* at 1238.

72. *Id.* at 1238-39.

73. *Id.* at 1238.

The court appointed counsel for the fetus and for A.C.; the District of Columbia intervened on behalf of the fetus, asserting standing as *parens patriae*.[74] The judge held a three-hour hearing at the hospital, but not in A.C.'s room.[75] During the hearing, a doctor twice tried to ascertain A.C.'s position on the surgery. At first she consented, but the second time she refused, mouthing the words "I don't want it done."[76] The judge found that her intentions were unclear and ordered the cesarean.[77] A stay was denied and the surgery was performed. The baby died in two and a half hours; A.C. died two days later.[78]

Even though the surgery had been performed and A.C. had died, the court of appeals agreed to hear the case because of the need for guidance in this area and because the situation was susceptible to repetition without possibility for review.[79] The court's analysis is the first involving a detailed balancing test that takes into account many of the legal doctrines discussed in this Comment. The court began with informed consent and the proposition that a competent adult can refuse treatment. Therefore, it stated, A.C.'s competency to decide should have been assessed.[80] The court then examined the four state interests that might override a competent refusal to undergo treatment.[81] It was irrelevant that A.C. was terminally ill: "the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door."[82] The court found that only the state's interests in the preservation of life and the protection of third parties were relevant.[83] It then examined whether either was sufficiently compelling to override A.C.'s refusal and concluded that neither was, pointing in part to the law of rescue.[84]

The court set forth a method for deciding requests for authorization to perform emergency cesareans. The first step is an inquiry into the

74. *Id.* at 1239.

75. *Id.* at 1238.

76. *Id.* at 1240-41.

77. *Id.* at 1241.

78. *Id.* at 1238.

79. *Id.* at 1241-42. In addition, representatives of A.C.'s estate filed suit against the hospital; therefore, there were collateral consequences. *Id.*

80. *Id.* at 1247. For further discussion of competency evaluations, see *supra* note 26.

81. *A.C.*, 573 A.2d at 1246. The four state interests are listed *supra* in the text accompanying note 27.

82. *A.C.*, 573 A.2d at 1247. One commentator reports that the attorney appointed for the fetus had argued that "Ms. C had no important interests in this decision because she was dying: 'unintended consequences on the mother' are 'insignificant in respect to the mother's very short life expectancy.' " Noble-Allgire, *supra* note 26, at 212 n.3 (quoting George A. Annas, *She's Going to Die: The Case of Angela C.*, 18 HASTINGS CENTER REP. 23, 24 (1988)).

83. *A.C.*, 573 A.2d at 1246 & nn.12-13.

84. *Id.* at 1244, 1252.

patient's competence to decide.[85] If, on the one hand, a patient is found competent, her decision controls in virtually all situations. The court, however, did not foreclose the possibility that a situation might arise in which overriding that decision nevertheless would be appropriate: "[W]e anticipate that such cases will be extremely rare and truly exceptional. This is not such a case."[86] If, on the other hand, the patient is incompetent, the court held that a substituted judgment analysis must be undertaken. Among the factors to be considered are prior statements by the patient (here, for example, A.C.'s consent to surgery at twenty-eight weeks as well as her consent to a palliative treatment that eased her pain considerably, but increased the risk to the fetus) and a general inquiry into her values, with assistance from her family and physicians, if appropriate. If the court's inquiry does not reveal enough information to make a substituted judgment, other women's actions in a similar situation are relevant.[87]

Judge Belson concurred in part and dissented in part. He disagreed with the majority that a case in which a woman's decision could be overridden would be so rare an event.[88] A competent decision should indeed be given great weight, and other factors, such as the mother's health or religious beliefs, should be considered;[89] so should the likelihood of the fetus' survival and its right to be born without impairment.[90] Judge Belson argued that the organ-donation analogy was inappropriate because "a woman who carries a child to viability is in fact a member of a unique category of persons. . . . [T]he expectant mother has placed herself in a special class of persons who are bringing another person into existence."[91] Because the pregnant woman's situation and the dependency of her fetus are unique, her decision should be easier to override than the majority opinion would suggest.[92]

*Jefferson* and *A.C.* reveal something of how the balancing test has been played out in practice. A new interest has been added to the balance since each of these cases was decided, however, and it remains to be seen how the courts will address it. In *Cruzan v. Director, Missouri Department of Health*[93] the United States Supreme Court explicitly recog-

