A COMPARATIVE ANALYSIS OF THE RIGHT OF A PREGNANT WOMAN TO REFUSE MEDICAL TREATMENT FOR HERSELF AND HER VIABLE FETUS: THE UNITED STATES AND UNITED KINGDOM

I. INTRODUCTION

Few legal topics have raised more debate than the right of a pregnant woman to refuse medical treatment for religious, moral, philosophical, or personal reasons.[1] A woman's decision raises common law, statutory, constitutional, and ethical questions. Courts must define the scope of a pregnant woman's right to privacy in her own bodily integrity and compare that right to the State's interest in protecting the health of the viable fetus.[2] Courts in the United States and United Kingdom have adopted the general rule that a pregnant woman may refuse medical treatment; however, each system provides different exceptions to the general rule.[3] This Note has two purposes. First, this Note will explain the development of a pregnant woman's right to refuse medical treatment in both the United States and the United Kingdom,[4] and second, this Note will explore the situations where each system allows courts to intervene and force treatment. While the judicial system of the United Kingdom allows a court to override a woman's choice in certain circumstances, a majority of courts in the United States have not used this approach. This Note will explain the source of the right to refuse treatment in the United States and United Kingdom and then compare and contrast the exceptions to the general rule in an attempt to formulate the best approach to these precarious moral and legal dilemmas.

II. THE RIGHT TO REFUSE MEDICAL TREATMENT

In both the United States and the United Kingdom, an individual has a right to refuse medical treatment, even life-saving treatment, in most circumstances.[5] The source and development of the legal right varies in the

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1. *See generally* James Nocon, *Physicians and Maternal-Fetal Conflict: Duties, Rights and Responsibilities*, 5 J.L. & HEALTH 1 (1990); Carson Strong, *Court-Ordered Treatment in Obstetrics: The Ethical Views and Legal Framework*, 78 OBS. & GYN. 861-68 (1991).

2. *See generally* Roe v. Wade, 410 U.S. 113 (1973). The Supreme Court defined the scope of maternal and fetal rights in the *Roe* decision.

3. *See generally* St. George's Healthcare N.H.S. Trust v. Collins, [1999] Fam. 26, 1998 WL 1043638; *In re* Fetus Brown, 689 N.E.2d 397 (Ill. App. Ct. 1997).

4. The Note will focus primarily on decisions from courts within England and Wales, which express the majority approach within the United Kingdom. English courts have addressed the issue in numerous cases. This body of case law addresses the different medical, ethical, and legal issues raised within this Note.

5. *See generally* Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990); Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 1993 WL 963744 (HL); *In re* C., [1994]1

two countries; however, the doctrine of informed consent provides the basis for the legal principle in both.[6] The right to refuse medical treatment developed differently in the United States and United Kingdom, and, consequently, it is important to understand the legal analysis in both countries.

A. *United States*

In the United States, a competent adult has the right to refuse medical treatment, even if refusal will result in death.[7] In *Cruzan v. Director, Missouri Department of Health*,[8] the U.S. Supreme Court held that the Due Process Clause of the Fourteenth Amendment to the United States Constitution[9] confers a constitutional right to preserve one's own bodily integrity by avoiding unwanted medical procedures.[10] The Court stated that the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's personal decision to reject medical treatment.[11] Justice O'Connor, in her concurring opinion, stated: "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause."[12] Because the right to refuse treatment implicates a constitutional right, courts must use the most rigorous standard of review when evaluating state intervention.[13]

W.L.R. 290, 1997 WL 1105230.

6. *See generally In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc); *In re* J.T., [1998] Fam. Law 23, 1997 WL 1105230.

7. *See generally* Mark Strasser, *Incompetents and the Right to Die: In Search of Consistent Meaningful Standards*, 83 KY. L.J. 733 (1995).

8. *See Cruzan*, 497 U.S. at 266. The case involved Nancy Cruzan, a twenty-four year old woman, who had lost control and wrecked her car. *See id.* Ms. Cruzan's brain was deprived of oxygen for roughly twelve to fourteen minutes, which placed her in a persistent vegetative state. *See id.* Ms. Cruzan was incompetent, and her parents asked the State of Missouri to remove her life support (i.e., a feeding tube and respirator); however, the hospital refused to remove the tube because it would result in Ms. Cruzan's death. *See id.* at 267-68. The Missouri Supreme Court overturned the trial court's order that directed the hospital to remove the life support. *See id.* at 268. The U.S. Supreme Court granted *certiorari* to determine if Ms. Cruzan, through her representatives, had the right to refuse medical treatment if such refusal would result in death. *See id.* at 269. The Supreme Court held that an individual has the right to refuse medical treatment and the effect of such refusal was not relevant. *Id.*

9. U.S. CONST. amend. XIV, § 1. The pertinent portion states:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Id.

10. *See Cruzan*, 497 U.S. at 278. *See also In re* Baby Boy Doe, 632 N.E.2d 326, 331 (Ill. App. Ct. 1994).

11. *See Cruzan*, 497 U.S. at 281.

12. *Id.* at 287 (O'Connor, J., concurring).

13. *See id.* at 281.

The right to refuse medical treatment is well established in American jurisprudence. At common law, the touching of another without that person's consent was considered battery.[14] The Supreme Court noted that "[n]o right is held more sacred . . . by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[15]

In the medical context, the doctrine of informed consent protects an individual's bodily integrity.[16] Informed consent is a legal construct, which has evolved over the past thirty years into a complex doctrine designed to promote autonomous decision-making.[17] Justice Cardozo once wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[18] In addition to their ethical obligations, courts impose a legal duty on physicians to inform their patients of all the risks associated with a surgery before obtaining consent to perform that surgery.[19] After receiving information concerning a surgery, the patient has the choice of whether to consent or refuse the treatment.[20] Chief Justice Rehnquist concluded that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[21] Consequently, physicians may be held responsible for failing to abide by a patient's choice.

Two cases in particular demonstrate the potential liability physicians face for failing to abide by their patient's wishes. In *Shorter v. Drury*,[22] the husband of a Jehovah's Witness brought an action against the obstetrician who treated his pregnant wife.[23] The obstetrician cut the woman's uterus and caused profuse bleeding.[24] Despite the immediate necessity of a blood transfusion, the patient refused and died from the loss of blood.[25] The jury found the physician negligent and awarded $412,000 in damages.[26] The jury

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14. *See id.* at 269.

15. Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

16. *See* Alan Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCH. 285, 286-87 (1977).

17. *See id. See also* Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996).

18. Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914).

19. *See generally* Meisel, *supra* note 16, at 287.

20. *See id.*

21. *Cruzan*, 497 U.S. at 270.

22. Shorter v. Drury, 695 P.2d 116, 118-19 (Wash. 1985).

23. *See id.* at 119.

24. *See id.* The physician was in a precarious situation because his negligence had caused the bleeding, yet he could take no remedial action to fix his error. *See id.* The woman would either die because of his mistake or he could save her life by compromising the woman's religious beliefs. *See id.* Under either facts, the physician faced liability for his actions. *See id.*

25. *See id.* at 118-19.

26. *See id.* at 119.

determined that the woman was 75% at fault for her refusal and reduced the damages accordingly to $103,000.[27] The Washington Supreme Court upheld the judgment and noted that the physician had informed the woman of the risk, which she chose to assume when she refused the transfusion.[28] It was the woman's refusal, not the physician's error that resulted in death.[29] One should note that the physician was not charged with malpractice for abiding by the woman's choice.[30]

Similarly, in *Corlett v. Caserta*,[31] a woman brought suit against a physician because the physician had abided by the wishes of her husband not to receive blood transfusions.[32] Upon the husband's death, his wife brought a malpractice suit.[33] The Illinois Court of Appeals held that the patient's choice to refuse a blood transfusion did not bar recovery for the physician's negligence; however, the refusal should reduce the recovery proportionally.[34] Because a competent adult has the right to refuse medical treatment, the court stated that an individual cannot impose liability upon a physician who disagrees with the consequences of the choice.[35] *Corlett* teaches that when physicians inform a patient of the risks and potential consequences of an action, and even then the patient refuses treatment, then the physician is not liable for the patient's actions.[36]

A competent adult may also refuse medical treatment for religious beliefs under the First Amendment of the United States Constitution.[37] Although those cases normally involve Jehovah's Witnesses, an individual may refuse medical treatment due to a number of traditional or non-traditional religious beliefs.[38] Both the First and Fourteenth Amendments of the U.S. Constitution guarantee that an individual has the right to refuse medical treatment.

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27. *See id.*

28. *See id.* at 123.

29. *See id.* at 124.

30. *See id* at 119-21. The court noted that the use and form of a medical release was appropriate. *See id.* at 120. The lack of a release would require the hospital to seek a court order to override the woman's decision. *See id.* The release clearly stated the woman's wishes, and, if it had not, then the outcome may have been different. *See id.*

31. Corlett v. Caserta, 562 N.E.2d 257 (Ill. App. Ct. 1990). *See also* Joelyn Knopf Levy, *Jehovah's Witnesses, Pregnancy, and Blood Transfusions: A Paradigm for the Autonomy Rights of All Pregnant Women*, 27 J.L. MED. & ETHICS 171, 173 (1999).

32. *See Corlett*, 562 N.E.2d at 257-58.

33. *See id.*

34. *See id.* at 259-60.

35. *See id.*

36. *Id.*

37. *See* U.S. CONST. amend. I. *See also* Cantwell v. Connecticut, 310 U.S. 296, 303 (1940).

38. *See generally* Julie A. Koehne, *Witnesses on Trial: Judicial Intrusion Upon the Religious Practices of Jehovah's Witness Parents*, 21 FLA. ST. U. L. REV. 205 (1993).

