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ARTICLES

DISSECTING WOMEN, DISSECTING LAW: THE COURT-ORDERING OF CAESAREAN SECTION OPERATIONS AND THE FAILURE OF INFORMED CONSENT TO PROTECT WOMEN OF COLOR

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Caesarean section deliveries increased markedly in the last twenty years. In 1970, the percentage of all deliveries by Caesarean section was 5.5 percent.¹ By 1991, the percentage of Caesarean section operations had increased to 23.5 percent of all deliveries.² Caesarean operations are now the most commonly performed major surgery in the United States.³

Unfortunately, as many as half of all Caesarean operations performed are unnecessary.⁴ On an annual basis, this “onslaught of unnecessary and dangerous surgery” results in 350,000 women being dissected needlessly.⁵

This article begins with the story of one woman, of one unnecessary and dangerous Caesarean section operation performed in 1987. The tragic dimensions of this story—a pregnant woman dying of cancer—make it appear unique. It is not. It is also the story of the hundreds of thousands of other women who have been unnecessarily sliced open by a medical estab-

* Professor of Law, University of Arizona; Assistant Professor of Law, Boston College (1989-91). This article is based on remarks made at the Heman Sweatt Symposium, University of Texas, March 1990. I would like to thank the Symposium Committee for inviting me to speak and Professor Patricia Cain for her special hospitality.

1. Michael Specter, *Caesarean Birth Rate Halts Its Sharp Rise*, WASH. POST, Jan. 27, 1989, at A4.

2. *U.S. Says 349,000 Caesareans in 1991 Were Not Necessary*, N.Y. TIMES, April 23, 1993, at A16 (indicating that the rate was unchanged from 1990 and had not changed substantially since 1986).

3. Robert Steinbrook, *Caesarean Birth Rate Falling in U.S., Researchers Say*, L.A. TIMES, May 13, 1992 at A1; see also Jeffrey B. Gould et al., *Socioeconomic Differences in Rates of Caesarean Section*, 321 NEW ENG. J. MED. 233, 237 (1989); Specter, *supra* note 1, at A4.

4. Leslie Laurence, *Unkindest Cuts? Caesarean Sections Come Under Watchdogs Scrutiny*, CHI. TRIB., June 6, 1993, at 5 (while the Centers for Disease Control and Prevention estimates that there were 349,000 unnecessary Caesareans in 1991, the Public Citizen's Health Research Group charges that half of the nearly 1 million Caesareans performed were not needed); Steinbrook, *supra* note 3, at A1; see also Robert Steinbrook, *Half the Caesarean Operations in U.S. Called Unnecessary*, L.A. TIMES, Jan. 27, 1989, at 3 (study of 2,400 hospitals in 30 states conducted in 1986-87 by the Public Citizen Health Research Group); Corea, *The Caesarean Epidemic*, MOTHER JONES, July 1980, at 28 (discussing the conflict between mother and doctor in considering whether a Caesarean should be performed).

5. *U.S. Says 349,000 Caesareans In 1991 Were Not Necessary*, *supra* note 2, at A16; Laurence, *supra* note 4, at 5; Steinbrook, *supra* note 4, at 3 (in 1987 the figure was 475,000 unnecessary operations).

ishment intent on seizing from women the power over reproduction.⁶ This is not, however, just a story about medicine.⁷ The judiciary collaborates in this continuing unnecessary surgery of women. There are at least nineteen cases where despite determined objections by the birthing mother, the courts have ordered the performance of a Caesarean operation.⁸ No one knows how many thousands of other women have been cajoled into consenting to Caesarean surgery under threat that the doctor or hospital would seek a court order.⁹

6. See, e.g., *Bowland v. Santa Cruz Mun. Court*, 18 Cal.3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976) (proscribing lay midwifery); *Smith v. State ex rel. Med. Licensing Bd.*, 459 N.E.2d 401 (Ind. Ct. App. 1984) (holding unlicensed midwifery illegal); *Leigh v. Bd. of Registration in Nursing*, 395 Mass. 670, 481 N.E.2d 1347 (1985) (holding that registered nurse's license can be suspended if she practices midwifery without the board's authorization).

It is, given the extent of unnecessary Caesarean operations, quite reasonable for women to question the recommendation for surgery. For example, women who have had a Caesarean section delivery are almost always pushed by the medical establishment to deliver subsequent children by Caesarean section. This treatment doctrine originated over 70 years ago because occasionally a uterine scar ruptured during vaginal delivery. In 1988, the American College of Obstetrics and Gynecology finally reversed this long-standing position. In a complete turnaround, the ACOG recommended to its members that *most* women who have had a Caesarean should be able to deliver subsequent children vaginally. Specter, *supra* note 1, at A4. Yet, only 24.2% of women with a previous Caesarean delivery have a vaginal delivery for subsequent births. *U.S. Says 349,000 Caesareans in 1991 Were Not Necessary*, *supra* note 2, at A16.