85. *Id.* at 1247.
86. *Id.* at 1252.
87. *Id.* at 1250-51.
88. *Id.* at 1256-57 (Belson, J., concurring in part, dissenting in part).
89. *Id.* at 1257-58 (Belson, J., concurring in part, dissenting in part).
90. *Id.* at 1258 (Belson, J., concurring in part, dissenting in part).
91. *Id.* at 1256 (Belson, J., concurring in part, dissenting in part).
92. *Id.* at 1256-57 (Belson, J., concurring in part, dissenting in part).
93. 110 S. Ct. 2841 (1990).

nized a constitutionally protected right to bodily integrity: "The Fourteenth Amendment provides that no State shall 'deprive any person of life, liberty, or property, without due process of law.' This principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[94]

This right is not an absolute one. It is only implicated if the state is an actor.[95] The doctrine of state action is a confusing one.[96] In constitutional cases there often is a state statute which authorizes the challenged conduct or standard; a state statute is clearly state action.[97] With court-ordered cesareans, however, no statute is involved. Nevertheless, one usually can find state action, most likely in the court order itself, since without the court order the physician's disregard of a competent woman's refusal would constitute a battery.[98] State action can exist in a

94. *Id.* at 2851 (quoting U.S. CONST. amend. XIV, § 1). In support of this right, the Court cited a number of cases. *See, e.g.*, Washington v. Harper, 110 S. Ct. 1028, 1041 (1990) (holding that the "forcible injection of medication," even into a criminally insane patient, is "a substantial interference" with that person's liberty); Vitek v. Jones, 445 U.S. 480, 494 (1980) (transfer to hospital and forced course of treatment affect liberty interests); Parham v. J.R., 442 U.S. 584, 600 (1979) (holding that children as well as adults have a liberty interest in avoiding unwanted treatment); Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905) (balancing individual's interest in bodily integrity against the state's interest in preventing smallpox and requiring individual to have vaccination).

In *Harper*, the Court held that the state's procedures for review of medical decisions were sufficient and allowed Harper to be treated against his will. In the prison setting, however, the standard of review is whether the treatment is reasonably related to legitimate penological goals. *Harper*, 110 S. Ct. at 1037. This less stringent standard explains in part how the Court could allow the nonconsensual treatment in this case but cite it as support for a constitutional right to bodily integrity in the same term.

The *A.C.* court did argue for a constitutional right to bodily integrity, pointing to some of the same cases cited by the Court in *Cruzan*. *See A.C.*, 573 A.2d at 1244-45. The court did not undertake a constitutional analysis, however, because there was no statutory provision involved. *Id.* at 1247 n.14. Presumably, the court therefore felt there was no state action involved. For an argument that state action is involved, however, see *infra* notes 95-100 and accompanying text.

There is a great deal more involved in the *Cruzan* decision than can reasonably be addressed in this Comment. For an excellent discussion of that case and its effect on the right to die, see Jennifer E.B. Overton, Note, *Unanswered Implications—The Clouded Rights of the Incompetent Patient Under* Cruzan v. Director, Missouri Department of Health, 69 N.C. L. REV. 1293 (1991).

95. U.S. CONST. amend. XIV, § 1.

96. TRIBE, *supra* note 42, § 18-1, at 1690.

97. *See, e.g., Roe v. Wade*, 410 U.S. 113, 117-19 (1973) (involving Texas statutes prohibiting the procurement of, attempt at, or performance of an abortion except to save the life of the mother).

98. One can also argue that there is state action because so many hospitals receive federal funding through Medicaid and Medicare. A great many women on whom forced cesareans are performed receive public assistance. *See infra* text accompanying note 125. It is important, however, that women in private hospitals or women who do not receive public aid also be

rule allocating decisions between a private actor and the government.[99] A court's holding that it can allocate the decision whether to proceed with surgery to a hospital rather than to the woman arguably is an example of state action.[100]

Even without state action, the constitutional recognition of the importance of bodily integrity weighs heavily in the balance. When only the informed consent doctrine weighed on the side of the woman, preservation of life and the interest of third parties, as seen through rescue law, were arguably insufficient to outweigh the patient's interest in making her own assessment of the risks and benefits of surgical intervention and, ultimately, in making her own decision. Certainly, then, the state's interests are insufficient to outweigh an interest grounded in the Constitution. The argument that the state has a compelling interest in fetal life is not adequately supported to uphold overriding the woman's decision.