B. United Kingdom

In the United Kingdom, courts operate on the legal principle that each individual's body is inviolate unless the individual consents to the surgical procedure.[39] There are a few exceptions; however, courts generally defer to an individual's choice even under the exceptions.[40] Generally, if a doctor performs medical treatment without obtaining a competent patient's consent, then his or her action violates medical ethics and a legal duty. In those situations, an individual may sue a doctor under the civil action for trespass of the person or criminally as an assault.[41] The consent must be informed, as doctors in the United Kingdom have an absolute duty to warn patients of all potential risks involved with a medical procedure before obtaining consent.[42] If a doctor informs the patient of all foreseeable risks, then the patient may decide to refuse the treatment, regardless of the effect that decision might have on the patient.[43]

III. THE RIGHTS OF PREGNANT WOMEN AND THE UNBORN FETUS

Pregnant women are presented with health issues that are both private and personal. Although each woman makes a choice to become pregnant (unless the woman was raped), no woman has an obligation to keep a fetus in her body under American or English law.[44] Courts in the United States and United Kingdom agree that pregnant women have a unique set of personal interests related to the pregnancy, which the courts must protect.[45] Both countries also agree that a viable fetus has limited right, and, consequently, it

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39. *See generally* Marc Stauch, *Rationality and the Refusal of Medical Treatment: A Critique of the Recent Approach of the English Courts*, 21 J. MED. ETHICS 162, 163-65 (1995); Robert Francis, *Compulsory Caesarean Sections: An English Perspective*, 14 J. CONTEMP. HEALTH L. & POL'Y 365 (1998).

40. *See* Francis, *supra* note 39, at 366-67. *See also* Gillick v. West Norfolk & Wisbech Area Health Authority, [1986] A.C. 112, 1985 WL 311014, at 2. Under English law, a person with parental authority may provide consent for a minor to undergo or forego medical treatment. *See id.* The minor may consent himself or herself, if he or she can show a sufficient degree of maturity. *See id.*

41. *See id. See also* Sidaway v. Bd. of Governors of Royal Bethlem & Maudsley Hosp., [1985] A.C. 871, 1985 WL 311459 (HL), at 10-11. The right to refuse treatment in the United Kingdom remains grounded on the traditional common law torts. *See id.* The key question is: what distinction should be made between medical treatment and assault? *See id.* In the United Kingdom, there is not a distinct difference. In the United States, there is a critical distinction.

42. *See* Francis, *supra* note 39, at 366.

43. *See id. See also In re* F., [1988] Fam. 122, 1988 WL 624168 (CA); *In re* S., [1993] Fam. 123; *In re* T., [1993] Fam. 95, 1992 WL 895109 (CA).

44. *See generally* Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992); Paton v. British Pregnancy Advisory Service Tr., [1979] Q.B. 276, 1978 WL 57203 (QBD).

45. *See Paton*, 1978 WL 57203, at 1.

is worth noting the development of women's rights and fetal rights in both countries.

A. *United States*

1. *Maternal Rights*

The Supreme Court of the United States has held that a pregnant woman has a right to personal autonomy and privacy that is not relinquished when she becomes pregnant.[46] This determination was made when the Court considered abortion rights, and it differs significantly from the right of a pregnant woman to refuse treatment that harms the health of a viable fetus.[47] Despite the difference, many of the guiding principles behind *Roe v. Wade* and *Planned Parenthood of Southeast Pennsylvania v. Casey* are involved in cases where a pregnant woman refuses medical treatment.

Perhaps the closest link between the maternal rights in *Roe, Casey*, and the right of pregnant women to refuse treatment can be found in *Thornburgh v. American College of Obstetricians and Gynecologists.*[48] The Supreme Court struck down a Pennsylvania statute that required physicians performing post-viability abortions to use the technique that provided the best opportunity for the fetus to be aborted alive.[49] The Court determined that the statute was unconstitutional because it both forced a "trade-off" between "a woman's health and fetal survival" and stressed that any procedure that increased the risk to the woman's health was unacceptable.[50] Applying this principle to maternal decisions, courts have honored the medical decisions of pregnant women in most circumstances.[51] The Supreme Court recognized the supremacy of maternal health over fetal interests; however, the maternal-fetal conflict has not been completely resolved.

In the United States, courts considering a maternal-fetal conflict distinguish between situations where: (1) a surgery is needed to save the life

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46. *See* Roe v. Wade, 410 U.S. 113 (1973). *See generally Casey*, 112 S.Ct. at 2791; David C. Blickenstaff, *Defining the Boundaries of Fetal Surgery*, 88 NW. U. L. REV. 1157 (1994); Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239 (1991); Lawrence J. Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 JAMA 1060 (1988). These three articles explore and analyze the development of maternal and fetal interests.

47. *See generally* Rebekah R. Arch, *The Maternal-Fetal Dilemma: Honoring a Woman's Choice of Medical Care During Pregnancy*, 12 J. CONTEMP. HEALTH L. & POL'Y 637 (1996); Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 9-58 (1987).

48. Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747 (1986). The Supreme Court's decision in *Casey* has limited the holding of *Thornburgh*; however, the Court's analysis is still instructive for purposes of this Note.

49. *See id.*

50. *Id.* at 768-69.

51. *See In re* Fetus Brown, 689 N.E.2d 397 (Ill. App. Ct. 1997).

of both the mother and fetus; and (2) a surgery is needed to save the life of the fetus at a risk to the mother.[52] The two situations involve separate sets of personal and state interests, and, therefore, courts have approached the cases very differently. When only the health of the fetus is in danger, the courts give absolute deference to the decision of the woman.[53] One court has written:

> A cesarean section, by its nature, presents some additional risks to the woman's health. When the procedure is recommended solely for the benefit of the fetus, the additional risk is particularly evident. It is impossible to say that compelling a cesarean section upon a pregnant woman does not subject her to additional risks — even the circuit court's findings of fact in this case indicate increased risk to [the patient]. Under *Thornburgh*, then, it appears that a forced cesarean section, undertaken for the benefit of the fetus, cannot pass constitutional muster.[54]

It appears that when the health of the mother is compromised, even to small degree, then a court will not overturn the woman's personal decision.[55] When both the health of the woman and fetus are compromised, then a court may be willing to intercede and force treatment, because the State has a compelling interest in protecting the health of both the mother and fetus.[56]

In the United States, the majority approach is that a woman is under no legal duty to guarantee the mental or physical health of her child, and, consequently, she cannot be compelled to do anything merely for the benefit of her unborn child.[57] Under this approach, the mother cannot be forced to compromise her own health for that of a fetus. The interests of the mother take priority over the interests of a viable fetus or the interests of the state.[58] One

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52. In *Thornburgh*, the abortion technique attempted to save the fetus while increasing the risk of harm to the mother. *See generally Thornburgh*, 476 U.S. at 747. The Supreme Court has not been presented with a case that involved the health of both the mother and fetus. *See id. See also In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994).

53. *See generally* Robin M. Trindel, *Fetal Interests vs. Maternal Rights: Is the State Going Too Far?*, 24 AKRON L. REV. 743 (1991).

54. *See generally In re* Baby Boy Doe, 632 N.E.2d 326, 333 (Ill. App. Ct. 1994).

55. *See id.*

56. *See* Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981).

57. *See In re Baby Boy Doe*, 632 N.E.2d at 401. *See generally* Nancy K. Rhoden, *The Judge and Delivery Room: The Emergence of Court-Ordered Obstetrical Interventions*, 74 CAL. L. REV. 1951 (1986); Finer, *supra* note 46, at 239.

58. *See In re Baby Boy Doe*, 632 N.E.2d at 333. The court stated as follows:

> Courts in Illinois and elsewhere have consistently refused to force one person to undergo medical procedures for the purpose of benefiting another person – even where the two persons share a blood relationship, and even where the risk to the first person is perceived to be minimal and the benefit to the second person may be great .... If an incompetent brother cannot be forced to donate a kidney to save the life of his dying sister, then surely a mother cannot be forced to undergo

should note that even under this majority approach, courts may intervene under certain circumstances, such as when a surgery is not "invasive."[59]

2. *Fetal Interests*

In contrast with the majority approach, a few courts have chosen to recognize fetal interests.[60] The Supreme Court of South Carolina, in *Whitner v. South Carolina*,[61] determined that a mother who was addicted to cocaine could be held responsible under South Carolina's child abuse and endangerment statute.[62] The court determined that the legislature intended the word "child" to include a viable fetus.[63] Thus, the court upheld the conviction of the mother for causing her child to be born with cocaine metabolites in its system.[64] The court recognized that a viable fetus has certain rights and interests that the State may protect.[65] This approach is highly controversial, and no other state supreme court has held a mother criminally responsible under a child abuse statute under similar circumstances.[66] The majority of

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a cesarean section to benefit her viable fetus.

Id. at 333-34 (citations omitted).

59. *Id. See also Jefferson,* 274 S.E.2d at 457 (ordering c-section to save both the mother and the fetus); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964)(ordering blood transfusion to save the life of the mother and fetus), *cert. denied*, 377 U.S. 985 (1964); *In re* Jamaica Hospital, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985)(ordering the transfusion of blood to save the life of a pregnant woman and her fetus); Crouse Irving Memorial Hosp., Inc. v Paddock, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985)(ordering blood transfusions as necessary over religious objections to save the mother and fetus).

60. *See Jefferson,* 274 S.E.2d at 457.

61. Whitner v. South Carolina, 492 S.E.2d 777 (S.C. 1997). South Carolina is the only state that has adopted this approach. *See generally* WILLIAM CURRAN ET AL., HEALTH CARE LAW AND ETHICS 848-59 (5th ed. 1998).

62. *See* S.C. CODE ANN. § 20-7-50 (2000). The pertinent portion of the statute reads:

> Any person having the legal custody of any child or helpless person, who shall, without lawful excuse, refuse or neglect to provide . . . the proper care and attention for such child or helpless person, so that the life, health, or comfort of such child or helpless person is endangered or is likely to be endangered, shall be guilty of a misdemeanor and shall be punished within the discretion of the circuit court.

Id.

63. *See Whitner*, 492 S.E.2d at 777-90.

