Pregnant Women: Judicial Intervention and the Right of Pregnant Women to Refuse Medical Treatment

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I INTRODUCTION

In the last ten years, several cases have been reported in the United States involving court intervention to compel a competent pregnant woman to give birth by Caesarean section against her will. It appears that courts in the United States, and more recently in England,[1] have shown some readiness to override the wishes of a pregnant woman where her decision causes a serious risk of harm or death to her foetus. This willingness to intervene has occurred not only in cases concerning a woman's refusal to comply with medical advice and undergo Caesarean section, but has also involved courts ordering blood transfusions against the wishes of a pregnant woman.

The right of an individual to refuse medical treatment is shown to be firmly entrenched by the common law and more recently by statutory law. A child en ventre sa mere, however, is not recognised by the law as a

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1 *In re S (Adult: Refusal of Treatment)* [1992] 3 WLR 806.

person and only enjoys prospective rights contingent upon a live birth and separate existence from its mother. It is the interest of the State in protecting life and children that appears to underlie the rationale of United States' courts sanctioning such interference.

Motherhood is valued in our society and most women traditionally will do all that is necessary to see the healthy birth of their children.[2] In this context, the cases and literature make alarming reading.[3] The cases are a forum for a legal and ethical battle of pregnant woman and foetus, woman and the State.

A number of writers have suggested that court intervention might extend beyond the realm of Caesarean section or blood transfusion. If the State's interest in protecting life is so compelling, arguably pregnant women may ultimately be required to submit to various forms of foetal surgery during pregnancy for the better health of a potential child. Some have gone as far as to suggest that the same rationale used to compel women to submit to Caesarean surgery might ultimately see a wide range of maternal behaviour controlled by the courts and the State; pregnant women might increasingly be legally accountable for their food, alcohol and drug consumption.

Although courts have shown a preparedness to intervene in the 'life and death' decisions of a woman in connection with her foetus, several good policy reasons exist to prevent a court from overriding a competent pregnant woman's decisions.

No Australian court has as yet had to consider the question of intervention to compel a pregnant woman to submit to an unwanted Caesarean section, or any other medical procedures for that matter. If and when that time comes, it is hoped more attention will be paid to these policy arguments in balancing the rights of a pregnant individual to make her own decisions with that of the potentially competing interests of the State in seeking the birth of a healthy child. Should the State become too oppressive in this context, it is likely that not only will women be less inclined to procreate, but those who do so might be less inclined to use the medical system at all. This would have the undesirable effect of putting the health of more children at risk.

Difficult as it might sound, it may be that the life of a foetus endangered by the actions of its mother is the price to be paid for the integrity of all women and all human beings to be able to refuse unwanted medical treatment.

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[2] K.A. Knopoff, 'Can a Pregnant Woman Morally Refuse Fetal Surgery?' (1991) 79 *California Law Review* 499, 502.

[3] J. Gallagher, 'Prenatal Invasions & Interventions: What's Wrong with Fetal Rights' (1987) 10 *Harvard Women's Law Journal* 9.

II BASIS OF THE RIGHT TO REFUSE MEDICAL TREATMENT

Common Law

The common law right of an individual to refuse medical treatment has been confirmed in a number of Anglo-American cases in recent years.

United Kingdom

The House of Lords in *In re T (Adult: Refusal of Treatment)*[4] confirmed that, *prima facie*, every competent adult has the right and capacity to decide whether to accept medical treatment, even where a refusal may risk permanent injury to his or her health or even lead to premature death.[5]

The case involved T's opposition to a blood transfusion. The main focus was upon T's capacity to make a decision in the circumstances. Although the court stated that it is immaterial that the reasons for the decision to refuse treatment are irrational, unknown or even non-existent,[6] an important qualification to this principle is that an adult patient may be deprived of the capacity to refuse treatment either by long-term mental incapacity, retarded development or by temporary factors such as unconsciousness, confusion or the 'effects of fatigue, shock, pain or drugs'.[7] Refusal to be medically treated where it does not truly reflect the patient's decision[8] may be vitiated by the undue influence of others.[9]

Where an adult does not have the capacity to decide to refuse treatment, it is the duty of the doctors to treat him or her 'in whatever way they consider, in the exercise of their clinical judgment, to be in his best interests'.[10]

An important remark was made by Lord Donaldson of Lymington MR when he stated that the 'only possible qualification [to the above] is a case in which the choice may lead to the death of a viable foetus'.[11]

The subsequent case of *Re C (Refusal of Medical Treatment)*[12] reinforces the notion of the *prima facie* right of every adult to refuse medical

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4 [1992] 3 WLR 782.
5 *Id.* 799, per Lord Donaldson of Lymington MR.
6 *Ibid*, per Lord Donaldson of Lymington MR; and *id.* 801, per Lord Justice Butler-Sloss.
7 *Id.* 799, per Lord Donaldson of Lymington MR.
8 *Ibid.*
9 *Id.* 801, per Butler-Sloss LJ; and 804, per Staughton LJ.
10 *Id.* 801. The 'best interests' test seems to be in conflict with the test of 'substituted judgment' used by US courts: *In re AC* (1990) 573 A 2d 1235.
11 *Id.* 786. This *obiter dictum* was employed in the case of *Re S (Adult: Refusal of Treatment)* [1992] 3 WLR 806.
12 [1994] 1 FLR 31.

treatment. In granting the injunction to prevent a hospital from amputating C's gangrenous leg, the High Court of Justice was prepared to extend the principle of a right of refusal of life-sustaining treatment from a present condition to an anticipated situation. The injunction applied to restrain doctors from amputating C's leg now whilst he was competent, but it also applied to the future should C lapse into unconsciousness or otherwise become incompetent.

United States and Other Jurisdictions

Many United States' courts have expressed the view that a competent patient has the right to refuse life-sustaining medical treatment. In the case of *In the Matter of Alice Hughs*[13] the plaintiff, a Jehovah's Witness, unsuccessfully appealed against an emergency judgment that had appointed a temporary guardian to consent to her receiving blood transfusions. The reason for her failure to succeed in an action merely reflected a doubt, on the facts of the case, as to whether the plaintiff had made a fully informed decision to refuse blood if this meant she would die — that is, her decision was not necessarily unequivocal.[14]

In *Nancy B v Hotel Dieu de Quebec*,[15] the Quebec Superior Court allowed the plaintiff to successfully bring an action to have herself removed from intubation on a respirator (even though it was clear that such a decision meant she would die within a very short time). Keeping an individual on a respirator without consent was held to be an improper interference with and violation of her person.

The withdrawal of life support has also been approved in cases of incompetent adults. In *Auckland Area Health Board v Attorney-General*,[16] for example, the High Court of New Zealand declared doctors were justified, as part of proper medical practice, in withdrawing artificial ventilation where a patient was unable to interact with their environment and whose condition was considered irreversible.[17]

Statute Law

There have been no recent Australian cases directly discussing the rights of a competent patient to refuse medical treatment, although such a prin-

[13] (1992) 611 A 2d 1148.

[14] For a further discussion of the basis of these principles in the United States, see 'Basis of the Right to Refuse Medical Treatment', at pp. 6–10.

[15] (1992) 86 DLR (4th) 385.

[16] [1993] 1 NZLR 235.

[17] This is one of a number of 'persistent vegetative state' cases considered recently in Anglo-American courts. See D. Mendelson, 'Jurisprudential Aspects of Withdrawal of Life Support Systems from Incompetent Patients in Australia' (1995) 69 *Australian Law Journal* 259.

ciple is implicit in the reasoning of cases in related areas of the law.[18] Furthermore, the right of patient autonomy is now stressed in most texts dealing with medical ethics.[19]

The only Australian State to supplement the common law in relation to the autonomy of patients to refuse medical treatment is Victoria. The *Medical Treatment Act 1988* (Vic.) has given a direct statutory right to competent patients to refuse medical treatment. Section 4(1) states that the rights of a person under any other law to refuse medical treatment is not affected — that is, these statutory rights are in addition to common law rights.

The Act does not apply to palliative care,[20] and the decision to refuse treatment must relate to a current condition.[21] The patient's decision must be voluntary without inducement or compulsion,[22] and the patient must be reasonably informed of his or her condition and the consequences of refusal.[23] Furthermore, the patient must be of full age and capacity.[24]

Where the patient has properly completed the prescribed certificate witnessed by the medical practitioner, it is an offence by the medical practitioner to undertake or continue the refused treatment.[25] Furthermore, the medical practitioner, acting in good faith and relying upon the medical certificate, is protected from civil and criminal proceedings.[26]

The Victorian Government has also provided for the protection of the authority of patients by enacting the *Medical Treatment Act 1990* (Vic.). A person may appoint an agent by way of an enduring power of attorney (medical treatment) in the prescribed form empowering the agent to make a decision to refuse treatment on the patient's behalf should they become incompetent.[27] The agent may refuse treatment on behalf of the patient if there are reasonable grounds for believing that the patient, if competent, would have considered the medical treatment unwarranted having given serious consideration to his or her health and well-being.[28] Thus a form of 'substituted judgment' has been provided for by the Act.[29]

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[18] *Ibid.* See *Rogers v Whitaker* (1992) 175 CLR 479 dealing with the doctrine of informed consent. See also *Marion's case* (1992) 175 CLR 218 which dealt with the non-therapeutic sterilisation operation of an incompetent minor.

[19] See V. Pleuckhahm et al., 'Ethical Principles and the Doctor', pp. 2–3 in *Law and Ethics in Medicine for Doctors in Victoria* discussing the 1981 34th Assembly of the World Medical Association in London *(The Declaration of Lisbon)*.

[20] *Medical Treatment Act 1988* (Vic.), s. 4(2).

[21] *Medical Treatment Act 1988* (Vic.), s. 5(1)(a).

[22] *Medical Treatment Act 1988* (Vic.), s. 5(1)(b).

[23] *Medical Treatment Act 1988* (Vic.), s. 5(1)(c).

[24] *Medical Treatment Act 1988* (Vic.), s. 5(1)(d).

[25] *Medical Treatment Act 1988* (Vic.), s. 6.

[26] *Medical Treatment Act 1988* (Vic.), s. 9.

[27] *Medical Treatment Act 1990* (Vic.), s. 5A.

[28] *Medical Treatment Act 1990* (Vic.), s. 5B.

[29] *Supra* n. 10.

The Victorian legislation is wider than that employed in other Australian jurisdictions in so far as it applies not only to terminally ill patients but to all competent adult persons under medical care.[30]

Basis of the Right to Refuse Medical Treatment

This article will look at a number of examples of cases of conflict between the rights of a woman to refuse medical treatment *and* the interests of the foetus or the State to ensure the live and healthy birth of a child. The judgments in those cases, and the resultant literature, provide a number of themes which form the basis of the right of a pregnant woman to refuse medical treatment.

Doctrine of Informed Consent

The United States has historically grounded the right to refuse medical treatment on the doctrine of informed consent. This doctrine is recognised as being firmly rooted in American tort law. The doctrine requires a physician to inform a patent of the risks involved with medical treatment.[31]

The Australian High Court decision of *Rogers v Whitaker*[32] clearly supports the notion of informed consent and confirms the duty of doctors to warn a patient of material risk inherent in a proposed procedure if a reasonable person in the patient's position would be likely to attach significance to it. Failure to warn might constitute negligence on the part of the doctor.

However, in the English case of *In re T (Adult: Refusal of Treatment)*[33] Lord Donaldson of Lymington MR stated that English law did not accept the American concept of 'informed consent' and accordingly would reject the concept of 'informed refusal'. Failure to warn might lead to negligence but does not vitiate consent or refusal.[34] It is problematic in the UK as to what role informed consent plays in the right of a patient to refuse medical treatment.

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[30] *Natural Death Act 1983* (SA); *Natural Death Act 1988* (NT) and *Natural Death Regulations 1989* (NT).
[31] *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, 129.
[32] (1992) 175 CLR 218.
[33] [1992] 3 WLR 782.
[34] *Id.* 798.