7. A study prepared by Helen Marieskind for the Department of Health, Education and Welfare, evaluating Caesarean sections found that "[t]hroughout the nation, physician focus has shifted from the mother, to the infant—to obtaining a perfect product." *MARIESKIND, AN EVALUATION OF CAESAREAN SECTIONS IN THE UNITED STATES* 7 (1979). In addition, many commentators point to the acceptance of the fetus as a second patient. For instance the leading obstetrical handbook, *WILLIAMS OBSTETRICS*, states that "the fetus is established as our second patient with many rights and privileges comparable to those previously achieved only after birth." *JACK A. PRITCHARD ET AL., WILLIAMS OBSTETRICS* xi (17th ed. 1985); see also *Watson A. Bowes & Brad Selgestad, Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 *OBSTETRICS & GYNECOLOGY* 209 (1981) (describing the care of a pregnant woman involving "two patients, the mother and the fetus"); *Helene M. Cole, Legal Interventions During Pregnancy*, 264 *JAMA* 2663, 2664 (1990) (a physician's ethical duty requires the physician to act in the interest of the fetus as well as the woman); *Renee I. Solomon, Future Fear: Prenatal Duties Imposed by Private Parties*, 17 *AM. J.L. & MED.* 411, 428 (1991) (discusses all the considerations a physician must make when a pregnant woman refuses treatment).

8. See *Veronika E.B. Kolder et al., Court-Ordered Obstetrical Interventions*, 316 *NEW ENG. J. MED.* 1192 (1987) (listing 15 cases of court-ordered Caesarean operations); *NATIONAL ORGANIZATION OF WOMEN LEGAL DEFENSE & EDUCATION FUND, WOMEN'S REPRODUCTIVE RIGHTS: FORCED CAESAREAN SECTIONS AND OTHER FORCED TREATMENT OF PREGNANT WOMEN—AN ASSAULT ON WOMEN'S AUTONOMY AND BODILY INTEGRITY* (July 1989) (available at NOW LDEF, New York, N.Y.) (claiming at least twenty cases as of summer 1989); see also *Rorie Sherman, Debate Renewed on Forced Caesareans*, *NAT'L LAW J.*, Jan. 7, 1991, at 16 (describing a Wisconsin case that ordered a Caesarean section operation).

9. An extreme example of coercion comes from an article by a group of Israeli doctors who argue that, "[i]f . . . the patient does not consent to undergo a given treatment directed to save the fetus, and which involves no undue risk to the patient, the doctor must be legally entitled to warn the patient that she is committing a felony." *J.R. Leiberman et al., The Fetal Right to Live*, 53 *OBSTETRICS & GYNECOLOGY* 515, 517 (1979).

Further, the cases on court-ordered Caesarean operations are precedent for other non-consensual medical interventions on pregnant women. There is a concern that a physician anxious to learn more in the area of fetal therapy, such as surgery, would coerce a woman into accepting experimental treatment "for the benefit of her fetus." *Jeffrey L. Lenow, The Fetus as a Patient: Emerging Rights as a Person?*, 9 *AM. J. LAW & MED.* 1, 18 (1983) ("perinatologists may be highly ambitious, and their alacrity may motivate them to be more concerned with finding a testing ground for their capabilities rather than with the best interests of the mother and the unborn child.").

Although there is a universality to the story told in this article, there is also a myopia. It is the narrowed and blurred vision of case law. The court tells the story in the form of a legal case. Analysis of the text of the court's story tells much about how all women are seen by the law. The story also reveals how, in constructing a vision of all women, the law is blind to the existence of women of color. Case law in the area of reproductive rights generally arises from the stories of women who have the social position and economic status to assert their rights. Yet, case law creates legal standards which govern the rights of all women.¹⁰

This article offers two alternative perspectives—a gender critique and a race critique—on the story we know as the case of *In re A.C.*¹¹ Finally, the vantage of other cultures—the culture of women and the culture of race—will demonstrate the failure of the informed consent doctrine to protect pregnant women, particularly women of color from the powerful oppression of the white male dominated medical profession.

I. THE STORY

A. *The First Telling: Judge Nebeker, Immediacy of Decisionmaking, Hindsight Reconstruction*

The case of *In re A.C.* (hereinafter “A.C. I”) provides a rich arena in which to do the work of varying our viewpoints.¹² The case initially came to us as an appellate decision of the District of Columbia Court of Appeals, written by retired Associate Judge Nebeker. The case was decided on June 16, 1987, and the opinion was filed on November 10, 1987.¹³ It is the text of the decision of Judge Nebeker, though later vacated by the court of appeals acting *en banc*, which is significant. Judge Nebeker perceived a narrative story which governed the decision by the court to force a Caesarean section on a woman called A.C.