64. *See id.*

65. *See id.*

66. *See* Reinesto v. Superior Court, 894 P.2d 733 (Ariz. Ct. App. 1995); Reyes v. Superior Court, 141 Cal. Rptr. 912 (Cal. Ct. App. 1977); State v. Gethers, 585 So.2d 1140 (Fla. Dist. Ct. App. 1991); Commonwealth v. Welch, 864 S.W.2d 280 (Ky. 1993); State v. Gray, 584 N.E.2d 710 (Ohio 1992); Nevada v. Encoe, 885 P.2d 596 (Nev. 1994); Collins v. State, 890 S.W.2d 893 (Tex. Ct. App. 1994). The preceding list of cases was found in CURRAN, *supra* note 61, at 856. In all the cases, the courts were asked to interpret child abuse statutes. With the exception of the South Carolina Supreme Court, courts have uniformly held that a viable fetus is not a child, and no legislature could intend such a definition absent such wording.

states have uniformly agreed that the fetus does not have protected constitutional rights until birth.[67]

Several other decisions that recognize fetal rights are worth noting; however, the cases are not binding on most jurisdictions within the United States.[68] One court held that the state has a compelling interest in protecting the health of a woman's children, who as third parties, would be deprived by the mother's refusal to undergo medical treatment and her subsequent death.[69] Further, some courts have held that the health of an unborn fetus outweighs a mother's right to refuse treatment in certain circumstances.[70] Despite these exceptional cases, most states follow the view that a competent pregnant woman has an absolute right to refuse medical treatment.[71]

In the United States, a pregnant woman, if competent, has the right to accept or forego medical treatment.[72] A viable fetus has no rights in most jurisdictions within the United States.[73] Consequently, a pregnant woman has no duty to a fetus within her body, as the courts have chosen not to compel one person to permit an intrusion on her body for the benefit of another.[74] The leading case supporting this legal premise is *McFall v. Shimp*,[75] in which a court refused to compel an individual to donate bone marrow to his cousin. The court explained its refusal by stating:

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67. *See generally* CURRAN, *supra* note 61, at 856-57. Some state prosecutors have attempted to prosecute pregnant drug offenders under laws that make it a crime to "deliver" drugs to another person. *See id.* The theory is that the mother ingested drugs and then transmitted the drug through her umbilical cord after the birth of the child. *See id.* All courts that have considered this issue have held that the drug delivery statutes were not intended to cover this type of situation. *See, e.g.*, Johnson v. State, 602 So.2d 1288 (Fla. 1992); State v. Luster, 419 S.E.2d 32 (Ga. Ct. App. 1992); People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App. 1991), *appeal denied*, 471 N.W.2d 619 (Mich. 1991).

68. Some decisions have been overturned, such as the initial Illinois case discussed later in this note. Others are likely invalid due to holdings in the same or other jurisdictions. One should also note that the attitudes of many courts have changed since the initial rulings noted in footnote 66.

69. *See* Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981). *See also In re* Madyun, 114 Daily Wash.L.Rptr. 2233 (D.C. Super. Ct. 1986).

70. *See* Application of President of Georgetown Coll., 331 F.2d 1010 (D.C. Dir. 1964), *cert. denied*, 377 U.S. 985 (1964); Crouse-Irving Memorial Hosp. v. Paddock, 485 N.Y.S.2d 443 (N.Y. App. Div. 1985); *In re Jamaica Hospital*, 491 N.Y.S.2d at 898; Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990).

71. *See* Application of President of Georgetown Coll., 331 F.2d at 1010.

72. *See In re* A.C., 573 A.2d 1235, 1240 (D.C. Cir. 1990)(en banc).

73. *See id.*

74. *See id.*

75. McFall v. Shimp, 10 Pa. D. & C.3d 90 (1978). The plaintiff suffered from a bone marrow disease and had needed a bone marrow transplant to survive. *See id.* The only known match was a cousin, who had consented to the test but refused to donate the marrow. The plaintiff died two weeks after the court issued its decision. *See generally* Fordham E. Huffman, *Coerced Donation of Body Tissues: Can We Live with McFall v. Shimp*, 40 OHIO ST. L.J. 409 (1979).

> The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue. A great deal has been written regarding this rule, which, on the surface, appears to be revolting in a moral sense. Introspection, however, will demonstrate that the rule is founded upon the very essence of our free society . . . . Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another . . . . For our law to compel defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.[76]

In this case, even though Mr. Shimp's refusal to donate his bone marrow meant that his cousin, Mr. McFall, would almost certainly die, the court did not order the invasive surgery.[77] The standard rule was applied in the context of a mother and fetus, and the same result was reached.[78] A mother does not have a duty to her fetus, and she may refuse invasive medical treatment (i.e., cesarean section, fetal surgery, or blood transfusions) if the treatment places the mother at risk.[79]

B. United Kingdom

Under English law, physicians owe certain ethical duties to pregnant women and unborn viable fetuses.[80] These obligations often conflict, and The Royal College of Obstetricians has formulated the following guidelines:

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76. *McFall*, 10 Pa. D. & C.3d at 92-93. The *McFall* decision has been adopted in virtually every jurisdiction within the United States. *See id.*

77. Of all the relatives tested, Mr. Shimp's bone marrow was the only match for Mr. McFall. Mr. Shimp resorted to the court as a last effort to save his life, but, as noted, the court refused. *See id.*

78. *See In re* A.C., 573 A.2d 1235, 1241 (D.C. Cir. 1990)(en banc). Although it was suggested that a mother has an enhanced duty to protect the fetus, the court determined that an unborn child cannot have a greater interest than a living person. *See id.* The mother has no enhanced duty to her fetus, and the mother has a right to refuse an invasive surgery such as a cesarean section. *See id.*

79. *See generally* Eric M. Levine, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229 (1994).

80. *See* Stauch, *supra* note 39, at 163-65.

> The aim of those who care for pregnant women must be to foster the greatest benefit to both the mother or fetus, and inform and advise the family, utilizing their training and experience in the best interests of parties. Obstetricians must recognize the dual claims of mother and her embryo or fetus and inform and advise the family, utilizing their training and experience in the best interest of both parties.[81]

Consequently, there are situations where the mother's health and child's health are opposed to each another.[82] It is under those circumstances that courts have been asked to intervene to protect fetal interests.

In the United Kingdom, courts have carved out a few exceptions to the general rule that competent adults have an absolute right to refuse medical treatment. The courts first acknowledged the possibility of an exception in the case of *In re T*:[83]

> An adult patient who . . . suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, refuse it, or to choose one rather than another of the treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable fetus.[84]

The court outlined two potential exceptions when treatment may be forced. First, courts may force treatment when a patient is mentally incompetent.[85] Second, courts may force medical treatment in certain circumstances when a viable fetus is involved.[86] The development of the exceptions has coincided with the manner in which the competing interests of a pregnant woman and a fetus developed within the English courts.

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81. ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, A CONSIDERATION OF THE LAW AND ETHICS IN RELATION TO COURT-AUTHORISED OBSTETRIC INTERVENTION, §§ 4.3.1 – 4.3.2 (1996). *See also* ACOG COMM. ON ETHICS, AM. COLL. OF OBSTETRICS AND GYNECOLOGY, COMM. OPINION, PATIENT CHOICE: MATERNAL-FETAL CONFLICT 1 (1987). The American College of Obstetrics and Gynecology issued a similar statement that stated: "[T]he obstetrician should be concerned with the health care of both the pregnant woman and the fetus within her, assessing the attendant risks and benefits to each during the course of care." *Id.*

82. *See id.*

83. *In re* T., [1993] Fam. 95, 1992 WL 895109 (CA), at 7.

84. *Id.*

85. *See* Tameside & Glossop Acute Serv. NHS Trust v. C.H., [1996] F.L.R. 762; *See also* St. George's Healthcare, [1999] Fam. 26, 1998 WL 1043638.

86. *See generally id.* The case involved a mentally incompetent pregnant woman and there were two issues involved: her competency and the presence of her fetus. *See id.*

1. *Maternal Rights*

Courts in England and Wales have refused to recognize the competing interests between a mother and a fetus.[87] Those courts have chosen to protect the rights of the pregnant woman by refusing to grant the fetus any standing to challenge the medical decisions of the mother.[88] Similarly, English courts considered and held that an unborn child has no standing to prevent a mother from consenting to an abortion.[89] The court stated that "the authorities . . . show that a child, after it has been born, and only then, in certain circumstances . . . may be a party to an action . . . ."[90] The child attains a legal persona upon birth, and only then, can it assert its rights.[91] The court did note that there are some exceptions when a child may bring a cause of action, however, those exceptions have been codified.[92]

2. *Fetal Rights*

Legislatures in the United Kingdom have taken very little action to protect the rights of unborn fetuses.[93] The English legislature has enacted three pieces of legislative material that are neither consistent nor controlling on the courts.[94] In the Infanticide Act of 1938,[95] the legislature outlawed the destruction of children that are capable of being born.[96] Conversely, the Abortion Act of 1967[97] allowed women to terminate a pregnancy by abortion

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87. *See id.*

88. *See* Paton v. British Pregnancy Advisory Service Tr., [1979] Q.B. 276, 1978 WL 57203, at 3-4. In the case, the court determined that a husband could not stop the abortion of the fetus he fathered. Sir George Baker wrote for the court:

> The first question is whether the plaintiff has a right at all. The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country . . . and is, indeed, the basis of the decisions in those countries where law is founded on the common law . . . there can be no doubt, in my view, that in England and Wales the fetus has no right of action, no right at all, until birth.

Id.

89. *See* C. v. S., [1988] Q.B. 276, 1987 WL 492060, at 3.

90. *Id. See also* Francis, *supra* note 39, at 369.

91. *See* Francis, *supra* note 39, at 369-70.

92. *See generally* Attorney General's Reference No. 3, [1996] 2 W.L.R. 412, 1995 WL 1083798. The opinion dealt with cases where an unborn child was killed with the mother. *See id.* The opinion stated that "Murder or manslaughter can be committed where an unlawful injury is deliberately inflicted either to a child in utero or to a mother carrying a child in utero . . ." *Id.*

93. *See generally* Francis, *supra* note 39, at 369-71. The Article discusses the development of English law.