Right of Bodily Integrity

In the United States, the Fourteenth Amendment to the Constitution protects the fundamental rights to liberty and freedom from unwanted bodily restraint.[35]

A number of writers view the right of bodily integrity as being a sufficient ground for respecting a woman's right to reject intervention required for the benefit of a foetus.[36] George Annas, for example, has said that the death of a near term foetus because of a mother's refusal to undergo a Caesarean section to save its life is 'the price society pays for protecting the rights of all competent adults, and preventing forcible, physical violations of women by coercive obstetricians and judges'.[37]

American courts have not regarded the right to bodily integrity as an unqualified right or irrebuttable presumption. Only bodily intrusions considered unreasonable by the State are prohibited.

In Australia, the analogous patient's right of autonomy is recognised by the medical profession[38] and the patient's right to refuse medical treatment is specifically mentioned both in the body and preamble[39] of the *Medical Treatment Act 1988* (Vic.).[40] Although the Preamble recognises that it is desirable 'to give protection to the patient's right to refuse unwanted medical treatment',[41] the Act is not conclusive in the denial of the rights of the foetus and the State to medically intervene against the wishes of a pregnant woman refusing treatment. There are many doctors who believe they have two patients in this context: the mother and the foetus.[42]

Right to Privacy

The body of law in the United States has long recognised a distinct right to privacy deriving from the Constitution and protecting certain aspects of personal autonomy from State intervention.[43] The right to privacy, though not specifically enumerated in the Constitution, emanates from the Bill of Rights adding substance to the United States' constitutional guarantees. Within the realm of privacy lies the right to bodily integrity, the right to decide matters of childbearing and the right to an abortion.[44]

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35 U.S. Constitution Amendment XIV, s. 1. '[N]or shall any State deprive any person of life, liberty or property, without due process of the law...' 1868.

36 Some policy arguments will be discussed below in Part V.

37 G. Annas, 'Forced Caesareans: The Most Unkindest Cut of All' (1982) 12 *Hastings Center Report* 16, 45.

38 See *supra* n. 19.

39 Paragraph (a) of the Preamble to the *Medical Treatment Act 1988* (Vic.).

40 See discussion of this legislation above.

41 See *supra* n. 39.

42 The question of the foetus as a separate entity is considered in Part III below. See *infra* n. 89.

43 H.L. Hornick, 'Mama vs Fetus' (1993) 39 *Medical Trial Technique Quarterly* 536, 546.

44 *Id.* 547.

Among the constitutional amendments from which the right to privacy emanates is the Fourth Amendment, which protects individuals from 'unreasonable searches and seizures'. In *Winston v Lee*,[45] for example, the Supreme Court of Virginia ordered a robbery suspect to undergo surgical removal of a bullet lodged beneath his collarbone. The operation required the use of general anaesthesia which was considered risky.[46] It was held that the procedure would be a violation of the Fourth Amendment even when balanced against the interest of the State in conducting the procedure to gather evidence. This line of reasoning was alluded to in the decision of *In re AC*[47] where a 'forced' Caesarean section was disapproved.[48]

There is generally no right to privacy recognised by the common law apart from administrative law matters and the protection of sensitive personal records.[49]

Equal Protection and Anti-discrimination

Some writers have canvassed the idea that forced medical intervention of pregnant women might breach that part of the Fourteenth Amendment dealing with equal protection under the law.[50] However, at least one commentator has argued that although discrimination on the basis of sex is prohibited,[51] when it comes to biological differences between men and women, women are given no protection against discrimination unless the discrimination is evident in an area where men and women are similarly situated. Accordingly, pregnant women are granted no special protection under this interpretation of the equal protection clause because men are currently not capable of experiencing pregnancy.[52]

Freedom of Religious Expression

United States' courts have heard a number of cases involving the rights of Jehovah's Witnesses to refuse life-saving blood transfusions on religious grounds. Some of those cases have involved pregnant women.[53]

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[45] (1985) 470 US 753.

[46] *Id.* 756–7.

[47] (1990) 573 A 2d 1235, 1245.

[48] This case is discussed more fully in Part IV.

[49] See, for example, *Privacy Act 1988* (Cth); *Victoria Park Racing and Recreational Grounds Co. Ltd v Taylor* (1937) 58 CLR 479; *Plenty v Dillon* (1991) 171 CLR 635.

[50] R.A. Halstead, 'A Pregnant Woman's Right to Refuse Medical Treatment — Is it Always Her Choice?: *In Re AC*' (1991) 24 *Creighton Law Review* 1589, 1608–10.

[51] This is clearly the case in Australia as well. See *Sex Discrimination Act 1984* (Cth) and relevant State legislation in this context.

[52] D. Johnsen, 'The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection' (1986) 95 *Yale Law Journal* 599, 621.

[53] *In re Dubreuil* (1992) 603 So 2d 538.

Although the First Amendment of the United States' Constitution guarantees freedom of religious expression, courts have generally decided such cases on other grounds, such as the patient's right to privacy.[54] In the case of *In re Dubreuil*,[55] the right to religious freedom was outweighed by the State's interest in protecting the woman's children from abandonment.

In the Australian context, freedom of religion is guaranteed by s. 116 of the Commonwealth Constitution.[56] This guarantee was confirmed in the *DOGS case*[57] which was concerned with Commonwealth grants to States in the context of a different funding regime for government and non-government Catholic schools. Freedom of religious expression might be a likely argument in 'forced' blood transfusion cases. To date there are no Australian cases reported in this area of the law.

The Duty to Rescue

This duty has been used in arguments by proponents and opponents of the right of a woman to refuse medical treatment. A number of writers have likened court-ordered surgery on a pregnant woman in the interests of the foetus to an organ donation ordered over the explicit refusal of a competent adult.[58] In *McFall v Shimp*,[59] Shimp, McFall's cousin, refused to take a compatibility test to determine his suitability to donate bone marrow from his body for the benefit of his cousin. The court held that there was no legal duty to rescue others and that to force an individual to undergo this medical procedure would 'change every concept and principle on which our society is founded' and 'would impose a rule which would know no limits'.[60]

There is, however, strong support for a duty of affirmative care, including aid and rescue, incidental to certain special relations of dominance and dependence such as employer and employee, driver and passenger, occupier and lawful visitor[61] even if a general affirmative duty to rescue is not recognised. A child would be owed this duty while in the care of an adult. It is likely therefore that a mother–foetus relationship might enjoy the same status.

Nonetheless, even in a special relationship, the courts might not require enormous sacrifice. Whereas a parent might have a duty to aid a

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[54] J. Bamonte and C. Bierman, '*In re Dubreuil*: Is an Individual's Right to Refuse a Blood Transfusion Contingent on Parental Status?' (1992) 17 *Nova Law Review* 517, 527.

[55] (1992) 603 So 2d 538.

[56] *Commonwealth of Australia Constitutional Act 1900* (Imp.).

[57] *Attorney-General (Vic.) (at the relation of Black) v Commonwealth* (1981) 146 CLR 559.

[58] For example, Hornick, *supra* n. 43 at 553.

[59] (1978) 10 Pa D & C 3d 90.

[60] *Id.* 91.

[61] For example, *Horsley v McLaren* [1972] SCR 441 (social guest on a pleasure boat); *Robitaille v Vancouver Club* (1981) 124 DLR (3d) 228 (employee).

sick child[62] by providing care and medicine, courts would be unlikely to force a woman to do something seriously detrimental to her own health in order for a child to thrive. It is difficult, for example, to imagine a court taking the view that a mother should donate one of her kidneys to a child.[63] This perhaps places too high a standard of care upon her. Proponents of foetal rights, however, argue that a mother is in a unique position to assist a foetus which places an even greater burden on her than the duty owed to a living child.[64]

Furthermore, the law in connection with the duty to rescue recognises the fact that where a person has created a situation of reliance and dependency, inference of a duty can be more readily drawn.[65] There is some argument to suggest that a pregnant woman has done exactly that — that is, created the relationship of dependency. Accordingly, it may not be open to her to relinquish that accepted responsibility prior to birth. The arguments in connection with duties of rescue either support or detract from a woman's right to refuse medical intervention.

III THE RIGHTS OF THE FOETUS

Recognition of the Foetus as an Entity

The law does not recognise the foetus as a person, nor does it recognise the right of a foetus to be born. Nonetheless the existence of a foetus is recognised by the law and has led to legal intervention to protect interests harmed while *in utero*.

Personhood Rights

In recent years, Anglo-American courts have consistently held that a foetus has no rights of its own until born alive with a separate existence from its mother.

In *Attorney-General for the State of Queensland (ex rel Kerr) v T*,[66] the applicant sought to restrain the respondent, allegedly pregnant with his child, from having an abortion. The Australian High Court rejected the claim. In an *obiter dictum* statement, Gibbs CJ confirmed that 'a foetus

[62] For common law principles, see J.G. Fleming, *The Law of Torts* (8th ed., Sydney: The Law Book Co. Ltd, 1992), 147–9.
[63] For a discussion of these issues, see Knopoff, *supra* n. 2 at 521–31.
[64] *Id.* 524.
[65] Fleming, *supra* n. 62 at 149–51.
[66] (1983) 57 ALJR 285.

has no rights of its own until it is born and has a separate existence from its mother'.[67]

Furthermore, in *K v Minister for Youth and Community Services; Re Infant K*,[68] the Supreme Court of New South Wales held that an unborn child does not have the requisite status to participate in proceedings to restrain its termination in pregnancy.

The English courts have also stated that an unborn child has no 'legal personhood' or enforceable rights until it is born. In *Re F (in utero)*,[69] the Court of Appeal held that it had no jurisdiction to make a child en ventre sa mere a ward of the court. The court accepted an incompatibility between a jurisdiction to apprehend a foetus *and* the welfare of the mother, the undesirability of creating a legal conflict between the existing legal interests of the mother and those of the foetus,[70] and the insuperable difficulties of enforcement of any such order.[71]

In *R v Tait*,[72] the Court of Appeal had to consider personhood rights in connection with the criminal law. An appeal was upheld by a person convicted of making a threat to a woman (five months pregnant) that if she informed the police of his commission of a burglary he would kill her baby. He had been charged with unlawfully threatening to kill *another* or a third person by virtue of s. 16 of the *Offences Against the Person Act 1861*.[73] The court held that the foetus *in utero* was not 'in the ordinary sense' another person distinct from its mother.[74]

Although there is evidence in the literature of American cases involving women being held in custody as a protection to the foetus (prior to its birth),[75] United States' courts have not gone so far as to recognise the personhood rights of a foetus.[76]

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[67] *Id.* 286.

[68] (1982) 8 Fam LR 250.

[69] [1988] 2 WLR 1297.

[70] *Id.* 1301, per May LJ.

[71] See also *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276 and *C v S* [1988] QB 135 which held that a foetus prior to separate existence of its own acquires no legal rights.

[72] J.G. Starke, 'The Problem of the Legal Status of the Foetus *in utero*' (1989) 63 *Australian Law Journal* 719 discussing *R v Tait* (reported in *The Times* (London), 28 April 1989).

[73] As embodied in a schedule to the *Criminal Law Act 1977* (Eng.).

[74] Starke, *supra* n. 72 at 719.

[75] See the section entitled 'The Doctrine of *Parens Patriae*' below.

[76] Canadian courts also support the lack of 'personhood' rights of a foetus. In *Re Baby R* (1987) 9 RFL (3d) 420, the Supreme Court of British Columbia overturned an apprehension order (for custody) and subsequent guardianship order against a woman resisting a Caesarean section. The court supported, *inter alia*, the reasoning of the English Court of Appeal in *Re F (In Utero)* [1988] 2 WLR 129.

Property Rights

In the context of inheritance, it is long established by the common law that the existence of a foetus may be recognised. The right to property vests once the child has been born alive.[77] The common law recognises that references in a will to 'children' may include children en ventre sa mere.[78] The situation is no different where the father dies intestate.[79]

The principle(s) in connection with inheritance have also been applied to other claims such as those under workers' compensation legislation in England[80] and Australia.[81]

Torts

Injury suffered by a foetus inflicted by the negligence of a third party. Although a foetus may not possess 'personhood' rights,[82] it would appear from recent cases that a child born with injuries sustained *in utero* is not prevented from bringing an action in negligence notwithstanding the difficult question of the legal status of the foetus.

The question of whether a plaintiff can claim damages in respect of the pre-natal infliction of injuries by a third party arose in *Watt v Rama*.[83] The Full Court of the Supreme Court of Victoria had to consider certain preliminary points of law which arose out of a car crash in which a pregnant woman (one of the drivers in the collision) was injured by the alleged negligent driving of the defendant. The pregnant woman subsequently gave birth to a child suffering from brain damage, epilepsy and substantial paralysis.