Both the Fourteenth Amendment's Due Process and Equal Protection Clauses bear on whether a court can order surgery despite a woman's refusal, particularly considering the Supreme Court's recognition that procreation is a fundamental interest, the attempted infringement of which is subject to strict scrutiny.[101] Rescue doctrine is an important part of assessing equal protection, just as it is in considering whether the State can override a woman's refusal to consent to surgery. Assuming that the requirement of state action can be met, the question is whether pregnant women can be treated differently from others. Other adults are not legally required to do anything to rescue someone. Parents are not required to risk their health and safety, as through an organ transplant, to benefit their child, or even to save the child's life.[102] Are pregnant women a unique group, as Judge Belson argues,[103] or are they simply a subgroup of parents?[104] A distinction based on pregnancy may not be

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protected. Therefore, it is much more satisfying to find state action in the intervention of the judge to remove the decision from the woman and make it the State's.

99. TRIBE, *supra* note 42, § 18-5, at 1707.

100. *See, e.g.*, Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488, 497-98 (W.D. Wash. 1967) (holding that doctors authorized to give blood transfusions to minor pursuant to a court order acted under state authority).

101. "[N] or shall any State . . . deny to any person within its jurisdiction the equal protection of the law." U.S. CONST. amend. XIV, § 1. The Court first recognized that procreation is a fundamental interest in Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 541 (1942). Strict scrutiny analysis is similar, but not identical to, the due process analysis described above, *see supra* notes 20-21 and accompanying text, in that the State's ends must be compelling and its means narrowly tailored to meet those ends.

102. *See supra* notes 49-56 and accompanying text.

103. *See supra* text accompanying note 91.

104. Rhoden, *supra* note 5, at 1988-89. Professor Rhoden points out that one could require all parents to be " 'Splendid Samaritans' " and provide organs when necessary. *Id.* She also

illegitimate because the biology of pregnancy is different.[105] Although this is undoubtedly true, the relationship between child and parent is not limited to the pregnancy setting. A requirement made of pregnant women but not of other parents therefore may violate the Equal Protection Clause.

The arguments for and against allowing court orders are many and complex. Considering all these points of view, the balancing test should support the woman's right to decide whether to consent to surgery. In other words, none of the asserted state interests is sufficient to override the woman's informed consent. The majority of judges who have heard these cases, however, have disagreed.[106] Although it is important to examine the various legal doctrines at issue in these cases it is more important to realize that these doctrines can change. The far more significant, and difficult, question is whether we as a society will choose to allow courts to override a woman's decision to forego recommended surgical intervention.

Behind the veil of legal niceties lies a tableau of disturbing violence. One example clearly illustrates the harm to dignity, both the patient's and the medical profession's, that can result from forced cesarean sections. In 1984 a Nigerian woman was admitted to a Chicago hospital, pregnant with triplets. Her physician strongly recommended a cesarean, but she and her husband consistently refused. The hospital proceeded to obtain a court order without informing the parents.

> "Confronted with the doctor's intentions, the woman and her husband became irate. The husband was asked to leave, refused, and was forcedly 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 a 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."[107]

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argues, however, that because the organ donation situation would arise so rarely, this route only points out the equal protection problem with requiring women to agree to surgery. *Id.*

105. *See* Geduldig v. Aiello, 417 U.S. 484, 496-97 & n.20 (1974) (holding that refusal to cover pregnancy under state insurance plan does not violate the Equal Protection Clause).

106. *See, e.g., New England Journal of Medicine Study, supra* note 2, at 1193 (Of 15 orders sought for cesarean sections all were granted except one. The orders were sought in Colorado, Hawaii, Illinois, Maine, Michigan, Minnesota, Ohio, Pennsylvania, South Carolina, Tennessee, and Texas; the Maine court refused to issue the order.).

107. Gallagher, *supra* note 17, at 9-10 (quoting Veronica E.B. Kolder, Women's Health Law: A Feminist Perspective 2 (August 1985) (unpublished manuscript, on file with the *Harvard Women's Law Journal*)).

While this case is extreme, it is not isolated. At least one court has authorized the police to bring a woman to the hospital if she does not report there on her own.[108] All this discussion, of course, leaves aside the violence inherent in anesthetizing and operating on an unconsenting patient, even one who reduces her protests in the face of a court order.[109]

One of the most dangerous aspects of court intervention in these situations is that it hides the violence. The court is protected from the violent aftershocks of its decision because it is not present when the woman undergoes surgery. The doctor is authorized by the court to take action and therefore is also able to shield himself from the violent consequences.[110] While both the court and the doctor may console themselves that in the end the action taken was for the best, this may not be the case.