94. *See id.*

95. Infanticide Act, 1938, c. 36, § 1. The Act outlawed abortions.

96. *See id.*

97. Abortion Act, 1967, c. 36, § 1 (amended by the Human Fertilisation and Embryology

in most cases. The Infant Life (Preservation) Act of 1929[98] and the Abortion Act of 1967[99] caused problems for the English courts for many years.[100] As a result, the English legislature enacted the Human Fertilisation and Embryology Act of 1990[101] to resolve the confusion and bring consistency among the various English courts. Finally, several courts have assumed that the lack of legislation gives women the right to refuse treatment. In the case of *In re F.* the court stated:

> If the law is to be extended . . . to impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child, then under our system of parliamentary democracy it is for Parliament to decide whether such controls can be imposed . . . . If Parliament were to think it appropriate that a pregnant woman should be subject to controls for the benefit of her unborn child, then doubtless it will stipulate the circumstances in which such controls may be applied and the safeguards appropriate for the mother's protection. In such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary to extend the law.[102]

The legislature intended for the courts to continue to use traditional tort theory when analyzing the right of women to refuse medical treatment, rather than creating an independent source for such a right.[103]

The development of common law rights for pregnant women have been controversial and are still evolving.[104] The general common law proposition is well established: "[A] competent adult patient cannot be forced to submit to medical treatment, however well-intentioned, and however necessary to preserve life or health."[105] The common law also allows medical professionals to intervene for incompetent patients and force treatment, if the treatment is in the "best interest" of the patient. This "best interest" standard created the

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Act, 1990, c. 37, § 37).

98. Infanticide Act, 1929, c. 87, § 1.

99. Abortion Act, 1967, c. 36, § 1.

100. *See generally* Francis, *supra* note 39. The Article provides insight into the English statutory scheme.

101. Human Fertilisation and Embryology Act, 1990, c. 37, § 37.

102. *In re* F., [1990] 2 A.C. 1, 1989 WL 650444 (HL), at 7-8. *See also* Francis, *supra* note 39, at 375.

103. *See* Francis, *supra* note 39, at 375.

104. *See In re F.*, 1989 WL 650444, at 7-8.

105. Francis, *supra* note 39, at 370. *See also* Sidaway v. Bd. of Governors, [1985] A.C. 871, 1985 WL 311459, at 1. The *Sidaway* court established the general proposition that an individual English patient can refuse medical treatment at his/her request. *See id.*

possibility that a pregnant woman could be forced into unwanted medical treatment if she was found incompetent.[106]

IV. THE RIGHT OF PREGNANT WOMEN TO REFUSE MEDICAL TREATMENT

A. *United States*

1. Before In re A.C.: Balancing Competing Interests

Although it is well established that a competent adult has the right to refuse medical treatment, the right of a pregnant woman to refuse treatment that would save the life of her fetus is not established. The right to refuse treatment is not an absolute right.[107] Prior to the *In re A.C.* decision, courts in the United States performed a balancing test to determine whether to intervene and force a competent adult to undergo medical treatment.[108] Courts balanced the woman's interest in her health and bodily integrity against four traditional State interests: (1) the preservation of life, (2) the prevention of suicide, (3) the protection of a third party,[109] and (4) the integrity of the medical profession.[110] The State's interest in protecting third parties and preserving the integrity of the medical profession has received the most attention from courts. Courts considering competing interests imposed a sliding scale to determine if state intervention was appropriate. The state's burden increased as the evasiveness of the procedure increased.[111] Courts are more willing to allow less invasive procedures, such as immunizations and blood transfusions, than invasive surgeries, such as transplants and cesarean sections.[112] The American Medical Association (AMA) recommended that physicians should honor a

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106. *See id.*

107. *See* Francis, *supra* note 39, at 270.

108. *See* Satz v. Perlmutter, 362 So.2d 160, 162-64 (Fla. Dist. Ct. App. 1978). *See also* James A. Filkins, *A Pregnant Mother's Right to Refuse Treatment Beneficial to Her Fetus: Refusing Blood Transfusions*, 2 DEPAUL J. HEALTH CARE L. 361, 362 (1998).

109. *See* Filkins, *supra* note 108, at 362. Courts are most likely to allow forced medical treatment when the health and interests of third parties are compromised. *See id.* It is well established that individuals can be forced to have vaccinations over personal or religious objections. *See generally* Jacobson v. Massachusetts, 197 U.S. 11 (1904). The State's need to protect the health of its citizens clearly outweighs the individual's interests. *See id.*

110. *See Jacobson*, 197 U.S. at 11. *See also* Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927, 929-30 (1994). Scholars, judges, and medical professionals fear that forcing a woman into a treatment gives her a disincentive to use medical institutions. *See id.* They argue that a woman in medical danger will avoid a hospital if she thinks it will force treatment upon her. *See generally* Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981). This was true in *Jefferson*. Although the court ordered treatment, the woman went into hiding and, eventually, gave birth to a healthy child. *See id.*

111. *See* Filkins, *supra* note 108, at 362.

112. *See In re* Baby Boy Doe, 632 N.E.2d 326, 331 (Ill. App. Ct. 1994).

pregnant woman's choice unless there are exceptional circumstances. One scholar interpreted the AMA decision as follows:

> The AMA's description of "exceptional circumstances" could encompass refusals of blood transfusions. Judging by the case law, in the opinion of most physicians, a transfusion poses little risk to the woman, is minimally invasive, and, in many cases, has the potential to save the fetus's life. Yet, if transfusions fall within the escape clause the AMA and ACOG have allowed physicians, they illustrate the pitfalls of encouraging physicians to assess for their patients the desirability of a treatment based solely on its medical risks and benefits . . . . Ultimately, the patient must decide, based on her values and beliefs, whether such a risk is tolerable. If the patient is pregnant, she necessarily will have to make the decision not just for herself, but for the fetus as well. Furthermore, so long as the patient is competent to make the decision, her decision need not be rational in the physician's opinion.[113]

The AMA and ACOG have not had an opportunity to explain the meaning of "exceptional circumstances"; however, the organizations make it clear that the woman's choice should be honored in most circumstances.[114] In 1987, a group of authors who were interested in the number of pregnant women who were forced to undergo court ordered medical treatment in the United States launched the Kolder Study.[115] The results demonstrated that physicians were not following the AMA recommendations.[116] The study showed that:

> Among 21 cases in which court orders were sought, the orders were obtained in 86 percent [17 cases]; in 88 percent of those cases, the orders were received within six hours. Eighty-one percent of the women involved were black, Asian, or Hispanic, 44 percent were unmarried, and 24 percent did not speak English as their primary language.[117]

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113. Filkins, *supra* note 108, at 177 (footnote omitted).

114. *See id.*

115. Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192-93 (1987).

116. *See id.*

117. *Id.* The study took place in 1987, so attitudes have likely changed since the study was conducted. *See id.* It does show the willingness of physicians to intervene. Also, very few of the cases went to court on appeal because the women chose to end their ordeals. *See id.*

Although the attitudes of physicians have evolved and the law has changed significantly, the Kolder Study is important because it shows that in most cases courts ordered treatment, and these cases rarely get appealed.[118]

After the Kolder Study, two distinct approaches to court ordered treatment have developed in the United States. The courts of Illinois and Georgia have helped define these two opposing viewpoints.

2. *Illinois Law: The Majority Approach*

The courts in the State of Illinois have considered several cases involving maternal-fetal conflicts.[119] Consequently, Illinois has a coherent, well-developed line of cases. Those cases hold that: (1) the rights of a fetus are subordinate to the rights of a mother in all circumstances; and (2) pregnant women have an absolute right to refuse medical treatment, even if the refusal harms the health of the mother or unborn fetus.[120]

In *Stallman v. Youngquist,*[121] the Illinois Supreme Court refused to recognize a tort action against a mother for unintentional infliction of prenatal injuries.[122] The Court determined that a child does have a right to recover from unrelated third parties for pre-natal injuries, but children do not have the right to recover from their mothers.[123] It feared that allowing the action would subject a woman's every act to state scrutiny during her pregnancy, which would intrude upon both her right to privacy and her right to control her own life.[124] The majority noted:

> No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts upon the development of the fetus . . . . That this is so is not a pregnant woman's fault; it is a fact of life.[125]

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118. *See id.*

119. *See* Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988); *In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994); *In re* Fetus Brown, 689 N.E.2d 397 (Ill. App. Ct.). The court's strong preference to strengthen maternal rights is founded both in the United States Constitution and the State of Illinois Constitution. *See id.*

120. *See In re Fetus Brown*, 689 N.E.2d at 397.

121. *See Stallman*, 531 N.E.2d at 360.

122. *See id.* at 360-61.

123. *See id.* at 361.

124. *See id.* at 360. The court held that a woman was not responsible for actions that she took during her pregnancy that resulted in harm to her child. *See also In re* Baby Boy Doe, 632 N.E.2d 326, 331 (Ill. App. Ct. 1994).

125. *Stallman*, 531 N.E.2d at 358.

Ultimately, a woman's rights supersede those of the fetus and the State.[126] The court gave preference to maternal rights over fetal interests.[127] This case set the precedent for all future Illinois decisions on the issue.

The next case heard by an Illinois Appellate Court concerning maternal-fetal interests was *In re Baby Boy Doe*.[128] The case involved a woman whose fetus was receiving insufficient oxygen in the thirty-fifth week of the pregnancy.[129] The obstetrician suggested either an immediate cesarean section or the inducement of labor.[130] The patient refused the doctor's recommendation because she was a member of the Pentecostal church.[131] The woman returned to the doctor's office two weeks later, and the doctor's diagnosis revealed the fetus had worsened.[132] The doctor again recommended an immediate cesarean section, but the woman refused.[133]

The hospital then contacted the State's attorney to seek his assistance in obtaining a court order compelling surgery.[134] The case was heard, and evidence was presented.[135] The court refused to grant the hospital's petition to compel the woman to consent to the cesarean section and stated that the woman should be allowed to make her own treatment decisions.[136] The State immediately appealed. The Illinois Appellate Court upheld the lower court's determination, noting that Illinois courts should never balance a fetus's rights against those of its mother.[137] The court's rationale was that a woman's choice to refuse medical treatment must be honored, even if the decision harms the woman's health or the health of the fetus.[138] The court wrote as follows:

> Applied in the context of compelled medical treatment of pregnant women, the rationale of *Stallman* directs that a woman' right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious

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126. *See id.* at 359.