Among the questions to be answered by the court were whether (1) the defendant owed a duty of care not to injure the unborn plaintiff, and (2) the damage complained of was in law too remote. For the purposes of determining these questions, it was assumed that the injuries sustained by the woman were caused by the defendant's negligent driving. All three members of the court found a requisite duty of care owed to the unborn child and held that the damage was not too remote.

Winneke CJ and Pape J held that it was reasonably foreseeable at the time of the collision that the defendant's conduct might cause injury to a pregnant woman in the car with which he collided. Therefore, the possi-

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[77] This formula appears to be the one used in tort as well: *Watt v Rama* [1972] VR 353.
[78] *Doe v Clarke* (1795) 2 H BL 399 (126 ER 617).
[79] *Wallis v Hodson* (1740) 2 Atk 115 (26 ER 472).
[80] *Villar v Gilbey* [1907] AC 139; *Williams v Ocean Coal Co. Ltd* [1907] 2 KB 422.
[81] *Connare v Pistola* (1943) 60 WN (NSW) 95.
[82] See the section entitled 'Personhood Rights' above.
[83] [1972] VR 353.

bility of injury upon the birth of the child she was carrying must also be reasonably foreseeable. It was on the birth of the child that the potential relationship between the defendant's duty and the child crystallised, since it was only then the child was suffering from injuries as a living person and a claim for damages arose.

Gillard J reached the same conclusion by different reasoning. On the assumed facts, the plaintiff was considered to be a member of a class which might reasonably and probably be affected by the defendant's carelessness since 'the regeneration of the human species implies the presence on the highway of many pregnant women'.[84] The defendant as a reasonable driver should have foreseen the presence of such a woman and the risk to her child if his failure to reach the standard of a reasonably careful driver should cause him to collide with and injure the mother. Gillard J differed from Winneke CJ and Pape J in that he was prepared to deem an unborn child a person in being at the time of the defendant's negligence,[85] although there was no entitlement to compensation until a live birth.[86]

All the judges stressed that there was nothing unusual in there being a time-lag between the defendant's careless driving and the consequential damage suffered by the plaintiff, since the duty of care was not dependent on the existence, at the time of the defendant's fault, of a person with a right correlative to the defendant's duty to take care.[87]

Subsequently, in *Kosky v The Trustees of the Sisters of Charity*,[88] the principle was extended to negligent behaviour by a defendant hospital in giving the plaintiff an incorrect blood transfusion which had resulted in the premature birth and illness of a child born eight years later. The defendant argued that as the plaintiff was not in existence at the time of the blood transfusion, no duty of care could be owed to him. Although concerned only with the issue of the limitations of actions, Tagdell J found *Watt v Rama* applicable.[89]

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[84] *Id.* 374.

[85] *Id.* 376.

[86] *Id.* 377.

[87] *X and Y (By Her Tutor X) v Pal* (1991) 23 NSWLR 26 supports the majority reasoning that where a plaintiff is not legally defined at the time of the tort, the duty and legal rights may nonetheless crystallise at birth.

[88] [1982] VR 961.

[89] Further authority is found in *Duval v Seguin* (1972) 26 DLR (3d) 418 where the High Court of Ontario recognised the tort is complete at birth, at which time there is no difficulty in attributing legal personality to a live and injured plaintiff. This accords with the US position where every jurisdiction allows an injured foetus subsequently born alive to recover for damage sustained by another's negligence while en ventre sa mere. See N. Hansbrough, 'Surrogate Motherhood and Tort Liability: Will the New Reproductive Technologies Give Birth to a New Breed of Pre-natal Tort?' (1986) 34 *Cleveland State Law Review* 311, 320.

Child's right to sue parents for negligence. Although these contingent prospective foetal rights have been recognised against a third party, the question of whether an unborn child's tortious rights will crystallise against its parents upon its live birth is problematic.

Certainly there is some authority in Australia for the proposition that a child may sue its parents for negligent acts or omissions during its life.[90] However, there is no generally accepted duty in tort of parents to feed, clothe, educate, maintain and care for children notwithstanding the moral or criminal liability of parents.[91] The duty owed by parents to children arises not because of the blood relationship but because of the factual circumstances involved — for example, where a parent has charge of his or her child in an immediate situation of danger.[92]

Thus although a blood relationship does not provide a basis for a cause of action in negligence, it also cannot be said to prevent one either. As Barwick CJ stated in *Hahn v Conley*, '[I]f there be a cause of action available to the child, the blood relationship of the child to the defendant will not constitute a bar to the maintenance by the child of the appropriate proceeding to enforce the cause of action'.[93]

Injury suffered by a foetus inflicted by the negligence of his or her parents. It appears that an action in negligence may be available to an infant against a third party for damages sustained by pre-natal injury. Parents may also be sued by their children. If a child suffers damage as a result of the pre-natal conduct by its mother, 'there is no reason why, in principle and in logic, an action should not lie at the suit of the child against his [or her] mother'.[94]

This, of course, is relevant not only to the immediate question of the recognition of the foetus as an entity but to the central issue of the rights of a pregnant woman to refuse medical treatment where adverse consequences might be suffered by a potential/actual child born alive.

In England, the *Congenital Disabilities (Civil Liability) Act 1976* (UK) operates to generally achieve an opposite result. Section 1(1) provides that a child born with a disability caused by another's fault should not be able to sue its mother if her conduct was the cause of the disability.[95] An exception is allowed by s. 2 where that disability is a result of the mother's negligent driving of a motor vehicle whilst pregnant. The reason for the exception is the existence of compulsory motor vehicle insurance for third party injuries.

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[90] See *Hahn v Conley* (1971) 126 CLR 276.
[91] *Rogers v Rawlings* [1969] Qd R 262, 274, per Lucas J and 277, per Douglas J.
[92] *Id.* 274, per Lucas J and 276–7, per Douglas J.
[93] (1971) 126 CLR 276, 283.
[94] P.J. Pace, 'Civil Liability for Pre-natal Injuries' (1977) 40 *Modern Law Review* 141, 153.
[95] The Act provides no such protection for the child's father.

The legislation is based on the recommendation of the United Kingdom Law Commission published in its *Report on Injuries to Unborn Children.*[96] The Law Commission Report argues that there is a wide range of conduct during pregnancy by which a mother may cause injury to her unborn child, either by ignoring medical advice or by taking unjustified risks of physical injury.[97] The resultant English Act makes logic and principle yield to social acceptability[98] for some very strong policy reasons.

The Law Commission Report argues that to allow the possibility of tortious liability in this context would add strain to an already stressful relationship between mother and child.[99] Second, proving the nexus between the maternal behaviour and the child's injuries may be a problem. It has been emphasised that the 'field of teratology is in a state of development and, in many cases, the evidence as to the causes of a child's congenital disability will be inconclusive'.[100] A further policy reason for disallowing such claims is that, in the absence of insurance against liability, there will often not be a fund to meet the mother's liability without causing hardship to the rest of the family.[101] The Law Commission placed a great deal of emphasis on the fact that pre-natal negligence might be used as a weapon between parents in a matrimonial conflict to the detriment of the child.[102] The vindictive father might be tempted to take action on behalf of the child against the mother whom he is seeking to divorce. Furthermore, the pre-natal misconduct of his wife may provide additional evidence for the father in any custody dispute.[103]

In considering the issue of parental liability for pre-natal injury to children, the British Pearson Commission Report on *Civil Liability and Compensation for Personal Injury*[104] reached a similar conclusion to the Law Commission but recommended that a child should not have a right of action against *either* parent for pre-natal injury. It stressed the potential damage and upheaval to family relations of allowing such claims.[105]

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[96] Great Britain, *The Law Commission Report on Injuries to Unborn Children*, Law Com. No. 60 (1974) Cmd. 5709.

[97] *Id.* para. 58.

[98] *Id.* para. 55.

[99] *Ibid.*

[100] *Id.* para. 28.

[101] *Id.* para. 55.

[102] *Ibid.*

[103] *Id.* para. 56.

[104] Great Britain, *Report of Pearson Royal Commission on Civil Liability and Compensation for Personal Injury*, Report 1, (1978) Cmnd. 7054.

[105] *Id.* paras 1465–72. A similar conclusion was reached by John Seymour in his report entitled: *Fetal Welfare and the Law*, A Report of an Inquiry Commissioned by the Australian Medical Association 1995, Chs 8 and 11.

Neither the Law Commission Report nor the Pearson Commission Report considered the issue of bodily integrity or autonomy of a pregnant woman to act as she so chooses.[106] It is clear that neither Commission had the benefit of considering the difficult cases which have arisen since the 1970s.

There is no legislation in relation to these matters in Australia. However, a recent decision of the NSW Court of Appeal suggested an approach similar to the United Kingdom legislation might be taken in Australian courts. In *Lynch v Lynch*,[107] an infant plaintiff (born with cerebral palsy) sought damages for the pre-natal injury she suffered allegedly as a result of her mother's negligent driving. The plaintiff succeeded both at first instance and on appeal.

The defendant in the Court of Appeal unsuccessfully argued that no duty of care was owed by her in respect of the pre-natal injury suffered by her child. Although the Court of Appeal rejected this argument and upheld the mother's duty of care (relying upon *Watt v Rama*[108] and *X and Y (By Her Tutor X) v Pal*[109]), it was careful to limit its decision to situations involving motor vehicle claims on the basis that under the *Motor Vehicles (Third Party Insurance) Act 1942* (NSW), compensation is available to everyone for injury as a result of negligent driving. Accordingly, the court found no reason to exclude the plaintiff[110] where it could avoid these far-reaching questions of policy.[111] The decision appears to follow the *Congenital Disabilities (Civil Liability) Act 1976* (UK). The issue is far from settled and in confining itself to the question in the context of insurance cases, the 'door' to such actions being brought by a child against its mother for pre-natal injury is not entirely closed in New South Wales or in any other Australian jurisdiction. The High Court has as yet not examined such issues.[112]

In the United States, courts in Michigan and Illinois have held that a child can sue its mother for her behaviour while pregnant, where such behaviour has adversely affected the child's development prior to birth. To date, no case has reached the United States' Supreme Court and as a consequence these decisions are of limited authority. In *Grodin v Grodin*,[113]

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[106] See Part II above.
[107] (1991) 25 NSWLR 411.
[108] [1972] VR 353.
[109] (1991) 23 NSWLR 26.
[110] (1991) 25 NSWLR 411, 415–16.
[111] *Id.* 415.
[112] See F. Forsyth, *'Lynch v Lynch & Anor'* (1992) 18 *Melbourne University Law Review* 950, where it is argued that a broader maternal liability for pre-natal injury is an unwelcome development.
[113] (1980) 301 NW 2d 869.

an action was brought by a son and his father (as the son's next friend) against his mother for damage to the son's teeth allegedly caused by the mother failing to exercise 'reasonable' discretion in using tetracycline during pregnancy. The Michigan Court of Appeals remanded the 'reasonableness' of the defendant's behaviour to be determined by a further hearing. In doing so it held that the child's mother bears the same liability for pre-natal negligent conduct as does a third party.

The case of *Stallman v Youngquist*[114] is of some significance. At first instance, it was held that a foetus once born, like any child, may recover damages from its mother for injuries sustained by her negligence. The Supreme Court of Illinois reversed the decision. In con-sidering a number of policy issues, the Supreme Court of Illinois concluded that a pregnant woman's interest in privacy and bodily integrity, as well as the difficulty in establishing a consistent standard of 'reasonable' pre-natal care, militated against recognising the right of a foetus to sue its mother for the unintentional infliction of pre-natal injuries.

It is worth noting that this case (like *Lynch v Lynch*[115]) concerned the negligent driving of a pregnant woman in the context of motor vehicle insurance. It is not insignificant that the appellate court was not prepared to find against the mother even where she was covered by insurance.

Although the court took a strong stance in connection with negligence actions, difficult cases involving intentional or reckless conduct by the pregnant woman leading to the infliction of pre-natal injury were not considered by the court. It may well be that the cases considered in Part IV of this article concerning, for example, the refusal to consent to a Caesarean section or receive a blood transfusion against the advice of doctors is more likely to fall within the realm of intentional torts than negligence.

