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Birth Directives: A Model to Address Forced and Coerced Cesareans

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— Comment —

BIRTH DIRECTIVES: A MODEL TO ADDRESS FORCED AND COERCED CESAREANS

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INTRODUCTION

In 2011, a doctor at a New York hospital followed an internal policy to force a patient, Rinat Dray, to have a C-section.[1] Dray had experienced two previous unwanted C-sections and hoped to deliver her third child naturally. After her first C-section, Dray experienced difficulty walking and holding her child for eight months, and Dray, who is a Hasidic Jew, worried that numerous C-sections would impact her ability to have a large family.[2] During her third pregnancy, Dray selected the Staten Island University Hospital because it had lower rates

1. Molly Redden, *New York Hospital's Secret Policy Led to Woman Being Given C-section Against Her Will*, GUARDIAN (Oct. 5, 2017, 6:00 PM), https://www.theguardian.com/us-news/2017/oct/05/new-york-staten-island-university-hospital-c-section-ethics-medicine [https://perma.cc/P7H2-773X].

2. Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56, 57 (2016).

of C-sections than the statewide average, and the hospital supported VBACs, or vaginal births after cesarean (or C-section), which some hospitals have policies prohibiting.[3] The hospital, however, had a private policy providing doctors with instructions for performing procedures and surgeries without a pregnant woman's consent. The policy authorized doctors to override a pregnant woman's decision if the doctors are unable to persuade the woman to consent and multiple doctors agree that the procedure or surgery has a "reasonable possibility of significant benefit" for her fetus that "outweigh[s] the possible risks to the woman."[4] The policy additionally provided that in the case of an emergency that threatens the fetus, a single doctor, without consultation, has the authority to override a pregnant woman's decision.[5] After Dray went into labor, her doctor began pressuring her to have a C-section, and when Dray refused, he threatened that she would be faced with child abuse or neglect proceedings.[6] As Dray begged for more time to deliver naturally, the doctor ordered his staff to wheel Dray into an operating room and delivered her son by C-section. While performing the procedure, the doctor cut into Dray's bladder, causing permanent damage.[7]

After Dray brought a claim against the hospital, its policy became public for the first time. In Dray's medical chart, the doctor wrote: "The probable benefits of a C-section significantly outweigh the possible risk to the woman . . . . I have decided to override her refusal to have a C-section."[8] While Dray reports no recollection of the doctor explaining to her that her baby was in danger, in legal records, the hospital claims that the C-section likely saved the baby's life by preventing a uterine rupture.[9]

Dray's is far from the first reported case of a forced C-section. Over the past several decades, as fetal rights activism has grown, doctors, hospitals, and judges have compelled women to undergo unwanted C-sections when the procedure is believed to be beneficial to the fetus. Perhaps the most well-known case is that of Angela Carder, which occurred in the late 1980s.[10] Carder, who was twenty-seven years old,

3. *Id.* at 58.

4. Redden, *supra* note 1, at 1.

5. *Id.*

6. Anemona Hartocollis, *Mother Accuses Doctors of Forcing a C-section and Files Suit*, N.Y. Times (May 16, 2014), https://www.nytimes.com/2014/05/17/nyregion/mother-accuses-doctors-of-forcing-a-c-section-and-files-suit.html [https://perma.cc/X79B-XZWL].

7. Diaz-Tello, *supra* note 2, at 58.

8. *Id.*

9. Redden, *supra* note 1, at 3.

10. Barton Gellman, *D.C. Court Wrestles with Fetal Rights Case*, Wash. Post (Sept. 23, 1988), https://www.washingtonpost.com/archive/local/

had suffered from cancer since the age of thirteen. Against the wishes of Carder, her family, and Carder's doctors, the hospital succeeded in securing a court order to perform a C-section on Carder. Neither Carder nor her daughter survived the surgery.[11] In ordering the C-section, the trial court balanced the state's interest in protecting potential fetal life, as recognized in *Roe v. Wade*,[12] against Carder's right to refuse unwanted medical treatment. After Carder's death, a D.C. Court of Appeals overturned the court order and found its application of a balancing test improper.[13] But state and lower federal courts remain split on whether a balancing test should be applied in this context and whether forced C-sections violate the constitutional rights of pregnant patients.

In the 1980s, around the same time that *In re A.C.* was decided, courts and legislatures were giving increased recognition to patient rights and autonomy in the context of end-of-life decision-making. In 1990, the Supreme Court recognized the right to refuse medical treatment in *Cruzan v. Missouri Department of Health*.[14] Whereas in the context of forced C-sections, some courts—like the trial court in *In re A.C.*—used *Roe* to override pregnant women's constitutional rights, *Cruzan* cited *Roe* to support patient rights.[15] *Cruzan*'s establishment of the right to refuse medical treatment coincided with states' widespread enactment of advance directive statutes, which are intended to protect patient autonomy by ensuring that doctors follow patients' end-of-life wishes. However, similar to forced C-sections, some states' advance directive statutes reject the autonomy of pregnant patients by providing that if the patient is pregnant, then her advance directive will be disregarded or life-sustaining treatment will be administered regardless of her wishes.[16]

This Comment argues that in the context of compelled C-sections, balancing pregnant patients' constitutional rights against state interests, particularly the state's interest in protecting potential life as recognized in *Roe v. Wade*, is misguided. Decisions that apply a balancing test misapply *Roe*, do not reckon with the magnitude of the constitutional right to refuse medical treatment, and ignore important public health concerns, such as the possibility of driving women with

1988/09/23/dc-court-wrestles-with-fetal-rights-case/dff5b6c5-70ec-4a58-a2c7-a4fe977875fe/?utm_term=.3a90449db356 [https://perma.cc/DD6T-EWL6].

11. *Id.*

12. 410 US. 113, 163 (1973).

13. *In re* A.C., 573 A.2d 1235 (D.C. 1990).

14. 497 U.S. 261 (1990).

15. *Id.* at 342; *see also In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976).

16. *See infra* notes 56–59 and accompanying text.

high-risk pregnancies away from health care. These policy concerns are particularly relevant given the public's increased attention to the high rates of maternal mortality and morbidity in the U.S., especially among women of color, who are disproportionately impacted by forced C-sections. Finally, decisions finding that forced C-sections do not violate the rights of pregnant patients are explicitly or implicitly based on the premise that pregnant women are a special class of persons with diminished constitutional rights, leaving pregnant women vulnerable to potentially unlimited state surveillance and intervention.

As a safeguard for the constitutional rights of pregnant patients, this Comment proposes a model based on advance directives that allows patients to document their wishes for medical care during childbirth. Similar to advance directive statutes, this model form would be most effective as legislation. Because advance directives, whether statutory or non-statutory, are enforceable through the constitutional right to refuse medical treatment, a non-statutory "birth directive" should likewise be enforceable. However, until the Supreme Court addresses the issue, and without relevant legislation, a "birth directive" would likely only be enforced by courts in certain jurisdictions. The issue is further complicated by pregnancy exclusions contained in many states' advance directives, the constitutionality of which have not been substantively addressed by any court. Despite these potential barriers, this model provides pregnant patients with a way to begin asserting their autonomy in medical settings.

Part I of this Comment examines the history of the advance directive statutory scheme and case law recognizing the right to refuse medical treatment. Part II provides an overview of cases considering the constitutionality of forced medical procedures on pregnant women. Part III reexamines the balancing test that has been applied by some courts in the context of forced C-sections and argues that the use of the balancing test is improper. Finally, Part IV provides a model birth directive form.

I. ADVANCE DIRECTIVES AND THE RIGHT TO REFUSE MEDICAL TREATMENT

The courts' recognition of the right to refuse medical treatment has been intertwined with the development of the states' advance directive statutory scheme, including the enactment of statutes providing for living wills and health care proxies.[17] As states began to enact advance

17. A living will is a written statement containing a person's wishes for medical treatment and typically only applies if the person's condition is "terminal" or their death is "imminent." Charles P. Sabatino, *Health Care Advance Directives*, 16 FAMILY ADVOCATE 61, 62 (1993). A health care power of attorney, or health care proxy, allows the drafter to appoint another person to make decisions about the drafter's medical care once the drafter is unable to. *Id.*

directive statutes, the most fundamental patients' rights cases were decided, primarily involving end-of-life decision-making.