Whether something is for the best depends ultimately on more than just the biological outcome. A number of sociological implications flow from allowing forced surgeries. Tragedy happens, unfortunately, often through the fault of no one, but it may be that greater harm can result from efforts to prevent tragedy. Court intervention to prevent tragedy may have tragic consequences itself: "[C]ourts have long recognized the wisdom of acting as *though* persons could never be used as a means to the ends of others, knowing that any clear departure from that ideal could spell the beginning of a disastrous slide."[111] In other words: "It is tragic that persons are harmed, but it is wrong that you harm them."[112]

Three issues lurk beneath the forced cesarean debate, each of which is worth closer consideration. First, there is the question whether women should be regulated throughout pregnancy. Commentators, notably Professor John Robertson, have argued that once a woman becomes pregnant and decides to forego her right to an abortion, she has assumed an obligation that limits her freedom of decision over her body and should be required to submit to whatever treatment is best for the fetus, regard-

108. *Id.* at 47 (noting that in a 1982 Michigan case the trial court authorized the police to pick up the woman and bring her to the hospital for whatever treatment physicians deemed necessary if she did not appear there by a specified time).

109. Some women do stop protesting in the face of a court order. *See, e.g.*, Bowes & Selgestad, *supra* note 13, at 211 ("The directive of the court was clear that necessary medical treatment could be administered against the will of the patient. Fortunately, the court's order had a salutary effect on the patient, and her attitude became one of reluctant acceptance and compliance.").

110. Rhoden, *supra* note 5, at 2004; *see also In re* A.C. 573 A.2d 1235, 1244 (D.C. 1990) (en banc) (pointing out the violence involved and that allowing the surgery "would surely give one pause in a civilized society, especially when A.C. had done no wrong").

111. TRIBE, *supra* note 42, § 15-9, at 1335.

112. Rhoden, *supra* note 5, at 2002.

less of whether it involves forcible bodily intrusion.[113] While "[t]he state would, of course, be free to favor the woman's autonomy over the fetus' well-being at any point in the pregnancy, if that choice were politically acceptable," the presumption would be that "the woman loses the liberty to act in ways that would adversely affect the fetus."[114] The State therefore could regulate alcohol consumption or smoking.[115] It also could impose criminal or civil liability for failure to undergo "safe and effective" fetal therapy; unless the risk to the woman's health is undue, she would have "no defense" because she waived her rights.[116]

Professor Robertson's theories are an extreme example of exactly what forced cesareans represent: the removal of critical decisionmaking about health and pregnancy from the woman to the State.[117] His theories are, however, indicative of a broader societal assumption that women cannot be relied on to make decisions about their pregnancies. It has become increasingly popular in recent years to speak of a maternal-fetal conflict.[118] Language of confrontation or disparity of interests is inap-

113. John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 437-38 (1983).

114. *Id.* at 437 & n.95; *see also* MEYERS, *supra* note 27, § 10:14, at 255-56 (arguing that the State should be able to override the woman's refusal to any treatment deemed necessary for a live birth).

115. Robertson, *supra* note 113, at 442.

116. *Id.* at 444-45.

117. For other examples, see Taft v. Taft, 388 Mass. 331, 335, 446 N.E.2d 395, 397 (1983) (A husband sued his four-month-pregnant wife to force her to undergo a "purse string" operation which would reinforce her cervix and reduce the chance of miscarriage. The trial court issued the order; the appellate court reversed.); *New England Journal of Medicine Study, supra* note 2, at 1195 ("16-year-old pregnant girl in Wisconsin has been held in secure detention for the sake of her fetus because she tended 'to be on the run' and to 'lack motivation or ability to seek prenatal care' ") (citing *Girl Detained to Protect Fetus*, WIS. ST. J., Aug. 16, 1985, § 3, at 2).

118. *See, e.g.*, Charles-Edward Anderson, *Mom vs. Fetus*, A.B.A. J., August, 1990, at 14; Bowes & Selgestad, *supra* note 13, at 209; Noble-Allgire, *supra* note 26, at 213-15; Robertson, *supra* note 113, at 437; Thomas L. Shriner, *Maternal Versus Fetal Rights—A Clinical Dilemma*, 53 OB. & GYN. 518, 518-19 (1979).