The question of the liability of a mother for the infliction of pre-natal injury to her child is far from settled in Australia. The balance of statutory and judicial material emanating from Anglo-American jurisdictions appears to favour the mother in defending an action brought by a child. If this should be the legal position, then it calls into question whether a court has the right to intervene in the decision of a pregnant woman to decline medical treatment.

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[114] (1988) 531 NE 2d 355.
[115] (1991) 25 NSWLR 411.

Arguments Employed for Judicial Intervention

Where the courts have been prepared to intervene, a number of theoretical justifications appear to have surfaced. These are discussed below.

Abortion

In cases involving judicially sanctioned medical intervention of pregnant women, particularly the 'forced' Caesarean cases,[116] 'abortion' arguments have predominated in the relevant judgments.

Although *Roe v Wade*[117] is a landmark United States' decision standing for a woman's right to privacy and the right to make her own decision about pregnancy or its termination, paradoxically it has been invoked by the courts to justify intervention in the decision-making of pregnant women.

A woman's unqualified right to abortion extends only through the first trimester of pregnancy. After the first trimester, the State may act to regulate abortion in the interests of maternal health and safety[118] and in the interest of the protection of potential life. A basic proposition under *Roe v Wade* is that a woman may elect to have an abortion prior to the viability of her foetus.[119] Once a foetus is viable,[120] however, the State's interest in potential life becomes compelling.

Since the State can prohibit the intentional termination of foetal life after viability, it can likewise protect a viable foetus by preventing vaginal delivery when it will have the same effect as abortion. In *Jefferson v Griffin Spalding County Hospital Authority*,[121] for example, the Georgetown Supreme Court relied, in part, on *Roe v Wade* when it upheld a trial court's decision compelling a pregnant woman to submit to Caesarean section to save the life of the foetus.

Some writers say that on the basis of this interpretation of *Roe v Wade*, a woman carrying a foetus with a congenital defect could be required to have *in utero* surgery to correct the defect.[122] Such a scenario is yet to be tested in the courts.

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[116] See Part IV below. For example, see *Jefferson v Griffin Spalding County Hospital Authority* (1981) 274 SE 2d 457.

[117] (1973) 410 US 113.

[118] *Id.* 163–4.

[119] *Ibid.*

[120] It is worth noting that advances in technology have meant that a foetus may be viable earlier in pregnancy: *Webster v Reproductive Health Services* (1989) 492 US 490 which held that a statute requiring viability testing at 20 weeks or more into the gestational period is constitutional.

[121] (1981) 274 SE 2d 457, 460 discussing *Roe v Wade* (1973) 410 US 113.

[122] See Hornick, *supra* n. 43 at 542 for a brief discussion of *Roe v Wade* (1973) 410 US 113 in this context.

Others argue that even though the State can go so far as to proscribe abortion in the third trimester (unless the woman's health is at stake),[123] there is a quantum leap in logic from prohibiting intentional foetal destruction to mandating major surgery to protect and preserve the life of a foetus.[124]

It is clear that *Roe v Wade*[125] does not grant the State unqualified authority to protect the foetus. In *Colautti v Franklin*,[126] the Supreme Court stated as a matter of constitutional law in the context of abortion that the woman's life and health must always prevail over the life and health of a foetus should there be a conflict.[127] This was confirmed by the United States' Supreme Court in *Thornburgh v American College of Obstetricians & Gynaecologists*[128] when it stated that 'this Court recognised the undesirability of any "trade-off" between the woman's health and additional percentage points of foetal survival'.[129]

As surgical delivery of a child involves approximately four times the maternal mortality rate of vaginal delivery,[130] a real trade-off is evident between maternal and foetal health. In the United States' context, this argument to preclude judicial intervention in the 'forced' Caesarean cases is used.

It is questionable whether the 'abortion' argument would be successfully run in Australia should a court be asked to judicially intervene in the decision of a pregnant woman affecting a foetus. Where the basis for the argument in the United States is the viability of the foetus as discussed above, Australian case law on abortion uses a different formula; it focuses on the necessity of a pregnant woman to be protected from serious danger to her life or to her physical or emotional health which the continuance of a pregnancy entails in proportion to the danger to be averted.[131] The matters to be addressed include economic, social or medical grounds which could result in serious danger to the woman's physical or mental health.[132]

Although the viability of the foetus might be relevant in considering the question of proportionability to the danger above, this is not the central focus; the health of the woman is. 'Abortion' might be used to support the decision of a pregnant woman not to undergo interventions damaging to her health.

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[123] *Roe v Wade* (1973) 410 US 113, 163–4.

[124] For example, N.K. Rhoden, 'Caesareans and Samaritans' (1987) 15 *Law Medicine & Health Care* 118, 119.

[125] (1973) 410 US 113, 163–4.

[126] (1978) 439 US 379.

[127] *Id.* 387.

[128] (1986) 476 US 747.

[129] *Id.* 769.

[130] Rhoden, *supra* n. 124 at 119, citing National Institute of Health, US Dept. of Health and Human Services, Pub. No. 82-2067, *Caesarean Childbirth: Report of a consensus development conference*, October 1981, p. 268.

[131] *R v Davidson* [1969] VR 667, 672, per Menhennitt J.

[132] *R v Wald* [1971] 3 NSWDCR 25.

Abortion rights in this country are not governed by the constitutional right to privacy[133] as is the case in the United States. In theory at least, the legislature has the ability to amend the law at any time.

The Doctrine of Parens Patriae

An alternative doctrine under which the State may intervene to protect the interests of the child is *parens patriae*. The doctrine authorises the State to intervene in family affairs to protect the health, welfare and safety of children. This prerogative is inherent in the supreme power of every State and has been used to enact statutes governing guardianship and custody, juvenile courts, child abuse and neglect, and may even extend to the unborn child where the State has a compelling interest.[134]

The concept of *parens patriae* has been used in a number of United States' cases to extend the area of child abuse and neglect to protect a foetus. Such actions have been brought by the State both prior to and subsequent to the birth of a child.

In the case of *In re Madyun*,[135] for example, a woman refused consent to surgery on religious grounds after medical staff explained the likely infection to her child if she should give birth by vaginal delivery. The court ordered a Caesarean section after balancing the State's interest in protecting the foetus over a woman's right to refuse treatment. The court, in discussing the *parens patriae* concept, suggested that it 'applies with the same force to an unborn child'.[136]

In a number of cases involving the court-ordered blood transfusions of pregnant women, courts have also referred to and relied on this concept. In *Crouse Irving Memorial Hospital v Paddock*,[137] the New York Supreme Court permitted State intervention of a pregnant woman who refused a blood transfusion for religious reasons. The court justified the blood transfusion under its *parens patriae* power because the State's interest in protecting the health and welfare of the unborn child required that the parents yield to the State's interest.[138]

The power has been used with limited success as a means of foetal apprehension by the courts — that is, as a means of removing 'legal custody' of the foetus from its pregnant mother for its own protection. An example of this is given by Gallagher,[139] when in 1984, in Chicago, a Nigerian woman who was expecting triplets was hospitalised for the final

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[133] *Roe v Wade* (1973) 410 US 113, 153.
[134] Hornick, *supra* n. 43 at 544.
[135] Reprinted in *In re AC* (1990) 573 A 2d 1235, 1259. See Part IV for further discussion of the case. The court also relied on the 'abortion' concept discussed above.
[136] *Id.* 1262.
[137] (1985) 485 NYS 2d 443.
[138] *Id.* 445.
[139] Gallagher, *supra* n. 3.

period of her pregnancy. She maintained an unwillingness to consent to a Caesarean section (which was regarded as necessary to ensure the safe delivery of the triplets). The treating doctors and hospital obtained a court order granting the hospital administrator temporary custody of the triplets and authorising a Caesarean section as soon as the woman went into labour.

Similarly, Seymour[140] mentions a case where an Illinois court ordered a pregnant woman, who had previously given birth to a heroin-addicted child, to refrain from using heroin. The court order appointing a guardian for the foetus was subsequently challenged. Before the issue was resolved, the woman gave birth to a non-addicted baby.

On the other hand, in *In the Matter of Dittrick Infant*[141] the Michigan Court of Appeals overturned an order granting a welfare agency temporary custody of an unborn child on the basis that the lower court lacked jurisdiction over a foetus.

In *Re Baby R*,[142] the Supreme Court of British Columbia considered an application for judicial review of an apprehension and subsequent permanent guardianship order concerning the foetus of a woman who refused her consent to a Caesarean section. The court held that the relevant legislation protecting a 'child' could only be applied to children who were already born.[143] Accordingly, the guardianship order was reversed.

Likewise, the English Court of Appeal concluded in *Re F (in utero)*[144] that it had no jurisdiction to make an unborn child a ward of the court (in spite of the mental imbalance and drug use of the woman concerned).

The pre-natal conduct of a pregnant woman has been successfully used as evidence in depriving a woman of custody of a 'neglected' foetus once born alive. *In the Matter of Baby X*,[145] for example, the Michigan Court of Appeals held that a newborn child suffering from narcotics withdrawal as a consequence of pre-natal maternal drug addiction could be considered a neglected child sufficient to give the Probate Court jurisdiction to remove the child from its mother.[146]

In *D (a minor) v Berkshire CC*,[147] the House of Lords heard an appeal concerning the jurisdiction of a juvenile court to make care orders under

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[140] Seymour, *supra* n. 105 at 116. A number of similar cases are mentioned here.

[141] *Id.* 117, citing (1977) 263 NW 2d 37.

[142] (1987) 15 RFL (3d) 225.

[143] *Id.* 234.

[144] [1988] 2 WLR 1297.

[145] (1980) 293 NW 2d 376.

[146] See also *In re 'Male' R* (1979) 422 NYS 2d 819 where an infant born with mild drug withdrawal symptoms was a 'neglected' child and was part of the evidence used to allow the newborn child to be removed from the mother. In *In re Smith* (1985) 492 NYS 2d 33, a child born with foetal alcohol syndrome was also considered neglected. Authority was given to the State to remove the infant from the mother's custody, at least temporarily. Further see *In re Ruiz* (1986) 500 NE 2d 935, where a court dealt with an infant born to a mother addicted to heroin. The court held that the unborn child was a 'person' under the relevant child abuse statute.

[147] [1987] 1 All ER 20.

s. 1(2) of the *Children and Young Persons Act 1969* (UK) in circumstances where a baby girl was born prematurely to a drug-addicted mother. The baby suffered from withdrawal symptoms. Although the *ratio decidendi* was concerned with the operation of the Act, it is significant that the House of Lords took into account the mother's pre-birth conduct towards her child in allowing the orders to stand.[148]

The 'foetal rights' movement has gained a foothold in the criminal law area. In 1986, a woman in San Diego was charged with statutory child neglect[149] after it was alleged she had contributed to the death of her child by failing to get prompt medical attention before its birth. The expected forum for highlighting the conflicting values of the privacy of women and the State's interest in protecting a foetus did not eventuate. The charges were dismissed. On interpreting the statute, it was held that the Act did not intend to cover such a situation; it was aimed at non-custodial parents delinquent in paying child support.[150]

The Interest of Third Parties

American courts, while recognising the right to accept or reject medical treatment,[151] have consistently held that the right is not absolute. In a number of cases (especially those involving life-or-death situations), the courts have recognised four countervailing interests that may involve the State as *parens patriae*.[152] These are:

1. preserving life;
2. preventing suicide;
3. maintaining the ethical integrity of the medical profession; and
4. protecting third parties.

Neither the prevention of suicide nor the maintenance of the integrity of the medical profession have been of significance in the cases. Courts have uniformly drawn a distinction between affirmatively acting to commit suicide and allowing one's body to follow its natural course without treatment.[153] The integrity of the medical profession has not been a major

[148] Discussed in S.P. De Cruz, 'Protecting the Unborn Child: Re D' [1987] *Family Law* 207.

[149] The statutory provision in the case is similar to a number of provisions in Australian State legislation purporting to protect children. See, for example, s. 261 of the *Children and Young Persons Act 1989* (Vic.); and s. 10 of the *Crimes Act 1958* (Vic.) which deals with child destruction of a viable foetus by any wilful act.

[150] D. Moss, 'Fetal Abuse isn't a Crime' (1987) 73 *American Bar Association Journal* 37.