127. *See id.*

128. *In re Baby Boy Doe*, 632 N.E.2d 326.

129. *See id.*

130. *See id.* at 327.

131. *See id.*

132. *See id.*

133. *See id.* The doctor no longer had the option of inducing labor because of the gravity of the situation. *See id.* He felt that the only chance for the fetus was immediate surgery. *See id.*

134. *See id.*

135. *See id.* at 328-29. The obstetrician testified that without the cesarean section surgery, the fetus had a zero percent chance of survival. *See id.* The mother faced a 1 in 10,000 chance of dying during the procedure, compared to a one in 20,000-50,000 for a normal birth. *See id.* at 328.

136. *See id.* at 329.

137. *See id.* at 330-31.

138. *See id.* at 331. The woman delivered a healthy baby boy several weeks after refusing to consent to the medical treatment. *See id.* at 329.

> liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant; to the contrary, the *Stallman* court explicitly rejected the view that the woman's rights can be subordinated to fetal rights.[139]

The right to refuse medical treatment extends to all competent pregnant women without any qualifications.[140] The court also noted that the woman's rights are always primary, and the rights of a fetus secondary.[141]

In re Baby Boy Doe left some difficult questions unresolved. First, the court did not discuss issues raised by an incompetent or mentally ill pregnant woman.[142] Second, it left open the door regarding whether a court could compel a pregnant woman to take a blood transfusion.[143] The court considered only the "massively invasive, risky, and painful cases,"[144] leaving the "non-evasive procedures . . . for another case."[145] Feminist and legal scholars did not have to wait long for an answer to their remaining questions.[146]

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139. *Id.* at 332.

140. *See id.* at 330-33.

141. *See id.*

142. No court in the United States has considered the competency of a woman during the birthing process. *See generally id.* Although a well-established proceeding in English law, no such procedure has occurred in the United States.

143. *See id.* at 333.

144. *Id.*

145. *Id. See also* Levy, *supra* note 31, at 174-75. The author noted that this part of the holding was inconsistent with the rest of the opinion. *See id.* She reconciled the discrepancy by noting as follows:

> There are at least two explanations for this seeming inconsistency in the court's reasoning. One is that the judge who issued the opinion felt that the potential demise of a fetus due to failure of the pregnant woman to accept a treatment much less invasive than surgery distinguished such a situation from [*In re* Estate of Brooks], which involved a non-pregnant woman placing only her own life at risk. In fact, part of the Doe court's analysis rested on the increased risks to the mother of undergoing a cesarean section rather than a normal delivery, although the court seemed more persuaded by the legal precedent than by the medical risks.
>
> A second possible explanation is that the appellants had raised, as precedent, cases where courts had ordered pregnant women to accept blood transfusions. Therefore, the Doe court was faced with earlier cases that had allowed physicians to override a competent adult's wishes and was forced to distinguish those cases from the one at bar. Furthermore, the Doe court was already forging new territory in holding that a woman could decline a cesarean section; only one other court in the country had so held. The Doe court therefore might have been reluctant to make a more general finding and sought to limit its holding to the facts before it.

Id. at 174-75.

146. *See id.*

In the case of *In re Fetus Brown*,[147] the Illinois Court of Appeals completed its body of law on the subject by holding that a pregnant woman has the right to refuse a blood transfusion for religious or personal reasons.[148] The case involved a twenty-six year old, pregnant Jehovah's Witness, who had surgery on a urethral mass.[149] The woman lost a large amount of blood during the procedure and needed a transfusion, which she refused.[150] The hospital feared that the life of both the woman and fetus were in grave danger and asked that the state appoint a temporary guardian, who could then consent to the surgery.[151] The court granted the request and appointed a guardian.[152] The woman survived, delivered a healthy child, and then filed an appeal to overturn the state's action.[153]

After considering prior Illinois case law and the Supreme Court's decision in *Cruzan*,[154] the lower court's decision was reversed, and the appellate court held that the woman should not have been forced to take the transfusion for the benefit of her fetus.[155] The State argued that a court should balance the interests of the mother against the interests of the fetus and State when a case involves a "minimally invasive" procedure.[156] The appellate court held that the right to refuse medical treatment is not absolute, and that a court must balance a woman's rights against the State's interests in: (1) preserving life; (2) preventing suicide; (3) maintaining the integrity of the medical profession; and (4) protecting third parties.[157] In turn, the appellate court disregarded each of the aforementioned state interests and determined that the real state interest is protecting the health of a viable fetus.[158]

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147. *In re* Fetus Brown, 689 N.E.2d 397 (Ill. App. Ct. 1997).

148. *See id.* at 405.

149. *See id.*

150. The physicians made every effort possible to reduce the amount of blood lost during the surgery; however, their efforts failed and the woman needed a transfusion to survive. *See id.*

151. *See id.* The woman was restrained, sedated, and fought the physician, but despite her clear objection, the transfusion was given. *See id.* at 400.

152. *See id.*

153. *See id.* The issue had become moot upon the birth of the child; however, the court chose to hear the case because of the probability it would rise again in the future. *See id.*

154. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990).

155. *See In re* Fetus Brown, 689 N.E.2d at 397, 405-06 (Ill. App. Ct. 1997).

156. *Id.* at 401. *See also* Levy, *supra* note 31, at 175. The author noted as follows:

> Although the difference may seem semantic, balancing maternal and fetal rights presents a greater challenge than weighing the state's interest in the fetus against the mother's right to autonomy. The difference stems in part from the state's shared interest in the mother's autonomy, which places it on both sides of the argument concerning the mother's right to refuse blood. In addition, it is much more difficult to balance the rights of mother and fetus than it is to balance the rights of the mother against an impersonal government entity.

Id.

157. *See In re Fetus Brown*, 689 N.E.2d at 403.

158. *See id.* at 403-04.

The court began its analysis by examining the state's interest in a viable fetus as set forth in *Roe v. Wade*.[159] It then determined that an intentional abortion differed from a refusal of medical treatment, meaning that *Roe* had limited application.[160] The court then turned to Illinois law, which recognized a fetus's right to life from the moment of conception.[161] Further, the court examined the Illinois state child abuse laws and determined that the legislature did not intend the term "child" to include viable fetuses.[162] Because a viable fetus was not included within the definition, there was no compelling state interest that would force medical treatment.[163] There was no dispute that a blood transfusion is "an invasive medical procedure that interrupts a competent adult's bodily integrity."[164] Finally, the court stated that "the State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus."[165]

Illinois has the most well defined body of case law concerning the right of pregnant women to refuse medical treatment. The law demonstrates the majority approach in the United States, which gives absolute deference to a competent woman's choice to refuse treatment.[166]

3. *Georgia Law: The Minority Approach*

In *Jefferson v. Griffin Spalding County Hospital Authority*,[167] the Supreme Court of Georgia balanced the rights of a fetus against the rights of a mother. It determined that an expectant mother, in the last weeks of her pregnancy, lacks the rights of other persons to refuse surgery or treatment if that refusal jeopardizes the rights of the fetus.[168] The Court intervened when a pregnant woman refused medical treatment for religious reasons.[169] In the decision, the court reasoned that the woman was legally obligated to accept treatment if it would benefit both her and her fetus.[170] After the court's order, the woman went into hiding and delivered a healthy child despite the physician's prognosis.[171]

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159. *Roe*, 410 U.S. 113. *See also* Shannon Such, *Lifesaving Medical Treatment for the Nonviable Fetus: Limitations on State Authority under Roe v. Wade*, 54 FORDHAM L. REV. 961.

160. *See In re Fetus Brown*, 689 N.E.2d at 404.

161. *See id.*

162. *See In re Fetus Brown*, 689 N.E.2d at 405.

163. *See id.*

164. *Id.*

165. *Id.* at 405.

166. *See generally id.*

167. *Jefferson*, 274 S.E.2d 457.

168. *See id.* at 460.

169. *See id.* at 458-59.

170. *See id.* The treatment would benefit both the mother and her fetus; therefore, the court reasoned that the treatment was not detrimental to the woman's health.

171. *See generally id.*

This approach, although not adopted in many jurisdictions, has found some support from legal scholars. In particular, one scholar noted:

> [T]he pregnant woman, in a pregnancy being taken to term, is ethically obligated to accept reasonable risks on behalf of the fetus .... Invasiveness should not be the sole criterion for assessing physical burdens, because invasiveness in this case is not associated with net harm. To the contrary, it is associated with net benefit, because it dramatically reduces the risk of maternal mortality .... The net effect of cesarean delivery for this complication is to benefit the pregnant woman, not burden her.[172]

The scholar reconciled the *Jefferson* approach with *In re A.C.* by explaining that, when the health of the mother is compromised, the court should not intervene.[173] Conversely, when treatment will help both the mother and fetus, then a court may force treatment because the treatment does not compromise the mother's health.[174] Although recent courts such as the *In re Baby Boy Doe*[175] and *In re A.C.*[176] courts and many other jurisdictions have declined to adopt this approach, Georgia recently reaffirmed the approach, and courts in Georgia may compel treatment in many circumstances after conducting a balancing approach.[177]

The U.S. approach differs from the approach employed by courts in the United Kingdom; however, both court systems have reached the same result: a pregnant woman has the right to refuse treatment. The major difference between the two nations lies in the exceptions to the general rule.[178]

B. United Kingdom

The right of pregnant women to refuse medical treatment has arisen in several situations: forced blood transfusions, forced cesarean sections, and forced treatment on incompetent pregnant women.[179]

An English court first considered the rights of pregnant women in the case of *In re S.*[180] A woman objected to the delivery of her fetus by cesarean

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172. F. Chervenak and L. McCullough, *Justified Limits on Refusing Intervention*, 2 HASTINGS CENTER REPORT 13-15 (1991).