A. The Development of the Advance Directive Statutory Scheme

Luis Kutner is credited with first proposing the idea of a "living will" in his 1969 Law Review article.[18] Kutner sought to address the dilemma in our criminal law in which a person seeks to take the life of another in order to end their suffering. His proposal relied on the right to refuse treatment and the right to privacy.[19] Consciousness and concern among the public and the legal community regarding the ability to make end-of-life decisions became prevalent several years later, in 1976, when the influential New Jersey case *In re Quinlan*[20] sparked growing awareness of the issue.[21] *In re Quinlan* involved a twenty-one-year-old woman, Karen Quinlan, who was in a state of unresponsive wakefulness.[22] Quinlan's father sought to be appointed as his daughter's guardian in order to discontinue her life support.[23] The court found that Karen Quinlan had a right to decline medical support, asserted by her guardian, under certain circumstances.[24] The court determined that the right stemmed from her right to privacy, similar to "a woman's decision to terminate pregnancy under certain conditions" as recognized in *Roe v. Wade*.[25] The court, however, found that this was not an absolute right and balanced it against the state's interest in the "preservation and sanctity of human life."[26]

A Time magazine article from 1975 discussing the case noted that some debate surrounding the issues in *Quinlan* arose because many doctors were "taught to regard death as an enemy and do all they can to defeat it" and viewed termination of life support "as an act akin to euthanasia."[27] Further, the article acknowledged that termination of life support gave rise to other policy concerns, such as ending life support in state hospitals for those with disabilities, the elderly, and children

18. Luis Kutner, *Due Process of Euthanasia: The Living Will, a Proposal*, 44 Ind. L.J. 539 (1969); Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. Rich. L. Rev. 313, 319 (1998).

19. Urofsky, *supra* note 18, at 319.

20. 355 A.2d 647 (N.J. 1976).

21. *Id.*

22. *Id.* at 654.

23. *Id.* at 653.

24. *Id.* at 664.

25. *Id.* at 663.

26. *Id.*

27. Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 Milbank Q. 211, 213 (2010).

with terminal illnesses.[28] One legal scholar has asserted that these policy concerns are what gave rise to the states' advance directive statutory scheme—advance directive statutes were created to function as "procedural protections intended to protect vulnerable populations from harm, specifically the premature termination of life due to the lack of understanding of, or diminished capacity of, or undue influence on, the signer of the living will."[29] The first living will statute in the country was enacted by California in 1976, the same year that *Quinlan* was decided.[30]

Within ten years, by 1986, forty-one states had adopted living will statutes.[31] Additionally, as legislators and the public became increasingly aware of the limitations of living wills—which only apply to a narrow range of end-of-life decisions—states increasingly began enacting health care power of attorney statutes or combining such statues with their already-existing living will laws.[32]

In 1990, the Supreme Court in *Cruzan v. Missouri Dept. of Health*[33] found a "constitutionally protected liberty interest in refusing unwanted medical treatment."[34] *Cruzan* involved the case of a twenty-five-year-old woman, Nancy Cruzan, who remained in a state of unresponsive wakefulness after a car crash. Prior to the accident, Cruzan had expressed that if she were sick or injured, she would not want to be kept on life support "unless she could live at least halfway normally."[35] Cruzan's parents sought to have her artificial feeding and hydration equipment removed.[36] The Court determined that a constitutional right to refuse unwanted medical treatment is "the logical corollary of the doctrine of informed consent,"[37] which has been "viewed as generally encompassing the right of a competent individual to refuse medical treatment."[38] The Court held that a right to refuse unwanted medical treatment "may be inferred from . . . prior decisions" as arising from the Fourteenth Amendment Due Process clause.[39] The

28. *Id.*

29. *Id.* at 213–14.

30. Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 738 n.1 (1987).

31. Sabatino, *supra* note 27, at 214.

32. *Id.* at 214–15.

33. 497 U.S. 261 (1990).

34. *Id.* at 278.

35. *Id.* at 268.

36. *Id.* at 265.

37. *Id.* at 270.

38. *Id.* at 277.

39. *Id.* at 278.

Court also recognized the state's interest in the "protection and preservation of human life,"[40] and thus found that the state's requirement for clear and convincing evidence of an incompetent person's wishes regarding the termination of life support is not unconstitutional as a procedural safeguard.[41] Although the Court in *Cruzan* did not directly address the legal validity of living wills, the opinion has been interpreted as supporting their validity.[42]

In 1997, the Court in *Washington v. Glucksberg*[43] again acknowledged that the right to refuse unwanted medical treatment is "entirely consistent with this Nation's history and constitutional traditions," "[g]iven the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment,"[44] but held that there is no constitutional right to assisted suicide.[45] The Court invoked *Planned Parenthood of Southeastern Pennsylvania v. Casey*[46] and noted "many of the rights and liberties protected by the Due Process Clause sound in personal autonomy" but stated that "it does not warrant . . . that any and all important, intimate, and personal decisions are so protected."[47]

None of these U.S. Supreme Court cases directly addressed advance directives, but as in *Cruzan*, courts that have addressed their enforceability have generally applied a balancing test.[48] The balancing test weighs several state interests against the individual's right to refuse medical treatment and common law right to informed consent. Generally, these state interests have included preserving life, preventing suicide, protecting third parties, and maintaining the ethical integrity of the medical profession.[49]

B. Statutory and Non-Statutory Advance Directives

Although almost every state has enacted some type of living will statute, living wills may be either statutory or non-statutory because they arise from the constitutional right to refuse medical treatment and

40. *Id.* at 280.

41. *Id.* at 281.

42. Elizabeth D. McLean, Comment, *Will Statutes in Light of* Cruzan v. Director, Missouri Department of Health*: Ensuring That a Patient's Wishes Will Prevail*, 40 EMORY L.J. 1305, 1305 (1991).

43. 521 U.S. 702 (1997).

44. *Id.* at 725.

45. *Id.* at 735.

46. 505 U.S. 833 (1992).

47. *Glucksberg*, 521 U.S. at 727 (citing *Casey*, 505 U.S. at 852).

48. Sam J. Saad III, *Living Wills: Validity and Morality*, 30 VT. L. REV. 71, 75 (2005).

49. *In re* Conroy, 486 A.2d 1209, 1223 (N.J. 1985).

the common law right to informed consent.[50] Statutory living wills often consist of forms for the drafter to fill out, indicating their wishes regarding end-of-life medical treatment. In some states, these forms are for suggested use or are model forms; other states require that declarants use the particular form that is provided. Additionally, living will forms often provide space for "other instructions," in which the drafter specifies treatment that is desired or not desired in particular circumstances.[51] The right to refuse medical treatment is the basis for the enforceability of these additional instructions. Thus, the concept of a non-statutory living will also arises in states with statutes that leave out certain components or that allow for other instructions to be provided.[52]

C. Pregnancy Exclusions in Advance Directives

In many states, pregnant women face statutory barriers to having their advance directives honored. More than half of the states have some requirement that, in at least certain circumstances, pregnant women remain on life support despite the wishes outlined in their advance directives. Twelve states automatically invalidate pregnant women's advance directives, no matter how far along the pregnancy is.[53] Some scholars have argued that in light of *Roe* and *Casey* these statutes are more obviously unconstitutional, as they apply to pregnant women whose fetuses are pre-viability.[54] The constitutionality of these limitations is beyond the scope of this Comment, but a recent lawsuit has challenged Idaho's pregnancy limitation for violations of the Due Process and Equal Protection clauses of the Fourteenth Amendment.[55] Other states require life support only when it is probable that the fetus will develop to the point of live birth or viability.[56] And some states

50. Susan J. Nanovic, *The Living Will: Preservation of the Right-to-Die Demands Clarity and Consistency*, 95 DICK. L. REV. 209, 214 (1990).