The idea that women are not reliable decisionmakers is not one which is limited to the area of reproductive health. A recent study of 22 right to die decisions from appeals courts in 14 states has found that women "are consistently portrayed as less capable of rational decision making than men." *Courts, Wills and Women*, N.Y. TIMES, July 23, 1990, at A13. The recent controversy surrounding the imposition of fetal-protection policies banning all women from working in lead exposure jobs unless they can prove medical inability to have a child is another area in which decisionmaking is being questioned. *See* U.A.W. v. Johnson Controls, Inc., 111 S. Ct. 1196, 1207 (1991) (refusing to permit company to ban women from holding jobs in which there is exposure to lead because the policy is not related to a business purpose). Judge Easterbrook summed up the issue well in his dissent to the Seventh Circuit's decision in *Johnson Controls*: "No legal or ethical principle compels or allows Johnson to assume that women are less able than men to make intelligent decisions about the welfare of the next generation." U.A.W. v. Johnson Controls, Inc., 886 F.2d 871, 913 (7th Cir. 1989) (reargued en banc) (Eas-

propriate in the context of pregnancy and motherhood. While there are undoubtedly times when what the woman wants to do and what is best for the fetus do not coincide, talk of conflict is not helpful in resolving these situations.

Instead, it is far more appropriate to acknowledge the woman's role as the logical decisionmaker for the fetus, even if the decision she makes is not the one the court, or even society, feels is the right one.[119] Furthermore, it is undoubtedly true, as a general matter, "that most pregnant women who eschew cesarean delivery truly believe, based on deeply held personal or religious convictions, that their decision is the best one for themselves and their babies."[120] Interestingly, not only is the woman being denied the right to make her own decisions, but so is her entire family. The *New England Journal of Medicine* study reports that in twelve cases in which custody of the fetus was sought, either in juvenile court, probate court, or family court, custody or guardianship was given to a hospital administrator, hospital attorney, the hospital and the doctor together, the medical staff, the doctor alone, or a guardian ad litem. In none of the twelve was custody or guardianship given to a family member.[121]

Rather than subject women to forced cesareans and criminal liability for smoking, states should seek to educate women about pregnancy, make prenatal care and nutrition more widely available, and encourage the physician-patient relationship. As one commentator has observed, the cuts in state and federal spending for maternal and child health and nutrition so pervasive in the United States, coupled with the fact that many group insurance policies do not provide maternity benefits, make talk of criminal liability simply cruel.[122]

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terbrook, J., dissenting), *rev'd*, 111 S. Ct. 1196 (1991). Even though the Johnson policy was struck down, the implications of such a systematic belittling of women's decisionmaking capacities and a consequent assumption of life's most critical decisions by the State are extremely serious and frightening for a society that prides itself on the preservation of liberty and autonomy.

119. *See, e.g.*, Ronna Jurow & Richard H. Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 OB. & GYN. 596, 597 (1984) (noting that woman refused a cesarean and "stated that if the fetus would die, it would solve her already-complicated life situation"). It also is important to point out that although physicians may feel that they are making the best decision, they are not always right. *New England Journal of Medicine Study*, *supra* note 2, at 1195 ("The prediction of harm to the fetus was inaccurate in six cases in which court orders were sought for cesarean sections." (citations omitted)); *see, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 86, 90 n.1, 274 S.E.2d 457, 458, 461 n.1 (1981) (placenta moved despite medical testimony that it was "virtually impossible that this condition will correct itself prior to delivery").

120. Daniels, *supra* note 5, at 1068.

121. *See New England Journal of Medicine Study*, *supra* note 2, at 1193.

122. Gallagher, *supra* note 17, at 56-57 n.242.

The second underlying issue concerns the status and background of women who are subject to forced cesareans. The *New England Journal of Medicine* study found that seventeen of twenty-one orders sought to authorize intervention (including cesarean sections, intrauterine transfusions, and hospital detention) involved African-American, Asian, or Hispanic women.[123] For five of the twenty-one English was not their primary language.[124] Finally, all twenty women for whom information was available were either patients at a teaching hospital or public assistance recipients.[125] Maternal competence was established in three cases, and not considered in the others.[126] The unfortunate conclusion from this data is that the women who are least able to get good prenatal care or nutrition during pregnancy, and for whom much needs to be done to encourage an ongoing relationship with a health care provider, are most likely to undergo a forced cesarean section.[127] Furthermore, these women are probably quite different from their physicians, both in background and socio-economic status. It is not clear whether these women are being given proper care or if they are falling prey to, at best, lack of good communication between physician and patient, or, at worst, discrimination.[128]

Finally, serious consideration must be given to the broader question of what role medical technology should play in our society. As more life-expanding techniques are developed, a stronger ethical framework is necessary to guide their application. It is important to remember that there

123. *New England Journal of Medicine Study*, *supra* note 2, at 1193.