[151] See Part II, 'Basis of the Right to Refuse Medical Treatment'.

[152] See *In re AC* (1990) 573 A 2d 1235, 1246 for a useful discussion and reference to a number of cases in this area.

[153] *Id.* 1246; N. Tonti-Filipini, 'Some Refusals of Medical Treatment which Changed the Law of Victoria' (1992) 157 *Medical Journal of Australia* 277, 279 where, for example, the Victorian Parliamentary Social Development Committee made a distinction between refusing active treatment (which concludes in death) and suicide.

issue in the reported cases of State intervention of a pregnant woman's right to refuse treatment. It is the doctor who is concerned whether he or she has one patient (the woman) or two (the woman and foetus)[154] and where the potential legal liability lies.[155] Courts have not put the medical profession's integrity above that of the patient.

The State's interest in preserving life must be truly compelling to justify overriding a competent person's right to refuse medical treatment where there is no third party interest involved.[156] Where a patient's right to decline treatment has been overridden by the courts, the courts have sometimes relied upon the State's interest in protecting third parties (whether a foetus or otherwise). This rationale can be found in the reasoning used in the 'forced' Caesarean section cases where, for example, in *Jefferson v Griffin Spalding County Hospital Authority*[157] a Caesarean section was ordered in the thirty-ninth week of pregnancy to save the lives of both the foetus and the mother. In that case, there was no trade-off between the health of the mother and potential child.

The interest of third parties has been a major basis for judicial intervention in refusal of blood transfusions. In the United States' decision of *In re Dubreuil*,[158] for example, the interest of the patient's three minor children was considered compelling, in so far as the likely death of the patient should she not receive a transfusion was tantamount to abandonment of the minor children. The interest of the minor children was considered sufficient for judicial interference in that case.

Some cases have addressed the rights of third parties by probing the general duty to rescue, noting that in general a court will not compel a person to submit to a significant bodily intrusion to benefit the health of another. The case of *McFall v Shimp*[159] (involving a refusal to order the defendant to donate bone marrow to save the life of his plaintiff cousin) and other 'rescue' cases and arguments were discussed in Part II. It was suggested there that the analogy to rescue could be modelled to support either the proponents or opponents of the right of a woman to refuse medical treatment.[160]

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[154] The current U.S. position according to the American College of Obstetricians and Gynaecologists (AOG) Ethics Committee Opinion No. 55 *Patient Choice: Maternal–Fetal Conflict* (October 1987) is that a physician treating a pregnant woman has two patients and should assess the risks and benefits to each in advising the mother on treatment. Referred to in *In re AC* (1990) 573 A 2d 1235, 1246.

[155] See also the discussion of *Medical Treatment Act 1988* (Vic.) in Part II for protection of the doctor in reliance on a patient's certificate of refusal of medical treatment.

[156] Refer Part II where there are strong arguments supporting this proposition and is the position both at common law and additionally by statute in Victoria.

[157] (1981) 274 SE 2d 457.

[158] (1992) 603 So 2d 538.

[159] (1987) 10 Pa D&C 3d 90.

[160] See 'The Duty to Rescue' in Part II above.

IV PREGNANT WOMEN

There are a number of areas of concern for foetal welfare that have surfaced in the cases and literature which remain debatable bioethical and legal issues in terms of the potential limitations on the liberty of pregnant women. These areas of concern have provided judgments and literature which are not homogenous in their reasoning or conclusions. It is difficult to ascertain a set of consistent principles to deal with the rights of a pregnant woman to refuse medical treatment.

A number of differing arguments have been employed by the courts and legal writers to distil some sense of the conflicting rights of mother and foetus in the different contexts in which the issues may arise.

'Forced' Caesarean Sections

Australian courts have not yet had to face the dilemma of whether or not to order a pregnant woman to undergo a Caesarean section in the context of a pregnant woman's informed decision to withhold consent. In a recent New South Wales case, however, a Family Court of Australia judge was prepared to hear such a matter. Before the matter could reach the court, the pregnant woman was persuaded to change her mind and consented to the procedure.[161]

The reported cases in this area (with the exception of one English case[162]) all emanate from the United States. In general, the American courts have been prepared to grant orders compelling a pregnant woman to have a Caesarean section without her consent. In a national United States' survey of cases published in 1987, it appears there were 36 judicial attempts to override maternal refusals of proposed medical treatment. In 15 instances, court orders were sought to authorise Caesarean interventions, and in 13 of the 15 cases, the orders were granted.[163] To those who believe in the sanctity of a woman's choice, the figures may sound alarming.[164] Of all the millions of births in America every year, the figures indicate a minuscule proportion of women refusing to do everything necessary to produce a healthy child; sometimes at great cost and discomfort to the woman.

The rate of Caesarean section in the Western world, and in the United States in particular, has increased dramatically in the last 25 years. Statistics show that the rate of Caesarean section in the United States jumped

[161] Seymour, *supra* n. 105 at 81 citing NSW Medical Defence Union, No. 3 (June 1993), 5–6.
[162] *In re S (Adult: Refusal of Treatment)* [1992] 3 WLR 806. Even in that case, the court relied on a U.S. judgment.
[163] V.E.B. Kolder, J. Gallagher and M.T. Parsons, 'Court-ordered Obstetrical Interventions' (1987) 316 *New England Journal of Medicine* 1192, 1192–3.
[164] The perspective of feminists in this area receives some attention in Part V.

from 4.5 per 100 deliveries in 1965 to 22.7 per 100 deliveries in 1985.[165] Australia, by comparison, also has a very high rate of Caesarean section. A 1986 survey of OECD countries showed Australia ranked third, only behind the United States and Canada, at a rate of Caesarean section of 16.4 per 100 deliveries.[166]

Why then do some women (albeit a rare few) refuse a Caesarean section? Reading the cases does not provide all the answers. Apart from religious reasons,[167] the patient simply may not accept the doctor's decision. This may be indicative of fear of surgery, prejudice, ignorance, language difficulties, poor rapport between doctor and patient, or some other secret or unknown reason.[168] Sometimes the woman's decision might be more insightful than the doctors realise.[169]

Courts have generally been more concerned with principles than with the reasons of women for refusing medical treatment.[170] Those who favour the rights of a woman to make her own choices as to whether and when to receive medical treatment are not concerned with the correctness of the decision of the women concerned. The focus of proponents of women's choice may point to the fundamental principle of the right of a competent person to refuse medical treatment. The view is held by some that to treat women's choice otherwise is to treat women as 'fetal containers'[171] like 'an inert incubator, or a culture medium for the fetus'.[172]

The view of the medical profession may be reflected in that in 13 out of 15 cases, orders have been obtained which override a woman's refusal to consent to Caesarean section. In a 1987 survey of senior practitioners, 46 per cent 'thought that mothers who refused medical advice and thereby endangered the life of the fetus should be detained in hospitals or other facilities so that compliance could be ensured'.[173] Forty-seven per cent 'thought that the precedent set by the courts in requiring emergency cesarean sections for the sake of the foetus should be extended to

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[165] Hornick, *supra* n. 43 at 557.

[166] M.Y. Renwick, 'Caesarean Section Rates Australia 1986: Variations at State and Small Area Level' (1991) 31 *Australian & New Zealand Journal of Obstetrics and Gynaecology* 299.

[167] For example, *Jefferson v Griffin Spalding County Hospital Authority* (1981) 274 SE 2d 457, 458.

[168] For a brief discussion of women's reasons, see B. Bennett, 'Pregnant Women and the Duty to Rescue: A Feminist Response to the Fetal Rights Debate' (1991) 9 *Law in Context* 70, 76.

[169] In *Jefferson v Griffin Spalding County Hospital Authority* (1981) 274 SE 2d 457, the doctor was shown to be mistaken. In that case, the woman ultimately gave birth to a healthy child by vaginal delivery. This is discussed in Part V. See the article by L. Ikemoto, 'Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women' (1992) 59 *Tennessee Law Review* 487, 500–2.

[170] Many of these cases are heard in the context of a medical emergency where a woman may, for example, be unconscious or there may be little time to conduct a formal hearing. Accordingly, the women are sometimes not even heard at the relevant hearing.

[171] G. Annas, 'Pregnant Women as Fetal Containers' (1987) 6 *Bioethics News* (Monash University) 18.

[172] *Id.* 20.

[173] Kolder et al., *supra* n. 164 at 1193.

include other procedures ... as these came to represent the standard'.[174] A recent survey of Australian midwives, on the other hand, shows much less support for these propositions.[175]

Nonetheless, these 13 decisions may be of only limited authority. As the District of Columbia Court of Appeals pointed out in *In re AC*,[176] there are few published decisions from an appellate court that deal with the question of when, or even whether, a court may order a Caesarean section.[177] These appeal cases are discussed here.

In *Jefferson v Griffin Spalding County Hospital Authority*,[178] the Georgia Supreme Court became the first appellate court to order the performance of a Caesarean section. The case involved a woman in her thirty-ninth week of pregnancy with a complete placenta previa (where the afterbirth is between the baby and the birth canal) who refused a Caesarean section for religious reasons. Evidence indicated it was virtually impossible that this condition would correct itself prior to childbirth. The court further accepted that without a Caesarean section, the prognosis was that the foetus would not survive and the mother had only a 50 per cent chance of survival.[179]

Although the mother had been diligent in seeking pre-natal care, she maintained her refusal to consent to the procedure (and indeed to a blood transfusion should it be recommended or required). The court relied upon *Roe v Wade*[180] and determined that a viable foetus has a right to the State's protection and was prepared to override the woman's rights to freedom of religion and bodily integrity.

The court ordered ultrasonography and a Caesarean section if necessary. Ironically, in spite of the medical evidence, the ultrasonography revealed that the placenta had shifted and the woman later delivered vaginally.[181]

The second United States' appellate court to consider the question of a 'forced' Caesarean section was the Superior Court of the District of Columbia in *In re Madyun*.[182] In that case, a pregnant woman's membranes had ruptured and the woman refused to consent to a Caesarean section because of her Muslim beliefs. There was no threat to the health of the woman if she refused the operation, but the prognosis of the foetus, should the woman not consent to the procedure, was a 50 to 75 per cent chance

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[174] *Ibid.*

[175] Seymour, *supra* n. 105 at 85. Midwives were asked if they believed a court should be used to obtain orders for a doctor to carry out treatment on a non-consenting pregnant woman for the benefit of her foetus. Of the 744 respondents, 64.4 per cent said 'No'.

[176] (1990) 573 A 2d 1235.

[177] *Id.* 1243.

[178] (1981) 274 SE 2d 457.

[179] *Id.* 458.

[180] (1973) 410 US 113. See discussion of the 'abortion' argument in Part III.

[181] See n. 9 above.

[182] Reprinted in (1990) 573 A 2d 1259 as an Appendix to *In re AC* (1990) 573 A 2d 1235.

of contracting foetal sepsis.[183] In contrast, the woman had almost a 100 per cent chance of surviving the Caesarean section.[184]

In these circumstances, the court relied on its *parens patriae* jurisdiction[185] and further relied on the viability of the foetus[186] (as postulated in *Roe v Wade*[187]) to order the operation. The court reasoned that the minimal risks to the mother and the significant risk to the life of the foetus, should the procedure not be performed, justified the order.

The latest United States' case to consider the right of a pregnant woman is of major importance. The District of Columbia Court of Appeals in the case of *In re AC*[188] is the first appellate court to hold that it is the right of the pregnant woman to decide whether or not to agree to proposed surgery.

The case itself involved a woman who was 25 weeks pregnant when she was diagnosed as having terminal cancer. She agreed to palliative treatment designed to extend her life, but at 26 weeks it became apparent that the foetus's chances of survival were rapidly diminishing. The patient lost consciousness soon after and her wishes in terms of a Caesarean section were unclear; she had made conflicting statements to various doctors about her wishes, some of which were made in semi-consciousness.