51. *Id.* at 213–14.

52. *Id.* at 214 n.33.

53. ALA. CODE § 22-8A-4(e) (LexisNexis 2015); IDAHO CODE ANN. § 39-4510(d) (2012); IND. CODE ANN. § 16-36-4-8(d) (West 2007); KAN. STAT. ANN. § 65-28,103(a) (West 2008); KY. REV. STAT. ANN. § 311.625(1) (West 2011); KY. REV. STAT. ANN. § 311.629(4) (West 2011); MICH. COMP. LAWS ANN. § 700.5509(d) (2005); MO. ANN. STAT. § 459.025 (1985); S.C. CODE ANN. § 44-77-70 (2017); TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West 2017); UTAH CODE ANN. § 75-2a-123(1) (West 2018); WASH. REV. CODE ANN. § 70.122.030(d) (West 2002); WIS. STAT. ANN. § 154.07(2) (West 2018).

54. *See, e.g.*, Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 112–13 (1997).

55. Complaint, Almerico v. Denney, No. 1:18-cv-00239-EJL (D. Idaho May 31, 2018).

56. ALASKA STAT. § 13.52.055(b) (2016); ARK. CODE ANN. § 20-17-206(c) (2014); COLO. REV. STAT. ANN. § 15-18-104(2) (2017); DEL. CODE ANN.

require life-sustaining treatment for pregnant women but make exceptions for pain or harm caused to the woman.[57] In contrast, New Jersey and Oklahoma explicitly allow women to include their wishes regarding pregnancy in their advance directives and require physicians to follow these instructions.[58] Finally, fourteen states and D.C. do not explicitly state whether a pregnant woman's advance directives must be followed.[59]

II. FORCED MEDICAL PROCEDURES ON PREGNANT WOMEN

Under common law, an individual cannot be compelled to undergo a medical procedure for another's benefit. This principle has been most famously illustrated by the case *Mcfall v. Shimp*.[60] In *Mcfall*, a man with a rare bone marrow disease asked a Pennsylvania court to compel his cousin, who had been determined to be the only suitable bone marrow donor, to submit to further tests and a bone marrow transplant. Without the transplant, Mcfall was not likely to survive. The court refused to compel Mcfall's cousin to submit to additional testing or the transplant, invoking the common law rule that "one human being is under no legal compulsion to save another human being or to rescue."[61] The court acknowledged that this "rule is founded upon the very essence of our free society," and to compel one person to undergo a medical procedure for the benefit of another "would change every

tit. 16, § 2503(j) (1996); FLA. STAT. ANN. § 765.113(2) (West 2016); GA. CODE ANN. § 31-32-9(1)(1) (2012); 755 ILL. COMP. STAT. ANN. 35/3(c) (2007); IOWA CODE § 144A.6(2) (2018); LA. STAT. ANN. § 40:1151.9(5)(E) (2014); MINN. STAT. § 145B.13(3) (2016); MONT. CODE ANN. § 50-9-106(7) (2007); NEB. REV. ST. ANN. § 20-408(3) (West 2018); NEB. REV. ST. § 30-3417(1) (1992); OHIO REV. CODE ANN. § 2133.06(B) (West 2018); OHIO REV. CODE ANN. § 1337.13(D) (West 2014); 23 R.I. GEN. LAWS § 23-4.11-6(c) (1956).

57. N.H. REV. STAT. ANN. § 137-J:10(IV)(a) (2015); N.H. REV. STAT. ANN. § 137-J:5(V)(c) (2015); N.D. CENT. CODE § 23-06.5.09(5) (2012); S.D. CODIFIED LAWS § 34-12D-10 (2011).

58. N.J. REV. STAT. § 26:2H-58(5) (2013); OKLA. ST. ANN. tit. 63, § 3101.4 (West 2016).

59. ARIZ. REV. STAT. ANN. § 36-3262 (2018); CAL. PROB. CODE ANN. §§ 4650–60, 4670–98 (West 2009); CONN. GEN. STAT. ANN. §§ 19a-571–573, 19a-575–580i (West 2011 & Supp. XI 2018); D.C. CODE ANN. § 7-622(c) (2001); MISS. CODE ANN. § 41-41-205 (1972); N.M. STAT. ANN. § 24-7A-2 (West 2011); N.C. GEN. STAT. § 90-321 (2017); OR. REV. STAT. § 127.510 (2017); TENN. CODE ANN. § 68-11-1803 (2013 & Supp. XII 2018); VA. CODE ANN. § 54.1-2984 (2017); W. VA. CODE ANN. § 16-30-4 (2000); WYO. STAT. ANN. § 35-22-403 (2017); MASS. GEN. LAWS ch. 201D § 4 (2012); ME. REV. STAT. ANN. tit. 18-A, § 5-804 (1964); N.Y. PUB. HEALTH LAW § 2982 (McKinney 2012).

60. 10 Pa. D. & C.3d 90 (1978).

61. *Id.* at 90–91.

concept and principle upon which our society is founded."[62] Additionally, the court expressed concern that dispelling this common law rule would create a slippery slope in which the legal compulsion of a bodily intrusion "would know no limits."[63]

Courts, however, have reached conflicting decisions in cases involving parents and children, and have at times required parents—usually mothers—to undergo certain medical procedures for the benefit of their children. For example, in certain cases, parents have been required to undergo lifesaving blood transfusions if they would leave behind dependent minor children without any other caregiver.[64] In these cases, courts have balanced the constitutional rights of the parent against the state's interest in protecting innocent third parties.

Further, some courts have required pregnant women to undergo medical procedures for the benefit of their fetuses. For instance, in 1964, the New Jersey Supreme Court ordered a pregnant woman, Willimina Anderson, to undergo a blood transfusion for the benefit of her fetus.[65] The hospital alleged that unless Anderson received a blood transfusion, it was probable that she would hemorrhage at some point during her pregnancy, and she and her fetus would die. Anderson was a Jehovah's

62. *Id.* at 91.

63. *Id.*

64. Application of President and Dirs. of Georgetown Coll., Inc., 331 F.2d 1000, 1008 (D.C. Cir. 1964) (ordering a mother to submit to blood transfusion because it is her "responsibility to the community to care for her infant"); Holmes v. Silver Cross Hosp., 340 F.Supp. 125 (N.D. Ill. 1972). *But see In re* Farrell, 108 N.J. 335, 413 (1987) (refusing to compel a mother to stay on respirator because she "did not disregard her children's interest when she decided to withdraw the respirator," but in part based her decision on their stress); Wons v. Pub. Health Tr. of Dade Cty., 500 So. 2d 679, 688 (Fla. Dist. Ct. App. 1987) (finding that a mother's constitutional rights were not overridden by state interests because "her death [would] not result in the children's abandonment," as other family would care for them). In another case in which the state sought to compel a mother to accept a life-saving blood transfusion, the court found that there was no evidence that the father would not care for the children, and thus the state failed to "satisfy the heavy burden required to override the patient's constitutional right to refuse medical treatment." *In re* Dubreuil, 629 So. 2d 819, 828 (Fla. 1993). The court noted that the state's rationale of there being no evidence the father could care for the children "could be read by some to perpetuate the damaging stereotype that a mother's role is one of caregiver," and did not wish to "reinforce these outdated ideas in a manner that effectively denies a woman her constitutional right to refuse medical treatment." *Id.* For a full discussion of a pregnant woman's affirmative duty in the context of fetal surgery, see Katherine A. Knopoff, *Can a Pregnant Woman Morally Refuse Fetal Surgery?*, 79 CAL. L. REV. 499, 521–31 (1991).

65. Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson, 42 N.J. 421 (1964) (per curiam).