124. *Id.*

125. *Id.*

126. *Id.* Interestingly, the population of women who have cesarean sections in general is highly heterogenous. Those who undergo this type of surgery can be found across the spectrum in terms of education, income, age, number of pregnancies, insurance, and prenatal care. Daniels, *supra* note 5, at 1065. The wide distribution raises other issues about the need for cesarean sections for those women at the highest levels of income and insurance. Presumably, if income were related to the likelihood a woman would need a cesarean, those women with the most prenatal care, highest income, and possibly highest nutrition level would need the fewest cesareans. This, however, does not seem to be the case. *Id.*

127. For discussions of the disparities in health care provision between whites and people of color, see HEALTHCARE ISSUES IN BLACK AMERICA 99 (Woodrow Jones & Mitchell F. Rice eds. 1987) ("It is well documented that black Americans as a group have been and continue to be recipients of what has been called 'second class medicine.' "); 1 MARGARET M. HECKLER, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH, EXECUTIVE SUMMARY 1-2 (1985) (compiling statistics of discrepancies in health and health care).

128. In response to a suggestion that women refuse cesareans for " 'occult' " reasons, one commentator asked whether a doctor can always be sure he has dealt with other possible explanations, such as "fear, prejudice, ignorance, difficulty with language, and inadequate rapport between doctor and patient." Shriner, *supra* note 118, at 519.

are limits to medical knowledge and medical certainty.[129] Society puts tremendous pressures on physicians and expects certainty in diagnosis and treatment, a certainty that is often, at least at present, impossible. This is especially true in the area of fetal technology. For example, electronic fetal monitoring (EFM), used to check for fetal distress, has been shown to have a false positive[130] rate of between 18.5% and 80%.[131] Blood scalp sampling, a follow-up technique used to confirm fetal distress, has a false positive rate of 44% when combined with EFM.[132] Furthermore, blood scalp sampling is difficult to perform, both because of the way the test is done and because the fetus must be in a certain position for the test to be attempted.[133] Simply because a test has a false positive rate does not make it useless. A test with a substantial false positive rate, however, is not a valid basis for ordering nonconsensual surgery.

Despite the uncertainty behind any diagnosis, at times courts have been willing to rely unquestioningly on medical assessments. In *In re Madyun*,[134] the court overrode the refusal of surgery by a nineteen-year-old woman whose decision was supported by her husband. The physician felt that a cesarean was necessary not because there were specific indications of problems but because labor had gone on for almost sixty hours, and the potential for problems was increasing.[135] The couple refused both on religious grounds and because, there being no problems yet, neither thought the surgery was necessary. In addition, the husband felt that the hospital had not given sufficient time to allow for a vaginal

129. *New England Journal of Medicine Study*, *supra* note 2, at 1195.

130. A false positive is a positive result when in fact the condition being tested for is not present. 2 J. E. SCHMIDT, ATTORNEYS' DICTIONARY OF MEDICINE F-17 (1991).

131. Daniels, *supra* note 5, at 1070; Rhoden, *supra* note 5, at 2014. Moreover, these tests are difficult to interpret. One study of 12 practitioners who interpreted identical patterns found that no two used the same criteria for evaluation and that only 69% of the time would any two agree on whether to continue monitoring or perform a cesarean. *Id.* at 2016.

132. Rhoden, *supra* note 5, at 2015. Blood scalp sampling is a procedure by which a plastic cone is inserted through the vagina to puncture the skin of the fetal head and draw a blood sample. Albert Haverkamp & Miriam Orleans, *An Assessment of Electronic Fetal Monitoring*, WOMEN & HEALTH, Fall/Winter 1982, at 115, 119 (1982). The procedure is difficult to perform and is uncomfortable for the woman. *Id.*; Barry Schifrin, *The Fetal Monitoring Polemic*, 9 CLINICS IN PERINATOLOGY 399, 406 (1982) (positing that the procedure is rarely done outside of academic circles because it is so difficult and because it is perceived as being of little assistance to the physician).

133. Rhoden, *supra* note 5, at 2016 n.327.

134. Misc. No. 189-86 (D.C. July 26, 1986), *reprinted in In re* A.C., 573 A.2d 1235, 1260-63 (D.C. 1990) (en banc). *Madyun* is an excellent example of the time pressures that can come into play in deciding these cases. Judge Levie, who decided *Madyun*, filed the decision at 1:05 a.m. *A.C.*, 573 A.2d at 1264. Two other judges affirmed it at 2:08 a.m. *Id.*

135. *A.C.*, 573 A.2d at 1260-61.

birth and was not helping further delivery by, for example, letting his wife get up and walk around.[136] The court authorized the forced surgery: "Neither parent, however, is a trained physician. To ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents, where, as here, there is a substantial risk to the unborn infant, is something the Court cannot do."[137] Of course, it is something the court can do; but rather than engage in any balancing test, the court instead merely authorized what the doctors requested.