173. *See id.*

174. *See id.*

175. *In re Baby Boy Doe*, 632 N.E.2d 326.

176. *In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc).

177. *See id.*

178. *See* Francis, *supra* note 39, at 369.

179. *See* Stauch, *supra* note 39, at 163-65.

180. *In re* S., [1993] Fam. 123, 1992 WL 894554 (Fam. Div.), at 1. One should note that the case presented a bizarre set of facts, and it is unlikely that any court will be faced with

section for religious reasons.[181] The woman was thirty-years old, an African immigrant on her third pregnancy.[182] The physicians informed the woman that she and her fetus were in serious danger due to the position of the fetus.[183] The woman understood that she and her fetus would die without the treatment; however, she continued to refuse.[184] The hospital applied to the court for a declaration that would authorize the surgery.[185] The court authorized the surgery after a brief hearing conducted in the judge's chamber.[186] The judge could not find any binding English law, so he turned to the American case of *In re A.C.*,[187] and, ultimately he granted the application.[188] The court order stated as follows:

> It is declared that the operation of caesarean section and necessary consequential treatment which the Plaintiff, by its servants or agents proposes to perform on the Defendant at [hospital] is in the vital interests of the Defendant and the unborn child she is carrying and can lawfully be performed despite the Defendant's refusal to give her consent.[189]

Unfortunately, by the time the order was issued the child had died, and the mother would have died if the surgery had not been performed.[190] The hospital performed the surgery, the mother lived, and she did not appeal the decision to force treatment.[191]

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similar facts. *See id.* Consequently, the decision of the court is neither applicable nor binding in future cases. *See id.*

181. *See id.* The cesarean section cases are of particular interest as they are the most controversial of the forced treatment cases and the most commented upon. *See generally id.* Normally, a woman objects for religious reasons. Many cases involve Jehovah's Witnesses, who object to all blood transfusions. *See id.* Cesarean sections almost always require blood transfusions, and, consequently, pregnant Jehovah's Witnesses opt not to have the treatment despite medical necessity. *See id.*

182. *See id.* at 130.

183. *See id.* at 130-31.

184. *See id.*

185. *See id.*

186. *See generally* Sir Stephen Brown, *Matters of Life and Death* (Lecture to the Medico-Legal Society, Oct. 14, 1993) 62 MED. LEG. J. 52 (1994). Sir Stephen Brown was the presiding judge at the hearing and stated:

> The question was, should [the cesarean section] be allowed? . . . It was very clear – this was minutes, not hours – both would die. I heard very helpful submissions by counsel for the Official Solicitor and I made the . . . declaration . . . it was as vital as that.

Id.

187. *In re* A.C., 573 A.2d 1235 (D. C. Cir. 1990) (en banc).

188. *See id.*

189. Sir Stephan Brown, *supra* note 186, at 65-66.

190. *See id.*

191. *See In re* S., [1993] Fam. 123, 1992 WL 894554 (Fam. Div.), at 7. *See also* Sir Stephan Brown, *supra* note 186, at 66. One of the obstetricians on duty noted

The court determined that it was permissible to override the intent of a mentally competent woman and perform the cesarean section for her benefit.[192] The *In re S* decision defies the House of Lords decision in *Sidaway v. Board of Governors of Royal Bethlem & Maudsley Hospital*,[193] which held that competent adults have an absolute right to choose whether to agree to surgery.[194] The House of Lords stated: "If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational or irrational – or for no reason."[195] Indeed, following the *In re S* decision, the Royal College of Obstetricians formulated standards that respect a competent mother's choices in most circumstances:

> A doctor must respect the competent pregnant woman's right to choose or refuse any particular recommended course of action whilst optimising care for both mother and fetus to the best of his or her ability. A doctor would not then be culpable if these endeavours were unsuccessful. We conclude that it is inappropriate, and unlikely to be helpful or necessary, to invoke judicial intervention to overrule an informed and competent woman's refusal of proposed medical treatment, even though her refusal might place her life and that of her fetus at risk.[196]

Although the statement summarizes the current state of the common law, there are still exceptions that allow a court to authorize court intervention.[197]

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the problems that occurred during the surgery and process. In regards to his fellow doctors, he noted:

> As far as the obstetricians are concerned, I think we are deeply divided about this. Having understood that our duty is to the baby through the mother, we don't quite like this idea of maternal/fetal conflict, because the vast majority of our work is done with the mothers and through the mothers, and the idea we can breach confidentiality and then go to make applications to divide mothers and children legally, when we can't divide them physically, is actually an anathema to many.

Id.

192. *See id.*

193. *See* Sidaway v. Bd. of Governors, [1985] A.C. 871, 1985 WL 311459 (HL), at 1, per Lord Templeman.

194. *See id.*

195. *Id. But see In re* T., [1993] Fam. 95, 1992 WL 895109 (CA), at 7. The court hinted that there were exceptions to the general rule. *See id.* Also, the court *In re S* operated on the presumption that the woman was competent. *See id.* It did not inquire into the mental state of the woman. *See id.*

196. A CONSIDERATION OF THE LAW AND ETHICS IN RELATION TO COURT-AUTHORISED OBSTETRIC INTERVENTION, *supra* note 81, §§ 5.11-5.12.

197. *See id.*

In the United Kingdom, the general rule remains that a pregnant woman has the right to refuse medical treatment in most circumstances.[198]

V. THE CURRENT STATE OF LAW AND EXCEPTIONS

A. *United States*

1. *The Majority Approach: In re A.C.*[199]

The current position of the majority of United State's courts can be found in the decision of *In re A.C.*[200] That case involved a terminally ill pregnant woman with cancer.[201] The hospital suggested that the woman undergo a cesarean section in order to save the life of her unborn fetus after it had reached viability.[202] The woman refused because the surgery would shorten her life and threaten the life of her unborn fetus.[203] The hospital sought a court order to compel the surgery, which was granted after the District of Columbia Court of Appeals refused to stop the surgery.[204] The surgery was performed, the child lived for a short period of time, and the mother died two days later.[205]

The District of Columbia Court of Appeals ordered an *en banc* hearing of the case and vacated the district court decision.[206] The court held as follows:

> What a trial court must do in a case such as this is to determine, if possible, whether the patient is capable of making an informed decision about the course of her medical treatment. If she is, and if she makes such a decision, her wishes will control in virtually all cases. If the court finds that the patient is incapable of making an informed consent

198. *See id.*

199. *In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc).

200. *See id.* at 1235-39.

201. *See id.* A.C. had suffered cancer for around fourteen years, and she became pregnant during a period of remission. *See id.* At twenty-five weeks, the doctors found a terminal tumor. *See id.* The woman chose to attempt to prolong her life until twenty-eight weeks, when the fetus would have a better chance of survival. *See id.* A.C.'s condition worsened, and numerous parties got involved in the pregnancy. *See id.* The pregnant woman originally consented to the treatment but withdrew without stating a reason. *See id.*

202. *See id.* The court determined that there was a 50 to 60% chance that the fetus would survive if a cesarean section were performed. *See id.*

203. *See id.* It was also undisputed that the fetus was viable and that the surgery would shorten the life of the mother by a short period. *See id.*

204. *See In re* A.C., 533 A.2d 611 (D.C. 1987). Tragically, the child survived for only a short period of time, and the mother died two days after the surgery was performed. *See id.*

205. *See id.*

206. *See In re* A.C., 573 A.2d 1235, 1238 (D.C. Cir. 1990)(en banc).

> (and thus is incompetent), then the court must make a substituted judgment.[207]

The trial court did not conduct a competency determination before proceeding, and, consequently, it had no authority to force treatment.[208] The court also stated that it would be improper to presume that a patient was incompetent; rather, competence must be proved by medical testimony.[209]

The court stated that the decisions of a competent pregnant woman should never be overruled.[210] The court adopted two other arguments that supported A.C.'s position. The court found that to allow court-ordered treatment would breach the confidentiality of the doctor and patient relationship.[211] By breaching the relationship, the court believed it would force women away from medical treatment,[212] especially those women with high-risk pregnancies and strong non-traditional religious views. Finally, the court determined that the complexity, gravity, and urgency of the matter make the courts ill equipped to deal with the question.[213] In regard to the legal proceedings, the court pointed out several problems presented to the pregnant woman:

> [A]ny judicial proceeding in a case such as this will ordinarily take place like the one before us here under time constraints so pressing that it is difficult or impossible for the mother to communicate adequately with counsel, or for counsel to organize an effective factual and legal presentation in defense of their liberty and privacy interests and bodily integrity. Any intrusion implicating such basic values ought not to be lightly undertaken when the mother not only is precluded from conducting pre-trial discovery . . . but also is in no position to prepare meaningfully for trial.[214]

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207. *Id.* at 1252.

208. *See id.* at 1252-53.

209. *See id.* at 1247. The Supreme Court has never held that competent adults have the right to refuse treatment. *See id. Cruzan* involved the right of an incompetent adult to refuse treatment. Competency has never been an issue before a court in the United States in this type of case. *See id.*

210. *See id.* at 1248-49.

211. *See id.* at 1248.

212. *See id.* The court appeared to anticipate problems posed by women with strong religious or personal beliefs. *See id.* For instance, if a Jehovah's Witness had a medical condition during her pregnancy that resulted in blood loss, she would be apprehensive of going to medical institutions if they could force blood transfusions upon her. *See id.* However, if she knew that the hospital could not force medical treatment upon her, then she would be able to go to the hospital and consent to or deny any or all suggested medical treatments.

213. *See id.* at 1248.