Witness and refused the blood transfusion on religious grounds.[66] In ordering the transfusion, the court did not decide whether an adult may be compelled to undergo a medical procedure necessary to save her own life, but it was "satisfied that the unborn child is entitled to the law's protection."[67]

Then, in 1981, the Supreme Court of Georgia ordered a hospital to perform an unwanted C-section on a pregnant woman, Jessie Mae Jefferson, if she returned to the hospital voluntarily.[68] Doctors testified that because Jefferson's placenta was blocking the birth canal, there was a 99 percent chance the baby would not survive a natural birth, and it was "highly and virtually impossible" for the condition to reverse itself.[69] The court found it "appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live," reasoning that a viable fetus has a constitutional right to the state's protection under *Roe v. Wade*, and the lives of the pregnant woman and the fetus are "inseparable."[70] After the court granted the order, doctors found that Jefferson's condition had reversed itself, and Jefferson gave birth to a healthy baby naturally.[71]

Several years later, in *In re Madyun Fetus*,[72] a D.C. court ordered doctors to perform an unwanted C-section on Ayesha Madyun.[73] Madyun's doctor believed the baby had an infection because Madyun had a low-grade fever and failed to progress in labor for sixty-five hours.[74] Madyun and her husband hoped to deliver naturally and were not convinced the baby was in danger.[75] Additionally, Madyun and her

66. *Id.* at 538.

67. *Id.* at 421–22.

68. Jefferson v. Griffin Spalding Cty. Hosp. Auth., 274 S.E.2d 457, 458 (Ga. 1981).

69. *AROUND THE NATION; Pregnant Woman Believes Prayers Obviated Caesarean*, N.Y. TIMES (Jan. 26, 1981), https://www.nytimes.com/1981/01/26/us/around-the-nation-pregnant-woman-believes-prayers-obviated-caesarean.html [https://perma.cc/CPD&-V6YH].

70. *Jefferson*, 274 S.E.2d at 458.

71. Cynthia Gorney, *WHOSE BODY IS IT ANYWAY? THE LEGAL MAELSTROM THAT RAGES WHEN THE RIGHTS OF MOTHER AND FETUS COLLIDE*, WASH. POST. (Dec. 13, 1988), https://www.washingtonpost.com/archive/lifestyle/1988/12/13/whose-body-is-it-anyway-the-legal-maelstrom-that-rages-when-the-rights-of-mother-and-fetus-collide/81f7c0dc-a0cf-47fb-b331-eb5d6066e51c/?utm_term=.3747a6222993 [https://perma.cc/BD3U-8BSP].

72. 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 26, 1986), *reprinted as In re* A.C., 573 A.2d 1235 (D.C. 1990).

73. *In re A.C.*, 537 A.2d at 1264.

74. Gorney, *supra* note 71.

75. Madyun and her husband reportedly knew that hospitals had been criticized in recent years for performing C-sections more often than

husband, both Muslim, asserted that according to their religious beliefs, the mother has the final decision over what happens to her body and her fetus.[76] After Madyun refused the C-section, her doctor sought a court order to perform the surgery. The court granted the order, finding that the state's interest in protecting fetal life becomes compelling at the point of viability, trumping Madyun's constitutional rights to privacy and the free exercise of religion.[77] Madyun delivered a healthy baby by C-section. Notably, the baby was found to be free of infection, the basis of the court-ordered surgery.[78]

One year after *Madyun*, a D.C. court relied on the decision to order another unwanted C-section.[79] The patient, Angela Carder, was twenty-seven years old and had suffered from cancer since the age of thirteen.[80] When Carder was six months pregnant, her doctors discovered that she had an inoperable tumor on her lung. After Carder was admitted to the hospital, her condition worsened. The hospital requested a declaratory judgment regarding the performance of a C-section. Carder was heavily sedated, but her mother testified in opposition to the C-section, stating that Carder wanted "to live long enough to hold that baby . . . even though she knew she was terminal."[81]

The trial court, relying on *Madyun* and the state's interest in protecting potential life, ordered the C-section to be performed.[82] Carder regained consciousness, and when she was told of the court order, mouthed repeatedly to her doctors, "I don't want it done."[83] The surgery took place, and neither Carder nor her baby survived. The baby was not sufficiently developed to live outside the womb and died hours after birth due to "extreme immaturity."[84] Carder died two days later, with the C-section listed as a contributing factor to her death.[85]

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necessary and hoped to deliver naturally. Madyun's husband told the Washington Post: "As a male, if there's no circumstantial situation in which you can force surgery on me if I'm of sound mind, then I don't feel that a woman, just because she's a woman, should be in a situation where surgery can be forced on her." *Id.*

76. *Id.*

77. *In re A.C.*, 573 A.2d at 1262 (citing Roe v. Wade, 410 U.S. 113 (1973)).

78. Gorney, *supra* note 71.

79. *In re A.C.*, 573 A.2d at 1240.

80. *Id.* at 1238.

81. *Id.* at 1238–39.

82. *Id.* at 1240.

83. *Id.* at 1240–41.

84. Gorney, *supra* note 71.

85. Jessica Valenti, *How an Anti-Abortion Push to Redefine 'Person' Could Wind up Hurting Women*, WASH. POST (Oct. 28, 2011), https://www.washingtonpost.com/opinions/how-an-anti-abortion-push-to-redefine-

After Carder's death, D.C.'s highest court reconsidered the case and found that the lower court erred in applying a balancing test and ordering the C-section.[86] The court determined that "in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus."[87] The court found that the trial court should have used the doctrine of substitute judgment because Carder was unable to give informed consent.[88]

In rejecting the application of a balancing test, the court emphasized the constitutional right to refuse medical treatment. The court also considered the policy issues inherent in forced C-sections, including the erosion of patient-physician trust and driving women with high-risk pregnancies away from the health care system.[89] The court did not foreclose the possibility that there could be a case in which a patient's constitutional rights would be overcome by a state interest, but stated that "such cases will be extremely rare and truly exceptional," and expressed doubt that such a situation would ever arise:

> We emphasize, [nevertheless], that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a cesarean section. . . . Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a cesarean section, against that person's will.[90]

Finally, the court considered how an order compelling an unwanted C-section would be enforced if the patient continued to refuse the surgery: through the use of physical force "or its equivalent." The court stated that "AC would have to be fastened with restraints to the operating table, or perhaps rendered unconscious by forcibly injecting her with an anesthetic, and then subjected to unwanted major surgery," an image that would "surely give one pause in a civilized society."[91]

After *In re A.C.*, an Illinois appellate court similarly found that the use of a balancing test is generally inappropriate in the context of forced

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person-could-wind-up-hurting-women/2011/10/26/gIQAQSwGQM_story.html?utm_term=.7b6803319a2b [https://perma.cc/DVH2-2UCX].

86. *In re A.C.*, 573 A.2d at 1247. The court found that the case was not moot because a corresponding case still existed in which Carder's estate was suing the hospital. *Id.* at 1241.

87. *Id.* at 1237–38.

88. *Id.* at 1238.

89. *Id.* at 1247–48.

90. *Id.* at 1252.

91. *Id.* at 1244 n.8.

C-sections.[92] The court held that "a woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[93]

In this case, Doe had refused the C-section on religious grounds.[94] The trial court found that the chances of Doe's fetus surviving a natural birth were close to zero, but the chances of the fetus surviving a C-section were close to 100 percent.[95] The trial court also found that while the chances of a pregnant woman dying in a C-section delivery are about 1 in 10,000, the chances of a pregnant woman dying during natural birth are 1 in 20,000 to 1 in 50,000.[96] Finally, the trial court found that, generally, a mother has much more pain due to a C-section and could experience other complicating factors, such as damage to organs, and would have to recuperate for about six weeks after a C-section, which is major abdominal surgery.[97]

The *Baby Boy Doe* court relied on *Cruzan*, which had been decided several years earlier, shortly after the D.C. Supreme Court's decision in *In re A.C.* In *Cruzan*, the U.S. Supreme Court recognized for the first time that the Due Process Clause of the Fourteenth Amendment confers a significant liberty interest in refusing unwanted medical procedures.[98] The *Baby Boy Doe* court also cited to a case decided by the Illinois Supreme Court, *Stallman v. Youngquist*, in which the court refused to recognize a tort action against a pregnant woman for unintentional infliction of prenatal injuries, finding that to do so "would subject the woman's every act while pregnant to state scrutiny, thereby intruding upon her rights to privacy and bodily integrity, and her right to control her life."[99]

92. *In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994).

