

Legal Intervention to Protect a Foetus?

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In England, the United States and Canada, there have been a number of cases in which courts have been asked to authorise legal intervention against pregnant women to protect their foetuses. The circumstances giving rise to these matters have varied. For the purposes of this article I shall concentrate on the two most typical situations. One has arisen when women's drug use or excessive alcohol consumption was threatening to harm their foetuses. The other has involved women who have declined to consent to medical intervention (typically a caesarean section) when their doctors believed that intervention was necessary to avoid the birth of stillborn or disabled children.

Drug or Alcohol Use

The cases arising from drug or alcohol use during pregnancy have frequently taken the form of child protection proceedings. In bringing these proceedings, welfare authorities have argued that the operation of child welfare laws should be extended to the unborn and that conduct putting foetuses at risk should be treated as a form of child abuse or neglect. Arguments of this kind have generally been rejected by United States, Canadian, and English courts.

An Ohio case, *Cox v Court of Common Pleas*,¹ involved a pregnant woman who was a known drug user and who had taken cocaine and opiates during her pregnancy. Her partner was also a drug user and did not encourage her to seek proper treatment. Their four children were in foster care. Child protection proceedings were taken and the juvenile court ordered her to avoid using illegal drugs and to submit to a medical examination. When she failed to obey the order, the welfare authorities sought to have her committed to a secure treatment institution. The woman successfully challenged the juvenile court's order: the majority of the Ohio Court of Appeals held that the juvenile

court could not exercise control over a pregnant woman for the benefit of her foetus. The decision reached in this and similar United States cases reflected the view that a reference in a child protection statute to a 'child' did not include a foetus.

In Canada, while an action to protect a foetus succeeded in 1987,² more recent and more authoritative rulings indicate that the courts are unlikely to sanction intervention against a pregnant woman. The leading case is *Winnipeg Child and Family Services (Northwest Area) v G. A Manitoba court had ordered that a woman who was five months pregnant with her fourth child be placed in the custody of a welfare agency and be detained until the birth of her child. The purpose of the order was to protect the foetus, which was at risk of damage from the woman's glue-sniffing. Previously, two of her children had been born seriously affected by the woman's addiction to glue-sniffing; the proceedings had been taken in an attempt to prevent a repetition of this outcome. Ultimately, the matter reached the Supreme Court of Canada, the major issue being whether the trial court had the power – under its *parens patriae* jurisdiction – to make an order designed to protect the foetus. The court held that it did not: 'The law as it stands is clear: the courts do not have *parens patriae* or wardship jurisdiction over unborn children'. It followed that 'the common law does not clothe the courts with power to order the detention of a pregnant woman for the purpose of preventing harm to her unborn child'.³ A similar result has been reached in England. In *Re F (in utero)*, the Court of Appeal decided that a foetus could not be made a ward of court.⁴*

As an alternative to child protection proceedings, agencies concerned about foetal welfare have used the criminal law against pregnant women. There have been a number of United States cases in which the mothers of children born suffering from drug-withdrawal have been charged with abusing, neg-

lecting, or endangering their foetuses. Although taken after birth, these cases raise the same question as child protection proceedings instituted during a pregnancy: does a law designed to protect a 'child' apply to a foetus? The Supreme Court of South Carolina has held that it does.⁵ This seems to be an isolated decision. There have been several cases in which courts have ruled that a reference to a 'child' in a statute proscribing child abuse, neglect or endangerment does not include a foetus.⁶ Decisions of this kind accept that a foetus does not become a 'child' until birth. Mention must also be made of another tactic used by prosecutors. When children have been born with the symptoms of drug-withdrawal, mothers have sometimes been charged with 'supplying' or 'delivering' drugs. Because the success of this charge depends on proof of supply to a 'person' (and a foetus is not a 'person'), prosecutors have occasionally argued that the supply or delivery occurred through the umbilical cord, after the child's birth. This argument has not been accepted. In *Johnson v State of Florida*, for example, it was held:

[T]he Legislature never intended for the general drug delivery statute to authorize prosecutions of those mothers who take illegal drugs close enough in time to childbirth that a doctor could testify that a tiny amount passed from mother to child in the few seconds before the umbilical cord was cut.⁷

Thus, when faced with cases involving pregnant women's use of illegal or harmful substances, the United States, Canadian and English courts have generally concluded that the law should not be invoked in an attempt to protect a foetus against this kind of conduct.