214. *Id.*

Although the court's opinion noted a strong disfavor for forced cesarean sections, the court declined to overrule *In re Madyun*.[215] In the *Madyun* case, a judge authorized a cesarean section over the religious objection of the pregnant woman.[216] The court intervened to protect the state's interest in the viable fetus, whose mere presence diminished the right of the woman.[217] Further, unlike *In re A.C.*, the surgery *In re Madyun* benefited both the mother and fetus, so there were not really conflicting interests.[218] It is that difference which did not require the District of Columbia Court of Appeals to overrule an earlier case, *In re Madyun*, which it affirmed in an unreported opinion.[219]

One should also note that the *In re A.C.* decision does not preclude court ordered intervention in all circumstances.[220] In its opinion, the District of Columbia Court of Appeals stated as follows:

> 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. Throughout this opinion we have stressed that the patient's wishes, once they are ascertained, must be followed in 'virtually all cases' . . . unless there are 'truly extraordinary or compelling reasons to override them'. . . . Whether such a situation may someday present itself is a question that we need not strive to answer here.[221]

The court limited the cases in which a court may override a patient's wishes; however, the court clearly did not foreclose the possibility, such as when a woman may be incompetent or mentally ill.[222]

There are only a few exceptions to the rule that a pregnant woman may refuse medical treatment. As noted previously, some jurisdictions are willing to force treatment when the treatment benefits both the mother and fetus.[223] In those cases, the surgery does not compromise the mother's health for that of the fetus; rather, it benefits the mother as much, or more, than the fetus.[224] Traditionally, courts allow this type of intervention when the treatment is

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215. *In re* Madyun, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 26, 1986).
216. *See id.*
217. *See id.*
218. *See id.*
219. *See In re* A.C., 573 A.2d 1235, 1243 (D.C. Cir. 1990)(en banc).
220. *See generally id.*
221. *Id.* at 1248.
222. *See id.*
223. *See generally* Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981).
224. *See id.*

"minimally invasive."[225] Consequently, a court may allow blood transfusions and other similar procedures.

A final exception may exist in competency determinations, as demonstrated by the English approach to this issue.[226] No court has heard a case where a hospital or state challenges the competency of a pregnant woman. This is largely due to the rare use of competency determinations in this situation within the United States; however, such a challenge may arise in the future. The United Kingdom's approach sheds light into how this exception works.

B. United Kingdom

In the United Kingdom, one exception to the general rule is that a pregnant woman must be *competent* in order to refuse medical treatment.[227] Therefore, if a court undertakes a competency determination and finds that the woman is incompetent, then the court can order medical treatment.[228] This exception has developed in recent years and continues to be very controversial.[229] Competency arises in two contexts: (1) mentally ill pregnant women and (2) competency determinations involving pregnant women.

1. Mentally Ill Pregnant Women

An English court first considered the competence of a pregnant woman in *Tameside & Glossop Acute Services NHS Trust v. C.H.*[230] A pregnant paranoid schizophrenic woman was in a mental health institute under the Mental Health Act of 1983.[231] Under the Act, a court may assume that an individual has lost the mental capacity to consent or refuse medical treatment.[232] The patient was convinced that the physicians were evil and wanted to harm her child.[233] The woman developed complications during the pregnancy and a cesarean section was needed to save the baby; however, the woman had a history of resisting treatment.[234] The hospital sought an order

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225. *See generally In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc).

226. *See generally* Frances Gibb, *Courts Wrong to Force Treatment on Pregnant Women*, TIMES LONDON, Apr. 12, 1994, *available in* 1994 WL 9163954.

227. *See id. See generally* Francis, *supra* note 39.

228. *See* Stauch, *supra* note 39, at 163-65.

229. *See id. See also* Janet Sayers, *Must a Mother Render unto Caesar?*, TIMES LONDON, May 26, 1990; Alex Richardson, *Life and Death Cases Decided in the Courts*, BIRMINGHAM POST, July 16, 1999.

230. Tameside & Glossop Acute Services NHS Trust v. C.H., [1996] F.L.R. 762.

231. *See id.* The case largely involved the interpretation and application of the Mental Health Act of 1980.

232. *See id. See also* Francis, *supra* note 39, at 376.

233. *See Tameside*, [1996] F.L.R. at 762.

234. *See id.*

from the court to permit it to use restraint and perform the surgery.[235] The court held a hearing and it was undisputed that the woman was incompetent under the standard established *In re C.*,[236] which defines competency as (1) the ability to understand information about the surgery; (2) the ability to believe that knowledge; and (3) the ability to balance the risks and arrive at an informed decision.[237]

Ultimately, the decision rested on the interpretation of the Mental Health Act of 1980,[238] which allows certain types of restraint and treatment free of liability.[239] The court had to decide if a forced cesarean section fell within the scope of the Act.[240] The evidence showed that without the surgery the fetus would die and the mother would fully recover.[241] The court determined that the death of a stillborn baby would have a negative mental impact on the woman, and consequently it ordered the cesarean section.[242] Although the court's interpretation of the Mental Health Act 1983 is controversial,[243] recent case law confirms that the court reached the proper result.[244]

2. *Competency Determinations Involving Pregnant Women*

Competency determinations are a relatively recent development in English law.[245] The standard for competency determinations was formulated by English courts in *T. v. T.*[246] and adopted by the House of Lords *In re F.*[247] The House of Lords held that, when adults are mentally incompetent or unable to communicate a personal choice concerning treatment, it is lawful for such treatment to be provided in the best interests of the patients.[248] The "best interest" of a patient is determined by examining the responsible and accepted

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235. *See* Francis, *supra* note 39, at 377.

236. *In re* C., 1 W.L.R. 290, 1993 WL 965301, at 5. The case provides the standards used in competency determinations in the United Kingdom.

237. *See id. See also* Francis, *supra* note 39, at 378.

238. Mental Health Act, 1980, c. 20, § 4 (Eng.).

239. *See* Francis, *supra* note 39, at 376.

240. *See id.*

241. *See id.* at 378.

242. *In re* C., 1 W.L.R. 290, 1993 WL 965301. The statute has been interpreted broadly. *See id.* Most treatments are considered treatment for the mental condition. *See also* B. v. Croydon Health Authority, [1995] Fam 133 (force feeding anorexic with personality disorder was determined permissible under the Act).

243. *See* Barbara Hewson, *Woman's Rights and Legal Wrongs*, 146 NEW L. J. 1385 (1996).

244. *See also* Francis, *supra* note 39, at 378-79.

245. *See generally* P.D.G. SKEGG, LAW, ETHICS AND MEDICINE 101 (1984). The author summarized the law regarding incompetent individuals by observing that it is generally accepted that a doctor is justified in providing treatment without consent to adult patients incapable of consenting for themselves." *See id.* at 104.

246. T. v. T., [1988] Fam. 52, 1987 WL 492876. *See also In re C.*, 1993 WL 965301, at 5.

247. *In re* F., [1988] Q.B. 122, 1988 WL 624168 (CA), at 13.

248. *See id.*

medical treatment for the incompetent individual's health dilemma.[249] If a physician decides that a medical procedure is in a patient's best interest, then the physician may administer the treatment without obtaining consent from a third person.[250]

The first case to consider the competency of a pregnant woman without a mental disorder was the case of *Roachdale Healthcare NHS Trust v. C.*[251] A woman in labor suffered from a ruptured uterus.[252] The medical condition developed so quickly that the physician had a one-hour window to obtain the court's permission to perform a cesarean section and save the child.[253] There was no representative at the hearing for the patient and the patient may not have even known of the hearing.[254] The woman had stated that she would rather die than have another cesarian section, because she had a bad experience with a previous cesarean section.[255] There was no evidence about the woman's mental condition; however, her obstetrician believed that she was competent. With little information and little time, the judge decided as follows:

> [I] concluded that the patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh up the considerations that arose so as to make any valid decision, about anything of even the most trivial kind, surely still less one which involved her own life.[256]

The decision is contrary to the *Sidaway*[257] decision, which prevents courts from deciding competence based on an individual's irrationality or the absence of good reasoning.[258] The holding is also problematic because: (1) the judge had little evidence; (2) the woman consented to the surgery; and (3) it stated that women in labor are incompetent.[259]

In *Norfolk and Norwich Healthcare NHS Trust v. W.*,[260] an English court was faced with a similar situation.[261] The case involved a woman who denied

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249. *See* Bolam v. Friern Hospital Management Committee, [1957] 1 W.L.R. 582.
250. *See id.*
251. Roachdale Healthcare N.H.S. Trust v. C., [1997] 1 F.C.R. 274.
252. *See id.*
253. *See id.* The judge probably issued his decision because of the circumstances of the case, as he was dealing with some difficult facts. *See id.*
254. *See id.*
255. *See id.*
256. *Id. See also* Francis, *supra* note 39, at 380.
257. Sidaway v. Bd. of Governors, [1985] A.C. 871, 1985 WL 311459 (HL), at 1.
258. *See id.*
259. *See generally id.*
260. Norfolk and Norwich Healthcare NHS Trust v. W., [1996] 2 F.L.R. 613.
261. *See id.*

being pregnant.[262] The woman's obstetrician realized that the fetus would die within about an hour if a cesarean section were not performed.[263] The obstetrician called a psychiatrist, who determined that the woman was free of mental illness, but he determined that she was not able to balance or form a decision about the suggested treatment.[264] The judge considered the information and again decided to allow the medical procedure because it would be in her best interest to protect her mental and physical health.[265] The judge also determined that the treatment would be reasonable and a necessary incident to treatment.[266] Both the *Roachdale* and *Norfolk* cases are problematic because the courts had a very small amount of information and characterized pregnant women in labor as incompetent.

Another competency determination arose in the case of *In re L.*[267] The case involved a pregnant woman who had such a severe treatment of needle phobia that she refused to consent to medical treatment.[268] The court allowed the forced treatment and stated "her extreme needle phobia amounted to an involuntary compulsion that disabled her from weighing treatment information in the balance to make a choice."[269] Again, the decision was problematic because the woman clearly made her intentions known, and the court overrode those intentions.[270]

3. *In re M.B.: The Current Law*

The current state of law in the United Kingdom regarding medical treatment for pregnant women was decided in *In re M.B.*[271] That case involved a woman in labor who had both a footling breech and needle phobia.[272] If natural labor were to occur, then the child would be at great risk, but the mother would be in no danger.[273] The woman consented to the cesarean

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262. *See id.* The woman also had some past psychological problems. *See id.*

263. *See id.* at 614.