93. *Id.* at 326.

94. *Id.* at 327.

95. *Id.* at 328.

96. *Id.*

97. *Id.* at 329.

98. *Id.* at 304.

99. *In re Baby Boy Doe*, 632 N.E.2d at 331 (citing Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988)). The *Stallman* court found that "there can be no consistent and objective legal standard by which to judge a woman's actions during pregnancy." *Id.* at 332 (citing *Stallman*, 531 N.E.2d at 355). The *Stallman* court additionally noted that the relationship between the pregnant woman and fetus differs from any other relationship between a plaintiff and defendant because "it is the mother's every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant woman's fault; it is a fact of life." 531 N.E.2d at 360. The *Baby Boy Doe* court concluded that a "woman is under no duty to guarantee the mental and physical health of her child at birth, and thus

The court in *Baby Boy Doe* acknowledged *Jefferson* and *In re Madyun*, which both found that the state's interest in the protection of potential life justified a compelled C-section.[100] But the court noted that unlike the decisions in *Stallman* and *In re A.C.*, the *Jefferson* and *In re Madyun* decisions did not recognize the woman's constitutional right to refuse medical treatment "or the magnitude of that right."[101]

Further, the court observed that decisions ordering or upholding the constitutionality of compelled C-sections, including *Jefferson* and *Madyun*, have relied on the state's interest in the protection of potential life, as recognized by the Supreme Court in *Roe v. Wade*.[102] But the court asserted that *Roe*'s holding is more narrow: in the context of abortion, the state's interest in potential life becomes more compelling at the point of viability, and therefore the state is permitted to place restrictions on post-viability abortions—with exceptions to preserve the health or life of the woman. The court determined that this principle "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 the pregnancy to term."[103] Moreover, in *Roe* and *Casey*, the Supreme Court made clear that the state's interest in the protection of potential life "is insufficient to override the woman's interest in preserving her health."[104]

The court then considered the four state interests that have generally been recognized as qualifying patients' rights in medical decision-making cases: the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession.[105] The prevention of suicide and the ethical integrity of the medical profession clearly did not apply in this case. The court acknowledged that some might argue that the preservation of life could apply to the preservation of fetal life, but courts have traditionally considered this factor to apply to the preservation of the life of the person making the decision. And the state's interest in the protection of third parties did not override Doe's right to refuse medical treatment for two reasons. First, "third parties" refer to family members,

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cannot be compelled to do or not do anything merely for the benefit of her unborn child." 632 N.E.2d at 332.

100. *In re Baby Boy Doe*, 632 N.E.2d at 329 (first citing Jefferson v. Griffin Spalding Cty. Hosp. Auth., 274 S.E.2d 457 (Ga. 1981); then citing *In re* A.C., 573 A.2d 1235 (D.C. 1990)).

101. *In re Baby Boy Doe*, 632 N.E.2d at 334 (first citing Roe v. Wade, 497 U.S. 261 (1990); then citing Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992)).

102. *Id.* at 333–34.

103. *Id.* at 334.

104. *Id.*

105. *Id.*

especially already-born children, of the person refusing medical treatment. Additionally, there is a stark difference between a forced blood transfusion and a cesarean section. Precedent ordering a forced blood transfusion for the benefit of a fetus "cannot be persuasive in a case involving a forced cesarean section."[106]

Finally, as in *In re A.C.*, the *Baby Boy Doe* court invoked the issue of physical force, noting that "[w]e simply cannot envision issuing an order that, if enforced at all, could be enforced only in this fashion."[107] Doe ultimately delivered a healthy baby vaginally.[108]

Although the *In re A.C.* and *In re Baby Boy Doe* decisions seemed to suggest that courts were moving away from the use of a balancing test, a U.S. District Court found that a court order compelling a woman to undergo a C-section did not violate her constitutional rights in the 1999 case *Pemberton v. Tallahassee Memorial Regional Medical Center*.[109] Laura Pemberton was at home in active labor when her doctors, under the belief that she was risking the life of her fetus by attempting a VBAC, sought a court order compelling Pemberton to undergo an unwanted C-section.[110] A sheriff came to Pemberton's home, strapped her legs together, and forced her to go to the hospital where the emergency hearing regarding the C-section was being held.[111] The judge granted the order, and doctors performed the surgery on Pemberton. Although doctors initially sought the order because they believed a VBAC would endanger the life of Pemberton's fetus, this medical prediction proved questionable after Pemberton gave birth to three more children vaginally.[112]

After Pemberton's doctors performed the court-ordered C-section, Pemberton brought a claim in federal court for violations of her constitutional rights.[113] The district court found that Pemberton's rights were not violated because the state's interest in preserving the life of the fetus outweighed Pemberton's personal constitutional rights.[114] Because *Roe* established that the state's interest in the preservation of potential life outweighs the mother's constitutional right

106. *Id.*

107. *Id.* at 335.

108. *Id.* at 329.

109. 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

110. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973—2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299, 306–07 (2013).

111. *Id.*

112. Paltrow & Flavin, *supra* note 110, at 307.

113. *Pemberton*, 66 F. Supp. 2d at 1250.

114. *Id.* at 1251–52.

to an abortion at the point of viability, the court concluded that "[t]he balance tips far more strongly" towards the state's interest in the case of a forced C-section, as "[b]earing an unwanted child is surely a greater intrusion on the mother's constitutional interests than undergoing a cesarean section to deliver a child that the mother affirmatively desires to deliver."[115]

III. REVISITING THE APPLICATION OF A BALANCING TEST TO FORCED CESAREANS

Courts have reached different conclusions as to whether forced C-sections violate the constitutional rights of pregnant women. As recognized by the appellate courts in *In re A.C.* and *In re Baby Boy Doe*, balancing the pregnant woman's constitutional rights against the state's interest in the protection of potential life is improper for several reasons. First, courts that have used a balancing test to override a pregnant woman's constitutional rights have improperly relied on *Roe v. Wade*. *Roe*'s recognition of the state's interest in potential life was narrowly applied to states' ability to enact abortion restrictions. Additionally, these courts have ignored a major premise of *Roe* and *Casey*: post-viability abortion restrictions must contain exceptions to protect the health and life of the mother.

Second, as recognized by *In re Baby Boy Doe*, the four state interests that courts have generally considered in the context of a competent adult's refusal of medical treatment are not sufficient to override a pregnant woman's medical decisions. This is especially true of forced surgery—no court has ever compelled a competent adult to have unwanted surgery in any other context. Third, compelled C-sections create a false adversarial relationship between the mother and fetus and give rise to serious public health concerns, which disproportionately impact low-income women and women of color. Finally, forced C-sections and other forced interventions of pregnant women relegate pregnant women to second-class citizenship, inviting the possibility of unlimited state surveillance and intervention of pregnant women.

A. Forced Surgery and the State's Interest in Potential Life as Recognized by Roe v. Wade

In *Roe* and *Casey*, the Supreme Court recognized the state's interest in the protection of potential life and established that states may limit abortion at the point of viability, as long as the limitations include exceptions for the preservation of the mother's life and health. Some courts have used *Roe* and *Casey*'s recognition of the states' interest in the protection of potential life to justify forced C-sections, balancing the state's interest against the woman's constitutional rights.

115. *Id.* at 1251 (citing Roe v. Wade, 497 U.S. 261 (1990)).