Although it was likely that a Caesarean section would shorten the woman's life, the trial judge ordered the procedure. In doing so, the trial judge balanced the compelling State interest of potential life over that of the bodily integrity of the patient. The Caesarean section was performed and both baby and mother died within two days. Subsequently, the District of Columbia Court of Appeals overturned the trial judge's decision. The majority stated that 'in virtually all cases the question of what is to be done is to be decided by the patient — the pregnant woman — on behalf of herself and the foetus'.[189]

The court reinforced the principle by stating that even if the patient (pregnant woman) is incompetent, or otherwise unable to give an informed consent to a medical procedure, the court must ascertain the likely wishes of the patient by a process of 'substituted judgment'.[190] This entails examining what decision a person would have made if they had been competent in taking into account all the surrounding circumstances, written or oral directions to family, friends and health-care professionals, the patient's past decisions concerning medical treatment, evidence as to the patient's value system, goals and desires, and any other factors that

[183] *Id.* 1261. This is an infection that potentially can lead to death or serious brain damage.
[184] *Ibid.* The evidence put the risk to Mrs Madyun at 0.25 per cent.
[185] *Id.* 1262. See discussion of this in Part III above.
[186] *Ibid.*
[187] (1973) 410 US 113.
[188] (1990) 573 A 2d 1235.
[189] *Id.* 1237.
[190] *Ibid.*

cast light upon the patient's likely decision in the circumstances.[191] In short, the court demands that a subjective test be used in the case of an incompetent patient.[192]

Other objective factors, such as the viability of the foetus, the mother's prognosis, and the probable result of refusing treatment for both the mother and foetus, should only be taken into account where after employing a substituted judgment test the patient's likely intentions remain unclear.[193]

The court also noted that although it was not prepared to foreclose the possibility that a conflicting State interest may be so compelling that it might prevail over the interests/wishes of a pregnant patient, it would need to be a truly extraordinary case. This was not such a case, and the majority cast doubt as to whether such an extraordinary situation could arise.[194]

In coming to its conclusion, the majority discussed a number of issues. Essentially, the basis for the decision was (i) the doctrine of informed consent,[195] (ii) the fact that no one is required to come to the 'rescue' of another,[196] and (iii) a person's constitutional right to privacy and bodily integrity.[197]

How did the court deal with authorities such as *Jefferson v Griffin Spalding County Hospital Authority (Jefferson)*[198] and *In re Madyun (Madyun)*?[199] The court simply distinguished *Jefferson* on the basis that it concerned a case where a clear refusal to surgery was present but a proposed Caesarean would benefit both parties,[200] whilst here the question of consent was unclear and it was likely that the Caesarean section might

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[191] *Id.* 1237 and 1249–51.

[192] There is some doubt as to whether the substituted judgment test forms part of English law. This was the view of Lord Goff in *Airedale NHS Trust v Bland* [1993] 2 WLR 316, a case dealing with the withdrawal of life support where a patient was in a 'persistent vegetative state'. The factors relevant in the substituted judgment test — i.e. the likely wishes of the patient — are certainly to be considered, at least in part, in determining what is in the 'best interests' of the incompetent patient. The 'best interests' test is more objective in nature than the subjective substituted judgment test and probably represents English law.

The article by T. Rivosecchi entitled 'Medical Self-Determination — A Call for Uniformity' (1992) 31 *Duquesne Law Review* 87, 94 sets out a number of the objective facts to be looked at in the 'best interests test'. These include the degree and duration of pain, the patient's life expectancy, the maturity of the patient, his or her prognosis, the level of his or her cognitive function, alternative treatments, the nature of the proposed treatment and the degree of humiliation involved.

[193] (1990) 573 A 2d 1235, 1251.

[194] *Id.* 1252. The dissenting judge (Belson J) at 1254 held that this might be such an extraordinary case which would require balancing the rights of the woman with those of the foetus and the State.

[195] *Id.* 1243.

[196] *Id.* 1243–4.

[197] *Id.* 1244–6.

[198] (1981) 274 SE 2d 457.

[199] Reprinted in (1990) 573 A 2d 1259 as an Appendix to *In re AC*.

[200] (1990) 573 A 2d 1235, 1243.

shorten the woman's life. In *Jefferson*, the placenta previa made it almost certain that the foetus would die and quite likely the mother would fail to survive in the absence of the proposed surgery. A potential trade-off existed here between mother and foetus. No such conflict of health was apparent in *Jefferson*.

Given the court's strong statements about the difficulty of imagining truly extraordinary circumstances[201] to justify challenging the decision of a competent woman, it is hard to reconcile the two cases. The court found it unnecessary to either approve or disapprove the decision in *Madyun*. The case was distinguished on the facts,[202] suggesting that there was no real conflict between the mother and foetus and that the proposed surgery would benefit both parties. In the case at hand, Caesarean section was likely to hasten the death of the pregnant woman. Also, in *Madyun* the woman was at full term; here the woman was only 26 weeks pregnant. Again, the failure to confront *Madyun* leaves some doubt as to the potency of the decision in *In re AC*.[203]

The only English authority in the context of a 'forced' Caesarean section is *In re S (Adult: Refusal of Treatment)*.[204] The case involved an application by a local health authority for a declaration that a Caesarean section be performed upon a patient who refused to consent to it. When Mrs S was admitted to hospital, her membranes were ruptured and she was undergoing spontaneous labour. If a Caesarean section was not carried out, there was a real risk of a rupture to the uterus threatening both the life of the woman and the foetus. The situation was described as a 'life and death' situation.[205] The woman and her husband, both 'Born Again Christians', refused to agree to the surgery for religious reasons. The emergency situation was dealt with in a 20-minute hearing by Brown P (President of the High Court's Family Division) where he granted the declaration allowing the Caesarean section despite the woman's refusal to consent. The case is of little authority because of the brevity of the judgment. The case was heard *ex parte* and the emergency situation gave the woman no time to be heard. Few reasons, if any, are offered in the judgment. The court purportedly relied on *In re T (Adult: Refusal of Consent to Treatment)*,[206] a case which does not support this decision. In that case, the court upheld the rights of a patient to refuse treatment even if she might die. Lord Donaldson of Lymington MR, however, in *obiter*, stated that an important qualification to this principle might be the case involving the potential death of a viable foetus.[207] Nonetheless, he simply left open that question without deciding it.

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[201] *Id.* 1252.
[202] *Id.* 1252–3.
[203] (1990) 573 A 2d 1235.
[204] [1992] 3 WLR 806.
[205] *Id.* 807.
[206] [1992] 3 WLR 782. The case is discussed in Part II above.
[207] *Id.* 786.

The only other authority referred to was the United States' case of *In re AC*,[208] where Brown P stated that if the case was being heard in the American courts the declaration would be granted. This would appear, without further explanation by the English court, to be an errant application of the United States' case. Clearly, the United States' case[209] did not agree with intervention to overrule a woman's decision in this context except in the most compelling and extraordinary circumstances. The United States' court doubted 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 the person's will'.[210] It is submitted, therefore, that *In re S (Adult: Refusal of Treatment)*[211] is practically of no authority.

In summary, there are a number of instances of court-ordered Caesarean sections in the cases, but few at an appellate level. The three United States' cases discussed above appear somewhat contradictory where only *In re AC*,[212] admittedly the most recent and extensive in reasoning, stands for the proposition that a woman's consent cannot be overruled in this context.

The Blood Transfusion Cases

The question of whether a pregnant woman can be compelled to submit to a blood transfusion which she declines to accept for religious or other reasons has also not arisen in Australian courts. United States' courts have consistently granted hospitals and doctors the authority to override a pregnant woman's decision in this context. These cases would most likely be the basis for argument if and when such litigation arises in Australia.

In *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson*,[213] for example, the New Jersey Supreme Court ordered a Jehovah's Witness, who was delivering a baby, to be given a blood transfusion either to save her own life or that of the foetus.[214] The court order requiring the medical treatment was aimed at protecting the life of the post-natal child justified by the State acting in its *parens patriae* role. In this context, the court stated, '[W]e are satisfied that the unborn child is entitled to the law's protection.'[215]

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[208] (1990) 573 A 2d 1235, 1240, 1246–8, 1252.
[209] *In re AC* (1990) 573 A 2d 1235.
[210] *Id.* 1252.
[211] [1992] 3 WLR 806.
[212] (1990) 573 A 2d 1235.
[213] (1964) 201 A 2d 537.
[214] *Id.* 538.
[215] *Ibid.*

Similarly, in the later New York Supreme Court ruling in *Crouse Irving Memorial Hospital v Paddock*,[216] State intervention was allowed over a mother's objections to administer necessary blood transfusions to a mother and foetus during surgical procedures. The court conceded that it may not have compelled a blood transfusion on a woman who was not pregnant over her religious beliefs.[217] In these circumstances, however, the court justified the blood transfusion on the basis of its *parens patriae* power since the State's interest in protecting the health and welfare of the unborn child required the parent's interest to yield to the interest of the State.[218]

The decision of *In re AC*[219] is the first appellate authority to give greater recognition to the right of a pregnant woman to make her own decision than to the welfare of the foetus in the context of court-ordered medical intervention cases. The more recent case of *In re Dubreuil*,[220] concerned with the right of a State to mandate a blood transfusion over a pregnant woman's religious objections, suggests the decision in *In re AC*[221] is far from the beginning of a judicial trend. *In re AC* is not mentioned in the majority judgment of *In re Dubreuil* and is only briefly alluded to in the dissenting judgment of Warner J.[222]

Notwithstanding the differing medical interventions in the cases, it is difficult to see how the two cases would not involve a major unity of issues. Clearly, both cases concern the right of a pregnant woman to make her own decision about medical intervention in the context of foetal interests and the State's *parens patriae* powers.

Ironically in the case of *In re Dubreuil*,[223] the pregnant woman concerned had consented to a Caesarean section and a healthy baby was born. As a Jehovah's Witness, however, the mother verbally objected to a blood transfusion, nullifying the effect of an earlier signed consent.[224] Due to uncontrolled bleeding as a result of the Caesarean section, the woman lost large quantities of blood. The court ordered the blood transfusion after the majority held that the compelling State's interest in preserving the rights of innocent third parties[225] took priority over the wishes of the patient.[226] The innocent third parties in this case were considered to be Mrs Dubreuil's four minor children. Should the emergency blood transfusion not be given, it was undisputed that the patient would die.[227] The

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[216] (1985) 485 NYS 2d 443.
[217] *Id.* 445.
[218] *Ibid.*
[219] (1990) 573 A 2d 1235.
[220] (1992) 603 So 2d 538.
[221] (1990) 573 A 2d 1235.
[222] (1992) 603 So 2d 538, 542.
[223] (1992) 603 So 2d 538.
[224] *Id.* 539.
[225] See 'The Interest of Third Parties', above.
[226] (1992) 603 So 2d 538, 541–2.
[227] *Id.* 539.

court took the view that such a death would constitute abandonment of the minor children. This was the compelling interest of innocent third parties that the State had a right to protect.

The decision has been criticised[228] not least because, in considering abandonment, the Florida District Court of Appeal took into account the fact that Mrs Dubreuil was separated from her husband and hence distinguished an earlier decision of *Public Health Trust of Dade County v Wons*.[229] In the *Wons* decision, the Florida Supreme Court approved the refusal by a trial judge to order a blood transfusion in circumstances where minor children lived with both parents. The court in that case was satisfied that no abandonment could be demonstrated.

Jennifer Bamonte and Cathy Bierman have criticised the Dubreuil decision on a number of grounds.[230] They argue that, on the facts, this case could not amount to abandonment since the woman's estranged husband was present during the procedure, indicating that parental concern for the children still existed. In these circumstances they suggest that the burden of proof is on the State to show that the children are abandoned (and not on Mrs Dubreuil to show that they are not so abandoned).

They also consider that even if the State's interest is compelling, the State must use the least intrusive means to achieve that interest. It is suggested that a blood transfusion may not be a medical necessity in such circumstances and alternative medical treatment is available.[231]

Bamonte and Bierman argue by analogy that if individuals are allowed to put children up for adoption, the State does allow abandonment. It should therefore be allowed here.[232] Analogy is further used to show that seriously ill patients (for example, cancer patients) are not precluded from refusing medical treatment by arguments of abandonment of their children.[233]

Other Procedures

If the State may potentially intervene in the rights of a pregnant woman to refuse a Caesarean section or blood transfusion, it is not illogical that interference may be litigated in other medical procedures concerning a pregnant woman.