A Decision to Decline Medical Intervention

When the relevant conduct has been a decision to decline medical intervention, the courts have given varying responses. There have been numerous cases in the United States. Many have

been rather superficial in their treatment of the problem. In *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson*, the issue was whether a decision by a Jehovah's Witness to refuse a blood transfusion should be respected. The woman was thirty-two weeks pregnant and the medical evidence was that there was a risk of haemorrhage which could cause the woman and the foetus to die if a transfusion was not undertaken. The Supreme Court of New Jersey authorised the transfusion:

We are satisfied that the unborn child is entitled to the law's protection and that an appropriate order should be made to insure blood transfusions to the mother in the event that they are necessary in the opinion of the physician in charge at the time.⁸

A similar result was reached in *Re Jamaica Hospital*, which also involved a pregnant woman's refusal of a blood transfusion. Evidence was given that the woman's condition was 'critical' and that the foetus was 'in mortal danger'. The trial judge ruled:

If her life were the only one involved here, the court would not interfere. ... Her life, however, is not the only one at stake. The court must consider the life of the unborn foetus. ... In this case, the state has a highly significant interest in protecting the life of a mid-term foetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds.⁹

Jefferson v Griffin Spalding County Hospital Authority was an example of a case arising from a woman's decision not to consent to a caesarean section. The procedure had been recommended because the woman had placenta praevia. Her doctors testified that if a vaginal delivery were attempted there was a ninety-nine per cent chance that the foetus would die and a fifty per cent chance that the woman would die. At an emergency hearing the court authorised the hospital to use 'all medical procedures deemed necessary by the attending physician to preserve the life of the defendant's unborn child'. The authorisation envisaged both the performance of a sonogram (ultrasound) and a caesarean section. An appeal against the order was rejected. The Supreme Court of Georgia ruled:

In denying the stay of the trial court's order and thereby clearing the way for immediate reexamination by sonogram and probably for surgery, we weighed the right of the mother to practice her religion and to refuse surgery on her-

self, against her unborn child's right to live. We found in favor of her child's right to live.¹⁰

The best known United States case is *Re AC*¹¹ (the Angela Carder case). Angela Carder was admitted to hospital when approximately twenty-five weeks pregnant. She was then in the terminal stages of cancer. Her condition deteriorated and she was given palliative treatment designed to extend her life. She was told that her foetus would have a better chance of being born healthy if it survived until at least the twenty-eighth week of her pregnancy. When her condition worsened a court was convened in response to the hospital's request for an order relating to treatment. She was expected to die within twenty-four to forty-eight hours. She was heavily sedated and unable to carry out a meaningful conversation. There was no evidence before the court that she had consented to or even contemplated having a caesarean section before twenty-eight weeks. Her wishes at the time of the hearing could not be ascertained. The court accepted that if an immediate caesarean section was performed, the chances of the foetus surviving were between fifty and sixty per cent. Echoing *Roe v Wade*,¹² the court referred to the state's 'important and legitimate interest in protecting the potentiality of human life'. Performance of a caesarean section was ordered. Ms Carder then regained consciousness and, after initially agreeing to the operation, later mouthed, 'I don't want it done.' The court re-convened and concluded that her wishes were not clear. Once again, it ordered the performance of the caesarean. This was undertaken. The baby died after a few hours and Ms Carder died two days later.