However, as the court recognized in *In re Baby Boy Doe*, *Roe*, and *Casey* more narrowly applied to the question at issue in those cases: whether states may place limitations on women's access to abortion procedures.[116]

In contrast, the court in *Pemberton* applied the state's interest in potential life recognized by *Roe* to forced C-sections. The court concluded that forced surgery is a lesser invasion of a woman's constitutional rights than restricting a woman's ability to have an abortion because she has chosen to have the child and only the surgery itself is unwanted.[117] There is a stark difference, however, between placing a restriction on a person's ability to procure a certain procedure and forcing a person to undergo major surgery for another's benefit. Despite the casual attitude in the United States towards C-sections, a C-section is major abdominal surgery, with increased risks and recovery time. Further, courts tend to view surgery as a particularly invasive procedure different from other medical interventions.[118]

For example, in *Winston v. Lee*,[119] the Supreme Court found that surgery on an attempted robbery suspect's chest to remove a bullet fired by the victim was unreasonable under the Fourth Amendment.[120] The Court concluded that the suspect's interests in privacy and security outweighed the state's need for evidence.[121] The Court emphasized that the surgery was a "severe" intrusion of the suspect's interests and considered the uncertainty of the medical risks of the surgery, such as risks of infection and risks of injury to muscle, nerves, blood vessels, and tissue; the risks, "although apparently not extremely severe, [were the] subject of considerable dispute."[122]

Similarly, the courts in *In re A.C.* and *In re Baby Boy Doe* seemed to place special emphasis on the fact that C-sections are a major surgery, constituting a "massive intrusion into a person's body."[123] Additionally, the brutality of forcing such a major surgery on a patient should not be overlooked. For instance, in one extreme example occurring in 1984, a Nigerian woman in a Chicago hospital refused a C-section, and the hospital obtained a court order without informing the

116. *In re* Baby Boy Doe, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994).

117. *Pemberton*, 66 F. Supp. 2d at 1251.

118. Knopoff, *supra* note 64, at 526–27; Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1984–85 (1986).

119. 470 U.S. 753 (1985).

120. *Id.* at 755.

121. *Id.* at 766–67.

122. *Id.* at 764, 766.

123. *In re* A.C., 573 A.2d 1235, 1252 (D.C. 1990); *In re* Baby Boy Doe, 632 N.E.2d 326, 335 (Ill. App. Ct. 1994).

woman or her husband.[124] After the doctor informed them of the court order, the woman and her husband became angry; the woman was placed in leather wrist and ankle cuffs, attached to the four corners of the bed, as she screamed for help and bit through her intravenous tubing.[125]

Moreover, courts that have looked to *Roe* and *Casey*'s recognition of the state's interest in the protection of fetal life have failed to address a major principle set forth by these cases: states may only place limitations on post-viability abortions if they contain exceptions to protect the health and the life of the mother.[126] As noted by the *Baby Boy Doe* court, the Supreme Court clearly established that the state's interest in protecting potential life is not sufficient to outweigh the woman's life or health.[127] Compelled C-sections necessarily impose some increased risks to a woman's health. Although C-sections can be lifesaving in some circumstances, the risks of maternal mortality and severe morbidity as a result of a C-section can be up to three times higher than the risks associated with vaginal birth.[128]

Moreover, when a C-section is conducted by coercion or force, the bodily intrusion and loss of autonomy may constitute trauma and has serious mental health implications, including the possibility of PTSD.[129]

124. Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 9–10 (1987).

125. *Id.*

126. Roe v. Wade, 497 U.S. 261, 163–64 (1990) ("If the 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."). In *Planned Parenthood v. Casey*, the Court reaffirmed that the state may "restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health." 505 U.S. 833, 846 (1992).

127. *In re Baby Boy Doe*, 632 N.E.2d at 334.

128. *See* Shiliang Liu et al., *Maternal Mortality and Severe Morbidity Associated with Low-Risk Planned Cesarean Delivery Verusus Planned Vaginal Delivery at Term*, 176 CAN. MED. ASS'N J. 455, 457, 458 tbl. 2 (2007).

129. *See, e.g.*, Rachel Reed et al., *Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions*, BIO. MED. CENT. PREGNANCY AND CHILDBIRTH, Dec. 2017 (describing women's experiences of birth trauma, including forced or coercive C-sections, as created or exasperated by the prioritization of health providers' own agenda over needs of the patient, lies and threats related to forced interventions, and violation related to a lack of control, which some women compared to sexual assault or rape); Susan Ayers et al., *The Aetiology of Post-Traumatic Stress Following Childbirth: A Meta-Analysis and Theoretical Framework*, 46 PSYCHOL. MED. 1121 (2016) (finding that risk factors during childbirth most strongly associated with PTSD include negative birth experiences and having an operative birth, including a C-section); Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH 216,

In one study, women who lacked control during their birth experience associated it with a sense of violation, and some "used language associated with sexual assault and rape."[130] Another study had similar results, with women framing their traumatic birth experiences "in a context of abuse, torture, and violence."[131]

B. State Interests Generally Recognized by Courts in Refusal of Medical Treatment Cases

Courts that have balanced state interests against an individual's constitutional right to refuse medical treatment have generally considered four state interests: the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession. As recognized by the court in *In re Baby Boy Doe*, of these state interests, the only interests that arguably apply when a competent woman refuses a C-section are the preservation of life and the state's interest in the protection of third parties.[132]

However, as traditionally applied, these two interests cannot justify forced C-sections. First, courts have typically applied the state's interest in the preservation of life to the life of the person refusing the medical treatment, rather than third parties.[133] Further, courts have never used the state's interest in the protection of third parties to justify forced surgery in any other context. Courts have considered the impact that a parent's refusal for medical treatment would have on minor children in the context of blood transfusions and life support.[134] However, with the exception of forced C-sections, no court has ever compelled a competent adult to have unwanted surgery, even for their own child. As noted by a Washington Post article published after the *In re Madyun* decision, "if Ayesha Madyun's baby had lain just outside her body, in mortal need of a kidney or bone marrow only she could provide, the state could not have forced her cut open to save the baby's

225 (2011) (finding that a high level of obstetric intervention, such as cesarean delivery, is associated with PTSD after childbirth); Gill Thomson & Soo Downe, *Widening the Trauma Discourse: The Link Between Childbirth and Experiences of Abuse*, 29 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 268 (2008) (finding that trauma was related to the patient's relationships with healthcare professionals and self-described traumatic birth experiences had commonalities with victim accounts of violent criminal offenses).

130. Reed et al., *supra* note 129, at 7.

131. Thomson & Downe, *supra* note 129, at 272.

132. *In re Baby Boy Doe*, 632 N.E.2d at 334–35.

133. *Id.* at 334.

134. *See, e.g.*, *In re* Jamaica Hosp., 491 N.Y.S.2d 898 (N.Y. App. Div. 1985); Crouse-Irving Memorial Hosp. v. Paddock, 485 N.Y.S.2d 443 (N.Y. App. Div. 1985); *In re* Dubreuil, 626 So. 2d 819 (Fla. 1993).

life."[135] This leads to an odd contradiction in which a fetus is afforded greater constitutional rights than a person.[136]

C. Public Policy Concerns

Forced C-sections give rise to a number of public policy concerns and have been opposed by organizations like the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG).[137] In 2016, the ACOG issued a committee opinion finding that competent pregnant women have the right to refuse medical treatment and "in the strongest possible terms" discouraged the use of "duress, manipulation, coercion, physical force, or threats . . . to motivate women toward a specific clinical decision."[138] The ACOG opinion expressly opposed the use of judicial intervention.[139] Additionally, in *In re A.C.*, the court quoted an *amicus curiae* brief submitted by the American Public Health Association, expressing concern that "court ordered intervention[s] . . . [drive] women at high risk of complications during pregnancy and childbirth out of the health care system to avoid coerced treatment."[140]

Further, advocates and scholars have argued that forced C-sections create a false adversarial relationship between a mother and her fetus, or a "maternal-fetal conflict."[141] The phrase refers to the idea that the mother and the fetus have conflicting interests and that the mother may put her interests above those of her fetus, endangering the fetus's well-being.[142] As one scholar described, when judges grant orders for the performance of forced C-sections, "doctors receive a message . . . that paternalism towards expecting mothers is not only acceptable, but necessary."[143]

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135. Gorney, *supra* note 71.