In *Taft v Taft*,[234] the husband of a pregnant woman, in her fourth month of pregnancy, brought an action seeking a court order to compel his wife, over her religious objections, to undergo surgery designed to sustain foe-

[228] Bamonte and Bierman, *supra* n. 54.
[229] (1989) 541 So 2d 96.
[230] Bamonte and Bierman, *supra* n. 54 at 542.
[231] *Id.* 522–5.
[232] *Id.* 540–2.
[233] *Id.* 545.
[234] (1983) 446 NE 2d 395.

tal life and avoid a miscarriage. In overruling the trial court's judgment, the Supreme Court of Massachusetts held that on the facts the record did not show 'circumstances so compelling as to justify curtailing the wife's constitutional rights'.[235] The State's interest in requiring the operation was not established; the evidence did not sufficiently demonstrate that medical treatment was necessary to sustain foetal life.[236]

Advances in medical technology, however, have increased significantly in the past decade and hold promise to treat or correct *in utero* a number of previously untreatable congenital defects. These include proposed intrauterine correction of congenital malformations for selected cases of obstructive hydrocephalus, obstructive urinary tract malformations, gastrointestinal anomalies, and other genetic and metabolic disorders.[237] In May 1990, for example, two healthy babies who had undergone successful foetal surgery for diaphragmatic hernias were presented to the press in San Francisco.[238]

While these procedures are in the experimental stage,[239] there is no requirement for the physician to recommend them or on the mother to undergo the surgery. Indeed, no cases have arisen where a court has been asked to order therapeutic foetal surgery against a pregnant woman's wishes.

While most women would want doctors to do everything to ensure the delivery of a healthy baby, some women will be most concerned about surgery to correct a foetal abnormality. Apart from conflicts with the woman's religious beliefs, her fear of surgery, the desire to avoid risks and uncertainty about the results, a major concern is the burden of raising a severely disabled child who is saved but not cured by the treatment.[240] In this context, many women may be inclined to refuse the treatment and let nature take its course.

It should be pointed out that pre-natal surgery is not recommended for all recognised foetal problems. Foetal surgery is used to correct only those defects that will either kill the foetus or cause the foetus progressive and irreversible damage if left untreated until after birth. A foetus with a defect that can wait for treatment until after birth is not a candidate for surgery during pregnancy.[241]

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[235] *Id.* 397.

[236] *Ibid.*

[237] Hornick, *supra* n. 43 at 556.

[238] *Id.* 556–7.

[239] Knopoff, *supra* n. 2 at 503–5 where some of the procedures and their results are discussed. An example is given where foetal surgery is used to correct obstructive hydrocephalus (a condition that causes fluid to accumulate in the brain and increasing pressure in the skull resulting in impeded development of the brain cells and likely brain damage). The procedure involves inserting a thin tube through the abdomen of the pregnant woman (guided by ultrasound) into the lateral ventricles of the brain of the foetus. The procedure is designed to allow excess brain fluid to drain into the amniotic space around the foetus. Unfortunately, although some 85 per cent of treated foetuses survive this procedure, about half of them are born mildly or severely handicapped.

[240] Knopoff, *supra* n. 2 at 502.

[241] *Id.* 503.

Nonetheless, with the available techniques of recognising foetal defects by amniocentesis and ultrasonography, doctors anticipate the development of many innovative types of foetal surgery in the future.

Those concerned with the rights of pregnant women to refuse medical treatment in the 'forced' Caesarean section and blood transfusion cases (discussed above) must surely be concerned that as the state of medical technological advances continues in this area, the likelihood of court-ordered intervention to compel foetal surgery will increase.

Two arguments might deter the courts from extending the power of the State into the foetal surgery area. First, unlike some of the Caesarean section cases[242] and blood transfusion cases[243] where court intervention was purportedly for the benefit of both the mother and foetus, foetal surgery is medically only for the benefit of the foetus. This argument would allow courts to thus distinguish foetal surgery cases and not order intervention.

The second argument is based on one of the reasons used to support court intervention in this context and is the decision of *Roe v Wade*[244] and the 'abortion argument'.[245] Although the rationale may have some validity in the Caesarean section and blood transfusion cases where the foetus is at the stage of viability, foetal surgery by its very nature is more likely to be employed on a pre-viable foetus, thus affording courts another opportunity to distinguish foetal surgery cases from the 'forced' Caesarean section and blood transfusion judgments.

Although these arguments might dissuade a court from ordering foetal surgery which is highly intrusive (and has associated risks connected with any surgery) on the life of a pregnant woman, courts might be less enthusiastic about employing these arguments in the case of pre-natal diagnostic screening procedures such as amniocentesis and ultrasonography which are far less burdensome and risky. Where doctors are concerned about the age or genetic history of a pregnant woman, it is not inconceivable that doctors might seek judicial assistance to compel a woman to undergo these procedures in order to ascertain the condition and prognosis of a foetus considered at risk of being born physically or mentally impaired.

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[242] See, for example, *Jefferson v Griffin Spalding County Hospital Authority* (1981) 274 2d 457 where the pregnant woman's chances of survival without Caesarean section were only 50 per cent.

[243] See, for example, *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson* (1964) 201 A 2d 537 where the blood transfusion was ordered to save the mother and/or foetus.

[244] (1973) 410 US 113.

[245] This is discussed in Part III above.

Substance Abuse

The connection between drug and alcohol abuse and foetal disorders has been of concern to health professionals for more than 30 years.[246] Children of drug-addicted mothers may be born experiencing drug withdrawal symptoms such as vomiting, diarrhoea and seizures. In addition, medical evidence suggests that these children may exhibit neurological disorders, behavioural difficulties and cognitive defects.[247]

Foetal Alcohol Syndrome may develop in some infants born to women who drink heavily during pregnancy and may result in life-long mental or physical disabilities to those children.[248] In spite of this, the percentage of women who continue to drink heavily during pregnancy in the United States remains high and may be as many as 15 per cent.[249]

In Part III, attention was paid to the rights of a child to sue its mother for injuries caused *in utero* by the mother's negligence. Although this remains largely theoretical, one or two cases of maternal negligence in this context have been recognised in the United States.[250]

If courts are prepared to compel a woman to undergo Caesarean section or a blood transfusion, it is not so far-fetched to imagine a society which controls and supervises a pregnant woman's drug and alcohol habits. Courts at first instance have already been prepared to use the *parens patriae* power of the State to appoint custody of a foetus prior to its birth to child welfare authorities.[251] Furthermore, courts have been prepared to use the pre-natal conduct of women as a factor in removing custody of a child subsequent to its birth.[252]

Courts recently have also been more aggressive in their desire to hold a mother legally responsible for harm suffered by the foetus. In South Carolina, a woman was charged with criminal neglect after traces of heroin were found in her newborn child.[253] In Florida, a judge sentenced a woman to 15 years' probation on her conviction of 'delivering' illegal drugs through her umbilical cord to her babies born in 1987 and 1989 respectively.[254] The Florida woman will be required to submit to random drug testing for a year and a supervised pre-natal program should she again become pregnant.

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[246] Hornick, *supra* n. 43 at 561.
[247] *Ibid.*
[248] *Id.* 560.
[249] *Ibid.*
[250] See, for example, *Grodin v Grodin* (1980) 301 NW 2d 869 discussed above in the section entitled 'Injury Suffered by a Foetus Inflicted by the Negligence of His or Her Parents'.
[251] See 'The Doctrine of *Parens Patriae*' discussed above. (For example, *In the Matter of Dittrick Infant* (1977) 263 NW 2d 37, where at first instance a welfare agency was granted custody of an unborn child.) See also Seymour, *supra* n. 105 at 116.
[252] See *In the Matter of Baby X* (1980) 293 NW 2d 376 and *D (a minor) v Berkshire CC* [1987] 1 All ER 20, also discussed in Part III above.
[253] Hornick, *supra* n. 43 at 562.
[254] *Ibid.*

Hornick further indicates that since 1987, 19 American States have instigated more that 50 criminal prosecutions against mothers for drug abuse during their pregnancies.[255] She also points out that eight States now include in their definition of 'child abuse' exposure to drugs *in utero*.[256]

How far can the *parens patriae* power of the State support intervention into maternal behaviour? Evidence mounts of a wide range of other products, including cigarettes, many foods,[257] hazardous chemicals and other pollutants, that may be injurious to the development of a foetus.

As the state of scientific knowledge increases and greater certainty can be attached to maternal behaviour as the cause for impeded development of a foetus, greater pressure may be exerted to allow the child injured *in utero* to sue its mother. Attaching legal recognition of a child's right to sue its mother for injuries sustained *in utero* may be more likely in this context. However, court intervention to control the mother's behaviour during pregnancy seems far more remote; it would require the ongoing supervision of the courts as opposed to one-off intervention such as a court-ordered Caesarean section or blood transfusion.[258]

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[255] *Id.* 563.

[256] *Ibid.*

[257] Sometimes special food may be necessary for the normal development of a foetus. The question of necessary special diet was explored by J.A. Robertson and J.D. Schulmon in 'Pregnancy and Pre-natal Harm to Offspring: The Case of Mothers with PKU' (1987) 17 *Hastings Center Report* 23. Phenylketonuria (PKU) is an enzyme deficiency that prevents the metabolisation of phenylalanine and may lead to severe retardation if untreated. PKU children can be treated at birth by special diet. The problem in this context arises when PKU females (who were treated at birth) reach child-rearing age. Evidence suggests that women with classic PKU are likely to have babies with severe retardation, congenital heart disease, an abnormally small head and other damage if these PKU women do not resume the special diet prior to or during pregnancy. In the context of tortious actions brought by a child against its mother for injuries sustained *in utero* and the question of court intervention into the lifestyle decision of a pregnant woman, the issues raised here encapsulate many of the issues discussed in this article generally.

[258] Even in connection with a one-off intervention, some would argue that an Australian court would not be prepared to order and supervise such a medical intervention. Seymour, *supra* n. 106 at 81 and 87, for example, suggests that any ruling by an Australian court would probably take the form of a declaration that the procedure could be lawfully performed by a doctor without the woman's consent. He partly bases this argument on the fact that no Australian court has yet asserted jurisdiction over a foetus. In the case of *In the Marriage of F and F* [1989] FLC 92-031, for example, the Family Court in deciding whether a man could prevent his wife from terminating her pregnancy was careful to point out that it was exercising jurisdiction in respect of 'parties to a marriage' and the word 'child' in s. 70C(1) of the *Family Law Act 1975* (Cth) does not include an unborn child.

Courts are generally reluctant to make orders for specific performance requiring constant supervision. This reluctance stems from a desire to avoid constant and protracted litigation as the plaintiff returns to the court to complain of every breach of the order: *Wolverhampton and Walsall Railway Co. v London and NW Railway Co.* (1873) LR 16 Eq. 433, 439.

V SOME BALANCING FACTORS: POLICY

The question of whether a pregnant woman has the right to decline a Caesarean section or other medical procedures when the life of a foetus is at stake is far from straightforward. A morass of legal and theoretical argument is evidenced in both the judgments and the available legal literature. The cases in this area are not easy to reconcile. While the majority judgment in *In re AC*,[259] for example, appears to be a clear mandate for the right of a pregnant woman to refuse a Caesarean section, that court was not prepared to overrule *In re Madyun*[260] and barely distinguished *Jefferson v Griffin Spalding County Hospital Authority*[261] on its facts. The brevity of *In re S (Adult: Refusal of Treatment)*[262] and its errant reasoning gives the only English authority in this area little, if any, weight.

Each of the wide legal arguments applied in the cases to both justify or refute the right of a court to order medical intervention in this context appears to have a relevant counter-argument.