An appeal was lodged to allow clarification of the law. The District of Columbia Court of Appeals ruled that the trial court had erred and that more attention should have been paid to ascertaining what Ms Carder's wishes would have been, had she been able to express them. For present purposes, this aspect of the decision (which involved a consideration of the concept of 'substituted judgment') is of less interest than the court's comments on compulsory intervention to protect a foetus. The court favoured the view that normally a pregnant woman has the right to decide whether or not to consent to medical treatment: '[I]n virtually all cases the question of what is to be done is to be decided by

the patient – the pregnant woman – on behalf of herself and the foetus'. The key word in the ruling is 'virtually'. Later this was explained: a court must abide by a patient's wishes 'unless there are truly extraordinary or compelling reasons to override them'. The court added:

[S]ome may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will.¹³

This decision can be seen as signalling a change of attitude; the court made it clear that generally intervention against the wishes of a pregnant woman should not be allowed. A stronger statement was made by the Appellate Court of Illinois in 1994. The case – *Re Baby Boy Doe* – also involved an application for court authorisation of a caesarean section. The court rejected the argument that the proper approach was to balance the interests of the viable foetus against the right of a competent woman to choose the medical care that she thought appropriate:

We hold today that Illinois courts should not engage in such a balancing, and that a woman's competent choice in refusing medical treatment as invasive as a caesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her foetus.¹⁴

In England, the same change of attitude is apparent. After two cases in which courts authorised caesarean sections to which competent women had declined to consent,¹⁵ the Court of Appeal handed down two decisions which strongly affirmed the view that a pregnant woman's wishes must be respected. In *Re MB (Medical Treatment)* the court ruled:

A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. ... If ... the competent mother refuses to have the medical intervention, the doctors may not lawfully do more than attempt to persuade her. If that persuasion is unsuccessful, there are no further steps towards medical intervention to be taken.¹⁶

This conclusion was confirmed in *St George's Healthcare NHS Trust v S*. The pre-eclamptic woman at the centre of this case regarded birth as a natural process and considered that interven-

tion should be avoided. The hospital, believing that her life and the life of her foetus were in danger, obtained an order dispensing with her consent to treatment. A caesarean section was performed. Though she did not physically resist, the woman made it clear that she had not given consent to any medical intervention. After her discharge from hospital, she lodged an appeal challenging the court order. The appeal was allowed:

Although human, and protected by the law in a number of different ways ..., an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant. The [order] in this case involved the removal of the baby from within the body of her mother under physical compulsion. Unless lawfully justified, this constituted an infringement of the mother's autonomy. Of themselves, the perceived needs of the foetus did not provide the necessary justification.¹⁷

Later the court added: 'The caesarean section ... (together with the accompanying medical procedures) amounted to trespass'.¹⁸

Identifying the Issues

Thus a review of the case law relating to the two types of situations discussed in this article suggests that the courts in the United States, England and Canada currently believe that a woman should not be subjected to coercion or control in order to protect her foetus. Were they right to reach this conclusion? In my view, they were. To understand the problems addressed by the judges, it is helpful to note some of the factors referred to in the judgment in *St George's Healthcare NHS Trust v S*.

The court accepted that a foetus is not 'a separate person from its mother'. This draws attention to the need to take account of the nature of the relationship between a pregnant woman and her foetus. The view that a foetus is no more than a body part (like an arm or a leg) cannot be sustained. Nor can the view that a pregnant woman and her foetus are separate entities. The relationship is best described in the concept of 'not-one-but-not-two.' The fact that a pregnant woman and

her foetus are 'not one' is most important. To appreciate this is to acknowledge that the issues considered in this article cannot be addressed solely by focusing on the promotion of maternal autonomy. The conduct of a pregnant woman cannot be regarded as affecting her alone. This conduct has the capacity to harm another human being – the child that the foetus will become. To ignore this fact is to adopt an over-simplified analysis.

Equally important is the realization that a pregnant woman is 'not two'. Overlooking this fact paves the way for legal action to protect the foetus against the woman. To regard a pregnant woman and her foetus as 'two' is to set the scene for a conflict between them. The relevant conduct (drug taking or declining medical intervention) can be characterized as manifesting a dispute as to 'rights'. To employ this framework is to accept the view that there is a dispute requiring – and susceptible to – a legal solution. Adoption of this view ignores the fact that woman and foetus are not separate. It pays insufficient attention to their unique interdependence.