136. *Roe v. Wade* recognized that for purposes of the Fourteenth Amendment, a fetus is not a person. 410 U.S. 113, 158 (1973).

137. Redden, *supra* note 1.

138. Committee on Ethics, *Refusal of Medically Recommended Treatment During Pregnancy*, Am. Coll. Obstetricians & Gynecologists, Committee Opinion No. 664, June 2016, at 2.

139. *Id.*

140. *In re* A.C., 573 A.2d 1235, 1248 (1990) (quoting Brief for American Public Health Association as Amicus Curiae).

141. *See, e.g.*, Elizabeth Kukura, *Obstetric Violence*, 106 Geo. L.J. 721, 776–78 (2018); Elizabeth Eggleston Drigotas, *Forced Cesarean Sections: Do the Ends Justify the Means?*, 70 N.C. L. Rev. 297, 314–15 (1991).

142. Kukura, *supra* note 141, at 776–77.

143. Margaret M. Donohoe, *Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating It, the Role of the Law in Stopping It*, 11 Wis. Women's L. J. 197, 235–36 (1996).

The belief that women cannot be trusted to make decisions for themselves and their families is particularly alarming given that, in several of the most high-profile cases, the medical predictions that provided the basis for the requested court order have been incorrect. For example, in *Jefferson*, doctors testified that there was a 99 percent chance the baby would not survive a natural birth, and it was "virtually impossible" for the condition to reverse itself; but the condition did reverse itself, and Jefferson gave birth to a healthy baby vaginally.[144] In *In re A.C.*, it was discovered after the C-section that the baby did not have an infection, the basis for the court-ordered C-section.[145] And in *In re Baby Boy Doe*, the trial court's findings included that the fetus's chances of surviving a natural birth were close to zero, but Doe gave birth to a healthy baby vaginally.[146] Further, in a 2004 case in which a Pennsylvania court granted an order for a compelled C-section, the woman fled the hospital in active labor and delivered a healthy baby vaginally.[147] Given that doctors' predictions are not always correct, it is troublesome that doctors and courts may be afforded the ability to make a "wrong" decision, but the patient herself may not. As Lynn Paltrow, a lawyer in Angela Carder's case, questioned at the time: "Why is it okay for the court to make a decision that results in a tragedy, but not okay for the woman on whom the surgery is going to be forced to make a decision that may result in tragedy?"[148]

No recent studies have documented the demographics of patients subjected to court-ordered C-sections, but a 1990 survey found that of the forty-seven cases in which the race of the patient could be identified, 80 percent of the patients were women of color.[149] Decisions by doctors and hospitals to request court-ordered C-sections have been criticized by scholars as being driven arbitrarily by stereotypes about the ability of women, particularly women of color, to make the right decisions for their families.[150] Along these lines, a committee opinion by the ACOG highlighted the importance of informed consent in the area of perinatal care, noting that there is "a historical imbalance of power in gender relations and in the physician-patient relationship, the constraints on

144. *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457, 458 (1981); Rhoden, *supra* note 118, at 1986–87.

145. *In re A.C.*, 573 A.2d at 1264; Gorney, *supra* note 71.

146. *In re* Baby Boy Doe, 632 N.E.2d 326, 328 (1994); Kukura, *supra* note 141, at 739–40.

147. WVHCS-Hosp., Inc. v. Doe, No. 3-E 2004 (Pa. Ct. Com. Pl. Jan. 14, 2004); Paltrow & Flavin, *supra* note 110, at 325, 330.

148. Gorney, *supra* note 71.

149. Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 Hastings L.J. 569, 613 (1992).

150. *See, e.g.*, Kukura, *supra* note 141, at 739; Nancy Ehrenreich, *Colonization of the Womb*, 43 Duke L.J. 501, 520–21 (1993).

individual choice posed by compelled medical technology, and the intersection of gender bias with race and class bias in the attitudes and actions of individuals and institutions."[151]

This issue corresponds with the larger problem of the high rates of maternal mortality and morbidity in the U.S., particularly among women of color, which has recently received increased attention from the media and the public.[152] Some studies have found that in recent years, rates of maternal mortality have increased.[153] While the possible reasons for the high rates of maternal mortality and morbidity are varied, one reason that has been cited by experts is the increase in the rate of C-sections.[154] The World Health Organization has asserted that the ideal C-section rate is between ten and fifteen percent of births; once the rate is higher, there is no evidence that C-sections reduce

151. Committee on Ethics, *Informed Consent*, Am. Coll. Obstetricians & Gynecologists, Committee Opinion No. 439, Aug. 2009, at 4.

152. *See, e.g.*, Jacqueline Howard, *Beyoncé, Serena Williams Bring Attention to Risks of Childbirth for Black Women*, CNN (Aug. 6, 2018, 4:52 PM), https://www.cnn.com/2018/08/06/health/beyonce-vogue-pregnancy-complication-bn/index.html [https://perma.cc/W29A-6PLW]; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. Times (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html [https://perma.cc/W9W3-ZB4Q]; Sari Aviv, *Maternal Mortality: An American Crisis*, CBS NEWS (Aug. 5, 2018, 10:06 AM), https://www.cbsnews.com/news/maternal-mortality-an-american-crisis/ [https://perma.cc/S2PY-5AFL]; Nina Martin, *U.S. Has the Worst Rate of Maternal Deaths In The Developed World*, NPR (May 12, 2017, 10:28 AM), https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world [https://perma.cc/6UH8-C46M].

153. Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstretrics & Gynecology 447, 450 (2016).

154. Alexandria Sifferlin, *Why U.S. Women Still Die During Childbirth*, TIME (Sept. 27, 2016), http://time.com/4508369/why-u-s-women-still-die-during-childbirth/ [https://perma.cc/4KBK-U365]; Molly Redden, *'A Third of People Get Major Surgery to be Born': Why are C-sections Routine in the US?*, Guardian (Oct. 4, 2017), https://www.theguardian.com/lifeandstyle/2017/oct/04/one-in-three-us-births-happen-by-c-section-caesarean-births [https://perma.cc/2SQP-LKYR]; Katherine Ellison & Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications Are Growing In U.S.*, NPR (Dec. 22, 2017, 12:17 PM), https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s [https://perma.cc/7E5K-T8NX].

maternal or newborn mortality.[155] In the United States, however, C-sections account for 31.9 percent of births.[156]

Experts have cited various factors to explain the high C-section rates in the U.S. One factor is the practice of defensive medicine, as physician fears of malpractice liability are associated with at least some increased likelihood that physicians will recommend C-sections.[157] One woman, Jennifer Goodall, who was coerced into having a C-section in 2010, said that the hospital's counsel explained "they would rather have a lawsuit against the hospital for . . . doing physical harm to me for giving me a surgery against my will than having litigation for something going wrong with my VBAC."[158] Another factor is the excessive use of the electronic fetal monitor in U.S. hospitals for low-risk births. Misinterpretations of the monitor are common, causing physicians to push for C-sections based on false reads of fetal distress.[159] These health and policy concerns underscore the importance of pregnant patients' ability to exercise their constitutional rights by refusing unwanted C-sections, which are overused and carry greater risks than vaginal births.

D. Second-Class Citizenship for Pregnant Women

Explicitly or implicitly underlying justifications for forced C-sections and the use of a balancing test in this context is an assumption that pregnant women are a unique class of people with diminished constitutional rights. For example, the dissent to the D.C. Supreme Court's *In re A.C.* decision justified the application of a balancing test on the grounds that pregnant women, because they have "undertaken to bear another human being," are a "unique category of persons."[160] The dissent argued that intrusions on the constitutional rights of

155. World Health Org., *WHO Statement on Caesarean Section Rates* (2015), http://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=5C60FAF3056B5F4CD564B383623C8FDC?sequence=1 [https://perma.cc/B2Q2-DQW4].