While *Roe v Wade*,[263] for example, has been used by the courts[264] and writers to justify overriding a pregnant woman's wishes, it has also been used to show that the health and well-being of a pregnant woman takes priority over the welfare of the foetus. While the State has a compelling interest to protect children under its *parens patriae* jurisdiction, a foetus is not a child and has no personhood rights; its rights have been characterised as prospective rights contingent upon live birth.[265] The 'duty to rescue' argument has been used by both the proponents and opponents of court-ordered intervention in such cases. Although there is no generally accepted duty to rescue, the mother and foetus are in a special relationship of dominance and dependence. Some have argued that the duty to rescue arises since the mother has 'caused' the relevant dangers to a foetus by becoming pregnant.[266] Against this serious ethical dilemma of resolving the potential conflict of an individual's right and basic liberty to refuse medical treatment and the right of a foetus to be born healthy, are a number of important policy considerations, some of which might tip the balance in favour of not allowing the courts to judicially intervene in the choices of pregnant women. In Part III, for example, it was demonstrated that although there is no reason in principle why a child born with injuries sustained *in utero* by the conduct of his or her mother could not succeed in a negligence action against her, English legislation[267]

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[259] (1990) 573 A 2d 1235.
[260] Reprinted in (1990) 573 A 2d 1259 as an Appendix to *In re AC* (1990) 573 A 2d 1235.
[261] (1981) 274 SE 2d 457.
[262] [1992] 3 WLR 806.
[263] (1973) 410 US 113.
[264] See, for example, *Crouse Irving Memorial Hospital v Paddock* (1985) 485 NYS 2d 443.
[265] Refer Part III generally.
[266] See Parts II and III above and Fleming, *supra* n. 62 at 146–51.
[267] *Congenital Disabilities (Civil Liability) Act 1976* (UK).

generally prevents legal action in these circumstances for some very strong policy reasons.[268] Similarly, here there may be legal grounds for court intervention to protect a foetus. It is arguable, however, that any legal rationale should yield to take account of some of the policy issues discussed below.

The majority in *In re AC*[269] makes the major observation that court-ordered Caesarean sections, rather than protecting the health of women and children, may achieve the opposite result. Such judicial intervention may erode the element of trust which permits a pregnant woman to communicate with her physician, without fear of reprisals, relevant information to her proper treatment and diagnosis.[270]

A serious consequence of any erosion of confidence by pregnant women in the medical system is that women at high risk of complications during pregnancy and childbirth may be driven out of the health system to avoid coerced treatment.[271] This occurred in *Jefferson v Griffin Spalding County Hospital Authority*[272] and in the later cases of *In re Baby Jeffries*[273] and *North Central Bronx v Headley*[274] where the pregnant women concerned went into hiding and fortunately vaginally delivered healthy infants.[275]

In a number of instances the medical profession, while relying on sophisticated medical technology, may be wrong in their assessment of the likely prognosis of mother and child. The court in *Jefferson v Griffin Spalding County Hospital Authority*[276] accepted evidence that it was virtually certain that the foetus would not survive[277] (and only attributed the mother's chances of survival at 50 per cent) in the absence of a Caesarean section. Medical evidence, however, was later shown to be flawed by the delivery of a healthy child by vaginal delivery.[278]

It appears that some medical tools are better than others. Despite the above, ultrasonography is regarded as highly reliable in detecting placenta previa. Other technology such as electronic foetal monitoring (which detects abnormal foetal heart patterns during pregnancy) has been shown to have a false positive rate of between 18.5 and 80 per cent.[279]

This casts some doubt on the judicial process as well. It must be noted that the 'forced' Caesarean and blood transfusion cases heard by the courts

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[268] See Part III above.
[269] (1990) 573 Ad 1235.
[270] *Id.* 1248 quoting the American Public Health Association.
[271] *Ibid.*
[272] (1981) 274 SE 2d 457.
[273] No. 14004, slip op. at 9 (Jackson County Michigan P Ct, 24 May 1982) referred to by Knopoff, *supra* n. 2 at 535.
[274] Knopoff, *supra* n. 2 at 535, referring to No. 1992-85 (Sup. Ct., Special Term, Bronx City, New York, 6 January 1986).
[275] Rhoden, *supra* n. 124 at 123.
[276] (1981) 274 SE 2d 457.
[277] For a discussion of the case, see Part IV, p. 26 above.
[278] See *supra* n. 18.
[279] Rhoden, *supra* n. 124 at 123.

have often occurred in the context of a perceived emergency.[280] The often required need for an expeditious decision means the woman is denied the right to be heard; a denial of natural justice. Even where a lawyer is appointed on her behalf, it is unlikely that there will be time to prepare a thorough case.

It would also appear that by intervening in the decisions of a pregnant woman, a court is assuming the ability to weigh the risks of surgery for someone who has completely chosen to forego them. Hence a Caesarean section was ordered in *In re Madyun*[281] where it was almost certain the woman would survive. The risk to Mrs Madyun was put in that case at only 0.25 per cent. The court took the view that Mrs Madyun was facing only a minor risk, but as Nancy Rhoden noted, '[M]inor surgery is surgery on somebody else'.[282] Rhoden also states that a judge cannot possibly take into account the woman's subjective response to these risks no matter how small.[283] No matter how small the risk, the court in interfering is accepting the moral responsibility for the outcome. Are judges prepared to 'shoulder this burden' should surgery go wrong?[284]

Moreover, if courts are to intervene in such cases on a regular basis to sanction surgery, litigation in this area may be multiplied. This is because a new duty of care may attach to doctors who seek judicial opinion where the life of a foetus is at risk and a pregnant woman refuses to agree to take the steps suggested by medical opinion.[285]

Childbirth is generally not the end of a relationship between mother and child. If a mother feels that her autonomy has been deprived, she may unconsciously blame the resulting child for the intrusion. This may later affect the child's behaviour patterns.[286]

Additionally, since the mother and foetus are physiologically linked, any emotional distress imposed on the mother by State intervention may have an effect on the foetus. In this regard, there is evidence to suggest that a mother's emotional distress can cause pregnancy disorders, premature delivery or stillbirth.[287]

Some United States' writers[288] have suggested that even if the State has a compelling interest in protecting foetal health that justifies overriding

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[280] For example, *In re AC* (1990) 573 A 2d 1235 involved a case where a dying woman had lapsed into unconsciousness. The court (at 1248) regarded the procedural shortcomings in these cases as being more serious than 'mere technical deficiencies'.

[281] Reprinted in (1990) 573 A 2d 1259 as an Appendix to *In re AC* (1990) 573 1235.

[282] Rhoden, *supra* n. 124 at 122.

[283] *Ibid.*

[284] *Id.* 123.

[285] B.A. Leavine, 'Court-ordered Caesareans: Can a Pregnant Woman Refuse?' (1992) 29 *Houston Law Review* 185, 211.

[286] R. Manson and J. Marolt, 'A New Crime, Fetal Neglect: State Intervention to Protect the Unborn — Protection at What Cost?' (1988) 24 *California Western Law Review* 161, 173.

[287] *Ibid.*

[288] See, for example, Manson and Marolt, *supra* n. 286 at 181; H.M. White, 'Unborn Child: Can You Be Protected?' (1988) 22 *University of Richmond Law Review* 285, 300–2.

basic constitutional guarantees (such as the right to bodily integrity, right to privacy, right to equal protection under the law, and freedom of religious expression[289]), judicial interference is not the least intrusive means by which to achieve that result. Less intrusive means of protecting the unborn include providing access to government-funded comprehensive pre-natal care and education programs.[290]

Lisa Ikemoto[291] further opens the debate on the rights of pregnant women by taking a feminist perspective of the issues involved. She argues that by focusing on a potential conflict between mother and foetus, the scope of the inquiry is too narrow. The conflict is more accurately characterised as one between a woman and dominant social mores rather than as a conflict between mother and foetus.[292] Ikemoto further argues that judges and doctors discount the woman's voice.[293] Women are portrayed as irrational, while the dominant male and 'rational' medical model is the focus of the court's inquiry.[294]

She states that 'judges listen to doctors because they are usually also male professionals and therefore presumptively rational; judges listen to doctors because medicine is regarded as a source of authority whereas individual women are regarded as a source of trouble ... these cases may be partially explained by the fact that stereotypes about men, doctors, women, and pregnant women inform the law'.[295]

In attacking male hegemony in the legal and medical world, Ikemoto draws on some disturbing facts. In Part IV, reference was made to a national United States' survey of cases dealing with judicial attempts to override a pregnant woman's refusal of proposed medical treatment.[296] In 44 per cent of those cases surveyed, the court orders were sought against unmarried women.[297]

Ikemoto further points out that the dominant male value system oppresses not only women in general and unmarried women in particular; discrimination is further apparent on the basis of race, class and culture. The 1987 survey of obstetricians reveals that of the 21 petitions for court-ordered medical treatment of pregnant women, 17 of the orders were sought against Black, Asian or Hispanic women.[298] All orders were sought against women receiving public assistance or using the public hospital system.[299]

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[289] These rights are discussed in Part II above.
[290] Manson and Morolt, *supra* n. 286 at 181.
[291] Ikemoto, *supra* n. 169 at 487.
[292] *Id.* 508.
[293] *Id.* 500.
[294] *Id.* 500–2.
[295] *Id.* 502.
[296] See p. 24 above.
[297] Ikemoto, *supra* n. 169 at 506.
[298] *Id.* 510.
[299] *Ibid.*

The cases discussed above by and large ignore the wide-ranging policy issues. If women are not to be oppressed and driven away from seeking medical help, if women are not to find another restraint placed on the already burdensome process of procreation, these policy issues must be taken into account by the courts if and when such cases present themselves. It may be greatly beneficial to society for our parliaments to consider this ethical dilemma and not leave such an important question to the unelected judiciary. Failure to do so, and allowing court intervention to override a pregnant woman's wishes, may protect some foetuses; as women flee the medical system, many more children are likely to be harmed. In the end, not interfering with the rights of the few pregnant women who refuse to co-operate with medical advice may be the 'lesser of two evils'.

VI CONCLUSION

The issues involved in the above discussion of cases and legal literature are emotionally charged. It may be difficult for the medical profession and courts to resist the urge to save the life of a foetus when threatened by the seemingly irrational conduct of its mother.

In some cases, religious beliefs[300] are proffered as the reason for the refusal of a pregnant woman to permit medical intervention by way of Caesarean section or blood transfusion. In other cases, the reasons for a woman declining to rescue her foetus are unknown.[301]

Whatever the reasons, the right of an individual to choose medical treatment is a fundamental right. The plight of the foetus when placed in conflict with the right of a woman to decline medical treatment does stir an emotional reaction that goes to the roots of life. Nancy Rhoden argues that '[e]motionally compelling cases often make bad law'.[302]

Courts in the United States (and, more recently, England) have shown a willingness (albeit a reluctant one) to judicially override the wishes of a pregnant woman in connection with Caesarean section and blood transfusion cases. These decisions are based on balancing difficult, confusing and often conflicting legal issues.

It is clear that, whatever the legal correctness of the decisions discussed above, the implications for policy and the way society functions cannot be removed from such decisions. A host of important policy issues have

[300] For example, *Jefferson v Spalding Griffin County Hospital Authority* (1981) 274 SE 2d 457; *In re Madyun* reprinted in (1990) 573 A 2d 1259 (as an Appendix to *In re AC* (1990) 573 A 2d 1235).

[301] See also p. 25 above.

[302] Rhoden, *supra* n. 124 at 123.

not been considered by the courts.[303] The policy issues are important reasons for courts not to override the decisions of pregnant women (whatever the cost to the foetus in those cases).

As technology develops, pregnant women may be increasingly pressured to agree to other invasions, such as foetal surgery, to ensure the safe delivery of a healthy baby. The 'slippery slope' argument suggests that the logical conclusion to State intervention is to appropriate all decisions of pregnant women in relation to work, food, drugs, alcohol and medical treatment. The title of a George Annas article, 'Pregnant Women as Fetal Containers',[304] is not so remote.

Australian courts have not been faced with the morass of legal and ethical arguments presented in these cases. If and when the situation arises, it is hoped that the courts here will look beyond the legal arguments and into the broader policy aspects of judicially overriding a pregnant woman's choices.

Given the enormity of the issues involved, it may be appropriate for the legislature to examine the broader issues and enact legislation before a court is forced to decide these issues.

It is certainly clear that reliance on legal precedent alone will be insufficient to resolve the potential conflict between mother and foetus. As one well-known United States' judgment observed: '[W]e are involved in a difficult and demanding area of the law in which each case presents issues of fundamental importance that require more than the mere mechanical reliance on legal doctrine ... We encourage and seek insights and the collective guidance of those in health care, moral ethics, philosophy and other disciplines.'[305]

[303] Perhaps *In re AC* (1990) 573 A 2d 1235 is an important exception to this. See, for example, the discussion of the erosion of women's confidence in the health-care system and its consequences (at 1248).

[304] *Supra* n. 37.

[305] *Superintendent of Belchertown State School v Saikerwicz* (1977) 370 NE 2d 417, 442.