The conclusion that the problems raised in this article cannot be resolved by coercive legal intervention is supported by a number of other arguments. Many of these focus on analysis of the techniques of the law. It should not be overlooked that if the criminal law or child protection law is invoked against a pregnant woman, the only way that the protection of the foetus can be ensured is by detaining the woman in an institution. This would be a clumsy and draconian response. There are also objections to the procedures that have been employed when women have declined medical intervention. Often the hearings have been rushed and unsatisfactory. It has been common for the woman not to be represented and for the court to hear only medical evidence. Further, the reality of making an order authorising coercive treatment must be addressed. It is objectionable to contemplate the idea of a patient being forcibly restrained and compelled to undergo surgery.

When considering intervention, it should also not be overlooked that doctors are not infallible and there may be doubts about a diagnosis or prognosis:

Doctors are sometimes wrong, and our increasingly sophisticated medical technology does not enable doctors to guarantee a particular outcome.¹⁹

Quite apart from her right to bodily integrity, the woman may simply disagree with the medical advice. In a society such as ours, she should be free to do so. There is also the fact that there are no convincing precedents for courts ordering the coercive treatment of one person for the benefit of another. Parents should not be forced to undergo treatment (such as providing bone marrow for a transplant) to benefit a child. As was pointed out in *Re AC*, if the law will not compel such a sacrifice for a person, it should not do so for a foetus: 'Surely ... a foetus cannot have rights in this respect superior to those of a person who has already been born'.²⁰

None of this analysis is intended to suggest that the issues are simple. The anguish of a doctor when faced with a decision that is highly likely to result in a stillbirth or the birth of an injured or disabled child cannot be ignored. Nevertheless, the courts should take a firm stand. The law should not be employed to restrain or coerce a competent pregnant woman in an attempt to safeguard her foetus.

Notes

- ¹ 537 NE 2d 721 (Ohio App, 1988).
- ² *Re Children's Aid Society and T* (1987) 59 OR (2d) 204.
- ³ (1997) 152 DLR (4th) 193, 215 and 219. For a similar result, see *Re A (in utero)* (1990) 72 DLR (4th) 722.
- ⁴ [1988] 2 WLR 1288.
- ⁵ *Whitner v State of Carolina* 492 SE 2d 777 (SC, 1997).
- ⁶ For example, *State of Ohio v Gray* 584 NE 2d 710 (Ohio, 1992) and *Reyes v Superior Court App*, 141 Cal Rptr 912 (1977).
- ⁷ 602 So 2d 1288, 1294 (Fla, 1992).
- ⁸ 201 A 2d 537, 538 (1964).
- ⁹ 491 NYS 2d 898, 899-900 (Sup, 1985).
- ¹⁰ Ga, 274 SE 2d 457, 460 (1981). It is interesting to note that a caesarean was not performed and a healthy baby was delivered.
- ¹¹ 573 A 2d 1235 (DC App, 1990).
- ¹² 410 US 113, 162 (1973).
- ¹³ 573 A 2d 1235, 1237, 1247 and 1252 (DC App, 1990).
- ¹⁴ 632 NE 2d 326, 330 (Ill App 1 Dist, 1994).
- ¹⁵ *Re S (Adult: Refusal of Treatment)* [1992] 3 WLR 806 and *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274.
- ¹⁶ [1997] 2 FLR 426, 436-438.
- ¹⁷ [1998] 3 WLR 936, 957.
- ¹⁸ *ibid* 967.
- ¹⁹ Goldberg, S. 'Medical Choices During Pregnancy: Whose Decision Is It Anyway?' *Rutgers Law Review*. 1989, 41, 591, 621.
- ²⁰ 573 A 2d 1235, 1244 (DC App, 1990).