156. Joyce A. Martin et al., *Births: Final Data for 2016*, 67 NATIONAL VITAL STATISTICS REPORT 1, 7 (Jan. 31, 2018), https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf [https://perma.cc/5J4L-U7PG].

157. *See, e.g.*, Yvonne W. Cheng et al., *Litigation in Obstetrics: Does Defensive Medicine Contribute to Increases in Cesarean Delivery?*, 27 J. MATERNAL-FETAL & NEONATAL MED. 1668 (2014); Y. Tony Yang et al., *Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section*, 47 MED. CARE 234, 235, 241 (2009).

158. Theresa Morris & Joan H. Robinson, *Forced and Coerced Cesarean Sections in the United States*, 16 CONTEXTS 24, 29 (2017).

159. Jacqueline H. Wolf, *American Women Are Having Too Many Cesareans, at Too Much Risk*, L.A. TIMES (Jul. 29, 2018, 4:05 AM), http://www.latimes.com/opinion/op-ed/la-oe-wolf-cesarean-rates-and-fetal-heart-monitors-20180729-story.html# [https://perma.cc/AG9S-5N2P].

160. *In re* A.C., 573 A.2d 1235, 1256 (D.C. 1990) (Belson, J., dissenting).

pregnant women that would not be justifiable on any other category of people are reasonable because "the viable unborn child is literally captive within the mother's body."[161]

The slippery slope of court-mandated medical procedures feared by the *Mcfall* court[162] becomes even more perilous for pregnant women. The argument of the *In re A.C.* dissent, that intrusions of the constitutional rights of pregnant women are justifiable because they are a unique category of people, could justify putting pregnant women under unlimited state surveillance and relegating pregnant women to second-class citizenship with diminished constitutional rights.[163] Illustrating this concern, in some forced C-section cases, courts have authorized police to bring women to the hospital if they do not arrive voluntarily.[164] Additionally, claims that the legal rights of a fetus diminish the pregnant woman's constitutional rights have led to a variety of documented arrests and forced interventions of pregnant women, such as arrests for delaying a C-section, not getting to the hospital quickly enough during labor, not following medical advice to rest during pregnancy, exposing a fetus to dangerous fumes in the air, and drug use.[165] In a majority of these documented cases, women gave birth to healthy babies.[166] Nevertheless, factors potentially impacting the health of a fetus that could be used to justify state intervention are limitless.

IV. Birth Directives

In the 1980s, as courts were beginning to wrestle with requests for forced C-sections, they were simultaneously bolstering protections for competent patients to make their own medical decisions in cases such as in *In re Quinlan*[167] and *Cruzan v. Dept. of Health*.[168] *In re Quinlan* and *Cruzan* involved end-of-life decision making and coincided with the movement by states to develop advance directive laws, which were developed to provide protection for vulnerable patients and to ensure that their wishes regarding medical treatment are followed.[169] Ideally,

161. *Id.*

162. McFall v. Shimp, 10 Pa. D. & C. 3d 90, 91–92 (1978).

163. Lynn M. Paltrow, Roe v Wade *and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration*, 103 Am. J. Pub. Health 17, 17 (2013).

164. Gallagher, *supra* note 124, at 47.

165. Paltrow & Flavin, *supra* note 110, at 313–14.

166. Paltrow, *supra* note 163, at 18.

167. 355 A.2d 647 (N.J. 1976).

168. 497 U.S. 261 (1990).

169. *In re Quinlan*, 355 A.2d at 651; *Cruzan*, 497 U.S. at 261.

states should similarly develop statutes to protect the choices of pregnant women regarding medical treatment.

Further, advocates in maternity care have expressed the need for a movement by pregnant patients demanding autonomy over their medical decisions.[170] Even without legislation, one way for patients to assert their autonomy is through a model similar to advance directives, in which a pregnant individual could draft a birth directive during pregnancy that details under what specific circumstances the patient consents to a C-section and present the document to her medical providers.

Advance directives, whether statutory or nonstatutory, are enforceable through the constitutional right to refuse medical treatment and common law right to informed consent.[171] Thus, a "birth directive," or a form modeled on advance directives, should likewise be enforceable as a safeguard for pregnant women's constitutional rights. The enforceability of a birth directive should be even more apparent than an advance directive because, in the case of a birth directive, the patient is presumably still competent and clearly has not changed her mind since the execution of the document. However, whether a court would agree to honor a birth directive would likely depend on the jurisdiction. D.C., for example, would likely find the document enforceable based on the highest court's decision in *In re A.C.*,[172] and given that D.C. does not place any restrictions on the enforceability of a pregnant woman's advance directive.[173]

A birth directive could take the following form:

170. Sarah Yahr Tucker, *There Is a Hidden Epidemic of Doctors Abusing Women in Labor, Doulas Say*, BROADLY (May 8, 2018, 12:08 PM), https://broadly.vice.com/en_us/article/evqew7/obstetric-violence-doulas-abuse-giving-birth [https://perma.cc/3ERN-W2Y6].

171. Carol J. Wessels, *Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives*, 6 MARQUETTE ELDER'S ADVISOR 217, 217 (2015).

172. *In re A.C.*, 573 A.2d at 1252–53.

173. *See supra* note 59 and accompanying text.

Birth Directive Declaration

This declaration serves as an extension of my constitutional right to refuse unwanted medical treatment and my common law right to informed consent. To protect these rights, this declaration documents under which circumstances, if any, I consent to a C-section.

I, _____, am competent and of sound mind, and I consent to a C-section only under the following circumstances:

[ ] I refuse to consent to a C-section under any circumstance.

[ ] I consent to a C-section only if _____ (number of doctors or names of doctors) believe it is necessary to preserve the life of the fetus.

[ ] I consent to the performance of a C-section only if _____ (number of doctors or names of doctors) doctors believe it is necessary to save my own life.

[ ] I consent to the performance of a C-section only under the following circumstance(s):

_____
_____
_____
_____
_____
_____
_____
_____.

I retain the right to withdraw my consent at any time.

Signed: _____

Date: _____[174]

Although the scope of this Comment is limited to forced and coerced C-sections, this form could include other medical interventions that are performed without pregnant patients' consent, such as episiotomies.

CONCLUSION

The Supreme Court has not addressed the validity of forced C-sections, and courts to consider the issue have reached differing conclusions. Courts that have authorized court-ordered C-sections or that have found such orders to be constitutional have applied a balancing test to conclude that the state's interest in protecting potential fetal life, as recognized by *Roe v. Wade*, outweighs the constitutional rights of the patient. These courts, however, have

174. Depending on the state, additional formalities may be advisable, such as notarization or filing the document with the state's health department.

misapplied *Roe*, failed to address the magnitude of women's constitutional right to refuse medical treatment, and have ignored pressing public policy concerns. These decisions are ultimately based on the dangerous theory that pregnant women are a unique class of persons with diminished constitutional rights, leaving the door open for pregnant women to be subject to potentially unlimited state surveillance and intervention.

Recently, the high rates of maternal mortality and morbidity in the United States have received increased attention, and legislatures should respond by protecting pregnant patients' rights to refuse unwanted medical procedures. Such legislation could be modeled after advance directive statutes, in the form of birth directives. Even in the absence of such legislation, pregnant patients could use birth directive forms to assert their autonomy in medical settings. This model should be enforceable based on the patients' constitutional right to refuse medical treatment and the common law right to informed consent. Until the Supreme Court addresses the validity of court-ordered C-sections, however, such a model would likely only be enforced by certain jurisdictions. Nonetheless, birth directives may provide a way for pregnant patients to begin demanding autonomy to make their own medical decisions during childbirth.

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