264. *See id.* at 616.

265. *See id.* at 616-17.

266. *See In re* F., [1990] 2 A.C. 1, 1989 WL 650444 (H.L.).

267. *See* Francis, *supra* note 39, at 382-83. The author cited to this unpublished case from the Family Division in footnote 67.

268. *See id.* The woman needed a cesarean section due to labor difficulties. *See id.*

269. *Id.* at 383.

270. *See id.* at 382-83.

271. *In re* M.B., [1997] 2 F.L.R. 426. Because of the subsequent proceedings, the case became the standard for forced medical treatment on pregnant woman. *See id.* The case had some unique circumstances: (1) the woman was represented by counsel at the hearing; (2) there was a more significant time period in which the court could deliberate; and (3) the decision was immediately appealed. *See id.* These factors and the court's past struggles with the issue caused it to deliberate and make a binding decision on future courts faced with this difficult issue. *See generally id.*

272. *See id.*

273. *See id.*

section until she saw a needle, when she retracted her consent.[274] The hospital then sought an order allowing the surgery via telephone with a judge.[275] Ultimately, the judge heard the evidence and issued the following order:

> It shall be lawful for 2 days from the date of this order, notwithstanding the inability of [the woman] to consent thereto: (i) for the hospital's responsible doctors to carry out such treatment as may in their opinion be necessary for the purposes of the [woman's] present labour, including, if necessary, caesarian section, including the insertion of needles for the purposes of intravenous infusions and anesthesia; (ii) for reasonable force to be used in the course of such treatment; (iii) generally to furnish such treatment and nursing care as may be appropriate to ensure that the [woman] suffers the least distress and retains the greatest dignity.[276]

The judge found that the woman lacked the mental capacity to make decisions about her medical treatment, and, consequently, he ordered the use of reasonable force to protect the best interests of the woman.[277] The woman's counsel immediately appealed the decision, and the full Court of Appeals heard the case, affirmed the lower court, and dismissed the appeal.[278]

The Court of Appeals began by stating that every adult is presumed to have the mental capacity to determine her own course of medical treatment, unless that presumption is rebutted.[279] Under the decision, a person may base his or her decision on "religious reasons, other reasons, for rational or irrational reasons or for no reason at all."[280] The court noted that a woman may "choose not to have medical intervention, even though the consequences

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274. *See id.*

275. *See id.* The judge was a Family Division judge and had previous experience with this type of emergency proceeding. *See id.* The woman was represented by counsel at the hearing. *See id.* Further, she had been interviewed by a psychiatrist who found:

> Away from the need to undergo the procedure, I had no doubt at all that she fully understood the need for a caesarian section and consented to it. However in the final phase she got into a panic and said she could not go on. If she were calmed down I thought she would consent to the procedure. At the moment of panic, however, her fear dominated all.

Id. See also Francis, *supra* note 39, at n.70.

276. *In re* M.B., [1997] 2 F.L.R. 426.

277. *See id.* at 430.

278. *See id.* at 432-33.

279. *See id.*

280. *Id.* at 433. Each individual may refuse treatment for a wide variety of reasons. *See id.* The decision noted that it was not the court's place to evaluate and judge that person's decision or the rationality of the decision. *See id.* Each individual has a unique set or moral standards, philosophical beliefs, and religious ideals. Consequently, each individual is the best judge of his or her own best interests. *See id.* The decision made it very clear that courts should attempt to stay out of individual's decisions. *See id.*

may be the death or serious handicap of the child she bears, or her own death."[281]

Although the courts prefer to give deference to an individual's personal beliefs, the court noted that there are some clear limitations:

> Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence required to take the decision.[282]

The court noted that confusion, shock, fatigue, pain, drugs, or panic induced by fear may destroy capacity.[283] The court noted that each case must be examined individually, and all evidence weighed thoroughly to determine if fear destroyed capacity or was a rational reason to refuse treatment.[284]

In the case of *In re M.B.*, the woman's needle phobia overrode her ability to rationalize and make an informed decision.[285] The woman was found incompetent and the court order was upheld.[286] The court further stated that the hospital could use reasonable force if it was in the best interest of the patient.[287] Further, and most importantly for our purposes, the court examined English common law[288] and held that it did not protect the interests of an unborn child or fetus. The court noted as follows:

> The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reason at all, choose not to have

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281. *Id.* at 433.
282. *Id.* at 434.
283. *See id.*
284. *See id.*
285. *See id.*
286. *See id.*
287. *See id.*
288. The court considered a large number of cases in reaching its decision including: Paton v. British Pregnancy Advisory Service, [1979] Q.B. 276; C. v. S., [1989] Q.B. 135; Burton v. Islington Health Auth., [1993] Q.B. 204; Villar v. Gilbey, [1907] A.C. 139; *In re* T., [1993] Fam. 95; and Patton v. United Kingdom, [1977] 3 E.H.R.R. 408. The court also considered several statutes and pieces of legislative materials including the *Attorney General's Reference No. 3* [1996] 1 Cr. App. R. 351 and the Offences against the Person Act, 1861, c. 1, § 58. The court also considered many cases from foreign jurisdictions including several American cases: Paul Morgan Memorial Hospital Authority, 201 A.2d 537 (N.J. 1964); Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981); *In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc); and *In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct.). The court did not rely on any specific case or legislative material; rather, it considered a wide range of legal issues and topics in reaching its final result.

> medical intervention, even though . . . [the] consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The fetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarian section operation.[289]

Ultimately, the court upheld the general premise that a competent adult woman has an absolute right to refuse treatment and protect her autonomy.[290] The court did allow physicians to intervene and override the decision of an incompetent woman, but even then, the intervention was to protect the woman's health and her best interests.[291] The court narrowed the exception and carefully defined when a court may intervene and force medical treatment.[292] A court may intervene only when the competency of the woman comes into questions, and only when the woman is found incompetent due to mental health reasons or due to the labor process.[293]

VI. BALANCING COMPETING INTERESTS: TWO APPROACHES COMPARED

Courts in both the United States and the United Kingdom have reached the conclusion that an individual has the right to refuse medical treatment.[294] Further, the majority of courts in both countries have reached the conclusion that pregnant women have the absolute right to refuse medical treatment, even if that choice results in her death.[295] Despite these similar outcomes, the legal and historical basis for the court decisions vary in the two countries and helps define the exceptions to the general rule.

Perhaps the greatest difference in the legal analysis of the United States and United Kingdom is the source of the right of pregnant women to refuse medical treatment. The right to refuse treatment in the United Kingdom is clearly grounded in traditional common law tort liability, and, specifically, the

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289. *In re* M.B., [1997] 2 F.L.R. 426, 435.

290. *See id.*; *See also* Francis, *supra* note 39, at 386.

291. *See id.*

292. *See id.*

293. *See In re* M.B., [1997] 2 F.L.R. 426, 431. The court stated that hospitals should bring forth the issue as soon as it is raised, rather than waiting for the last second, when intervention is difficult. *See id.*

294. *See generally In re* A.C., 573 A.2d 1235 (D.C. Cir. 1990)(en banc); *In re* C., [1994] 1 W.L.R. 290.

295. *See In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994); *In re* M..B., [1997] 2 F.L.R. 426, 431.

doctrine of informed consent.[296] Therefore, courts within the United Kingdom have developed, and continue to develop, the doctrine of informed consent in such a way that it protects an individual's right to self-autonomy.[297] The House of Lords and English courts are less interested in "personal" rights or "constitutional" rights, than they are in developing a workable tort doctrine of informed consent.

The United Kingdom's focus on traditional tort theory has allowed the courts to formulate one major exception to the right of pregnant women to refuse treatment: the use of competency determinations.[298] This exception is logical and consistent with English law.[299] A court has set guidelines and specific medical factors that must be examined before it may override a pregnant woman's decision.[300] Specifically, the exceptions apply if the woman's decision is both incompetent and irrational and the woman's decision will result in the death of a viable fetus. The exception insures that there is some flexibility to the traditional tort liability and common law rights within the United Kingdom.

In the United States, the right to refuse medical treatment arises from both Constitutional and common law doctrines.[301] Again, it is the common law doctrine of informed consent that prevents physicians from giving unwanted treatment; however, it is an individual's right under the U.S. that protects the individual from unwanted State intervention.[302] Because Constitutional rights trump common law rights, the focus of American jurisprudence is on the individual and his or her rights. Consequently, a majority of courts in the United States give an absolute right to individuals to refuse treatment on Constitutional grounds.[303] Although this is an inflexible doctrine, there can be no exceptions if the courts are truly going to protect the rights that they and the Constitution have created.

VII. CONCLUSION

Because the source of the right of pregnant women to refuse treatment varies in the United States and United Kingdom, it appears that the countries will always have some variations on a pregnant woman's fundamental rights. The United Kingdom's exception that allows the State to intervene when a woman is incompetent seems inconsistent with American jurisprudence and

296. *See* Francis, *supra* note 39, at 430.

297. *See In re M.B.*, [1997] 2 F.L.R. at 431.

298. *See id.*

299. *See generally* Francis, *supra* note 39.

300. *See generally id.*

301. *See generally* Krista Newkirk, *State-Compelled Fetal Surgery: The Viability Test Is Not Viable*, 4 WM. & MARY J. WOMEN & L. 467 (1998).

302. *See generally* Levine, *supra* note 79.

303. *But see* Pemberton v. Tallahassee Memorial Medical Center, 66 F.Supp.2d 1247 (N.D. Fla. 1999).

will not likely receive attention from American courts. Courts in the United States refuse to examine the rationality of an individual's choice, as the individual has a Constitutional protected interest in her decision. Because of the difference in legal analysis, it appears that the United Kingdom exception and U.S. Constitutional protections prevent a coherent approach to this difficult legal problem.

Bradley J. Glass[*]

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