The forced cesarean situation is one in which medical judgment cannot be questioned through the usual challenges of expert opinion.[138] There may be no time for the woman to go out and get a second opinion, or she may not know the hospital is planning to seek a court order.[139] As a result, the only medical testimony at the hearing may be that of the doctor seeking the order.[140] What may appear to be uncontrovertable may therefore be merely uncontroverted at the time. On a broader level, it is dangerous to say that what can be done, must be done.

What, then, should a court do when confronted with a petition for an order authorizing a hospital to perform surgery over a woman's refusal? It is not appropriate for the court to refuse to decide whether the woman's decision not to have surgery should be respected. Such petitions present serious questions involving rights and responsibilities. A court cannot refuse to hear these issues simply because they are difficult ones.[141] The refusal of a pregnant woman to undergo recommended treatment is "[a]mong the most harrowing experiences for obstetricians."[142] The doctor quite likely will want to go ahead with the surgery. The *New England Journal of Medicine* study revealed that at least the doctors surveyed were quite aggressive in their attitudes about surgery. Twenty- six of fifty-seven (forty-six percent) agreed that "mothers who refused medical advice and thereby endangered the life of the fetus should be detained in hospitals or other facilities so that compliance could be ensured."[143] Twenty-seven of fifty-seven (forty-seven percent) felt that "precedent set by the courts in cases requiring emergency cesarean sections for the sake of the fetus should be extended to include

136. *Id.* at 1260.

137. *Id.* at 1263.

138. *See supra* notes 16-18 and accompanying text.

139. *See supra* text accompanying note 107.

140. For example, this was the case in *A.C.*, in which medical records were missing and one of A.C.'s long-term physicians who would have opposed the cesarean was not notified of the hearing. *A.C.*, 573 A.2d at 1248 & n.17.

141. *See* Rhoden, *supra* note 5, at 2008-10.

142. *New England Journal of Medicine Study*, *supra* note 2, at 1194.

143. *Id.* at 1193.

other procedures that are potentially lifesaving for the fetus, such as intrauterine transfusion, as these procedures come to represent the standard of care."[144] Fifteen of fifty-eight (twenty-six percent) "advocated state surveillance of women in the third trimester who stay outside the hospital system."[145]

Furthermore, the risk-benefit analysis for the physician seems to favor intervention. It seems more likely that the outcome will be positive if the surgery is performed; people with positive outcomes do not sue. If no intervention occurs and there is a negative outcome, however, the parents might sue.[146] Nor is it unreasonable for obstetricians to be concerned about medical liability. The role of the court is not only to make it clear that there cannot be a suit for damages against a physician who abides by the decision of a competent patient,[147] but to uphold that right to consent or refuse by hearing the cases and denying requests for orders.

The approach suggested by the District of Columbia Court of Appeals in *In re A.C.*[148] seems a logical one. Most critical is the assessment of whether the patient is competent to make a decision.[149] Once a patient is found competent, her decision should control. If, however, she is not competent, the court should engage in either a best-interests or substituted-judgment analysis.[150] Forced surgery should be allowed only in

144. *Id.*

145. *Id.* at 1193-94. The survey also included questions about home birth: 22% felt home birth should be illegal because it poses an "inherent increase in risk"; 33% felt that it should be legal, despite this inherent risk; 37% felt that "competent adults, including pregnant women with viable fetuses, were autonomous and might refuse medical care, and therefore, home birth should be legal." *Id.* at 1194. The study points out that seven of the 20 who felt competent pregnant women should be able to refuse medical care had, in response to earlier questions, supported court-ordered interventions such as hospital detentions, intrauterine transfusions, and state surveillance. This left only 24% who supported a woman's right to consent or refuse treatment throughout the entire questionnaire. *Id.*

146. Rhoden, *supra* note 5, at 2009.

147. A physician is under no liability if she acts in accordance with the wishes of a competent patient. In the *New England Journal of Medicine* study, none of the respondents knew of any case in which a physician was sued for failing to get a court order. *New England Journal of Medicine Study*, *supra* note 2, at 1196. The authors point out, however, that if physicians insist on practicing in such an aggressive manner, they may change the standard of care. *Id.* Of course, a physician who is in any way concerned about the competency of a patient should have her evaluated. *See supra* note 26.

148. 573 A.2d. 1235 (D.C. 1990) (en banc). For a discussion of *A.C.*, see *supra* notes 70-92 and accompanying text.

149. *See supra* note 26 for discussion of competency evaluations.

150. A substituted-judgment analysis focuses on what the particular patient would decide to do if competent. A best-interests analysis, on the other hand, focuses solely on what is in the best interests of the patient herself. Because it is doubtful whether any court confronted with an incompetent woman would refuse to order the surgery, regardless of the test it applies, these tests are not treated separately. The tests can, however, lead to different results. *See supra* note 53.

truly extraordinary circumstances.

There are other proposals. One, proposed by Alice Noble-Allgire, would require the court to consider four factors.[151] First, the court should consider whether the state has a compelling interest. Noble-Allgire argues that after viability, the state does have a compelling interest in protecting fetal life. Moreover, the treatment must prevent "serious, irreversible harm to the fetus"; the benefit to the fetus must be great, and the level of certainty in this outcome high.[152] Second, there must be no less intrusive means available of achieving the State's interests.[153] Third, the court should consider whether the treatment will impose any additional harm on the woman.[154] She acknowledges that under the no trade-off rule of *Thornburgh v. American College of Obstetricians & Gynecologists,*[155] a judge may not issue a court order. She advocates, however, a general balancing test in which the risks associated with a usual cesarean section would not count as additional risks.[156] Finally, if there is uncertainty, "[b]ecause of the serious nature of the intrusion, it seems only fair to tip the balance in favor of the mother when all other considerations are equal."[157]

Noble-Allgire applies her test to two familiar situations, namely, those described in the *Jefferson* and *A.C.* cases. In *Jefferson*, which she calls "an easy case," she would allow the order because of the potential benefit to the mother and the fact that without the surgery the fetus was predicted to die.[158] In *A.C.* she would not allow the court order: there was no benefit to the mother, but rather a serious risk; the chances for the fetus were not as good; and finally, in close questions the woman's wishes should control.[159]

Noble-Allgire's proposal is inadequate, not only because it is far from clear that the State does indeed have an interest in fetal life after viability sufficient to override the woman's refusal to consent,[160] but also because it does not afford sufficient respect to the woman, the proper proxy decisionmaker. Noble-Allgire places tremendous trust in the doctor's ability to be certain, and in the judge's ability to evaluate the medi-

151. Noble-Allgire, *supra* note 26, at 244-48.

152. *Id.* at 244-45.

153. *Id.* at 245.

154. *Id.*

155. 476 U.S. 747 (1986). For a discussion of *Thornburgh*, see *supra* text accompanying notes 63-65.

156. Noble-Allgire, *supra* note 26, at 246.

157. *Id.*

158. *Id.* at 247.

159. *Id.* at 247-48.

160. *See supra* notes 57-62 and accompanying text.

cal testimony critically.[161] She includes no provisions to balance procedural shortcomings such as the lack of second opinions or the lack of time for reflection or preparation.

That a court should not be willing to issue a court order authorizing a forced cesarean does not mean that a physician cannot discuss the medical situation with his patient, the risks to the fetus caused by her refusal, or the risks to her own health. That kind of careful and intimate discussion between physician and patient should be encouraged. The physician cannot bully his patient, but he certainly can appeal to the woman in her role as proxy decisionmaker. Most women do take their physician's advice.[162] When there is a disagreement, however, it is simply destructive to encourage physicians to go to court to override their patients' wishes. Overriding the woman's decision assaults her right to bodily integrity. Perhaps more important, it furthers a dangerous recent trend that views the woman as the enemy of the fetus. This trend is not healthy for society, for women, or for babies. It is popular these days to cure perceived social ills through tougher criminal sanctions, but this is not the right approach to maternal and child health.[163] This approach degrades women, both as human beings and as decisionmakers. It also sets up an adversarial relationship between physician and patient that impedes physician-patient trust and discourages improved prenatal care and nutrition. If improving pregnancy outcome is really important, then subjecting women to forced surgery is hardly the best way to achieve that goal.

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161. *See* Noble-Allgire, *supra* note 26, at 245.

162. Rhoden, *supra* note 5, at 1959.

163. Which is not to say, of course, that criminalizing pregnancy-related conduct has not been suggested by other authors. *See, e.g.*, Robertson, *supra* note 113, at 442-49; Shriner, *supra* note 118, at 518-19 (arguing that it would not be the best approach to inform a woman who refuses a cesarean that she is committing a felony).