Judge Nebeker set forth the facts in the case: The dispute came to the court on appeal as an emergency request for a stay of an order that permitted a Caesarean section on a terminally ill woman who was *in extremis*.¹⁴ The court sent its condolences “to those who lost the mother and child.”¹⁵

10. Doctors rely on the courts for guidance. See Thomas E. Elkins et al., *Court-Ordered Caesarean Section: An Analysis of Ethical Concerns in Compelling Cases*, 161 Am J. Obstet. Gynecol. 150, 151 (1989) (arguing that analysis of patient management in situations involving maternal fetal conflict calls for court intervention in limited situations); Bowes & Selgestad, *supra* note 7, at 211 (justifying court intervention); Frank A. Chervenak & Laurence B. McCullough, *Justified Limits on Refusing Intervention*, 21 HASTINGS CENT. REP. 12, 16 (1991) (contends that when a doctor is unable to alter the patient's refusal, court orders may be justified).

11. *In re A.C.*, 533 A.2d 611 (D.C. 1987) [hereinafter A.C. I] *reh'g granted, judgment vacated*, 539 A.2d 203 (D.C. 1988), *judgment vacated and remanded*, 573 A.2d 1235 (D.C. 1990).

12. Martha Minow & Elizabeth V. Spelman, *In Context*, 63 S. CAL. L. REV. 1597 (1990); Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411 (1989).

13. A.C. I, 539 A.2d at 611.

14. *Id.*

15. *Id.*

A.C. was a young woman diagnosed as having leukemia at age 13.¹⁶ Over the years, she underwent a series of treatments and operations.¹⁷ At age twenty-seven, her cancer had been in remission for three years and she had not received chemotherapy for one year. She subsequently married and became pregnant. In the twenty-fifth week of her pregnancy, A.C. went to her regularly scheduled prenatal visit where she complained of some difficulty in breathing. During this visit, a large, cancerous tumor was found in her lungs. She was admitted to the hospital that week; the prognosis was terminal.¹⁸

In the hospital during the next week, in her twenty-sixth week of pregnancy, A.C. was sedated to make her breathing easier. Her doctors had discussed radiation and chemotherapy but had decided that passive treatment was the most appropriate course of action because, as the court tells us, "the mother would not survive, and the child's chances of survival were grim."¹⁹

The administration of the George Washington Hospital decided to test this treatment decision in court. On June 16, 1987, the hospital filed a petition in the District of Columbia Superior Court asking, "what it should do in terms of the fetus, whether to intervene, by Caesarean section, and save its life."²⁰ The trial court held a hearing at the hospital, appointing counsel for A.C. and for the fetus. The District of Columbia intervened as *parens patriae* for the fetus.²¹

There was dispute as to whether A.C. would have chosen a Caesarean section on June 16.²² Based on the opinion of her doctors that at twenty-eight weeks there was much more medically to offer the fetus, she indicated that if, at twenty-eight weeks, there was a choice between her life and the life of the fetus, she would consent to a Caesarean section.²³ However, she also chose to take a number of medications that kept her more comfortable, despite being told by her doctors that the medications might harm the fetus.²⁴

The trial court found that the fetus was viable, and ordered the Caesarean section.²⁵ A.C. was informed of the decision and stated that she

16. *Id.* at 612.

17. While Judge Nebeker notes that A.C. underwent treatments and operations, he does not tell the reader that three years earlier, A.C. had developed a second malignancy which was treated successfully by the amputation of her leg and part of her pelvis. Note, *Terminally Ill and Pregnant: State Denial of a Woman's Right to Refuse a Caesarean Section*, 38 BUFF. L. REV. 619, 623 n.19 (1990)[hereinafter *Terminally Ill and Pregnant*].

18. A.C. I, 533 A.2d at 612.

19. *Id.*

20. *Id.*

21. *Id.* A.C. was not notified of the hearing until it had already commenced. *Terminally Ill and Pregnant*, *supra* note 17, at 625-26.

22. A.C. I, 533 A.2d at 612.

23. John F. Tuohey, *Terminal Care and the Pregnant Woman*, 88 PEDIATRICS 1268 (1991).

24. A.C. I, 533 A.2d at 613.

25. *Id.* This determination was made on the basis of testimony by Dr. Edwards, a neonatologist. Dr. Edwards had never met or examined A.C. Further, the viability of the fetus was much lower than would normally be predicted at 26 weeks because the fetus was in a "chronically asphyxiated state" due to A.C.'s respiratory failure. Diane M. Gianelli, *Others Oppose Ruling in C-Section Case*, AM. MED. NEWS, Dec. 18, 1987, at 3, col. 4.

would agree to the surgery.²⁶ A few minutes later, when another physician asked her to verify her decision, she mouthed the words, "I don't want it done."²⁷ The court tells us that there was no explanation for either decision.²⁸

Despite this discussion of A.C.'s apparent equivocation, neither the superior court nor Judge Nebeker of the Court of Appeals regarded A.C. as consenting to surgery.²⁹ The issue of her consent was not operative in the opinion.³⁰ The court based its decision to order a Caesarean operation on "the necessity to balance the delicate interests of the fetus survival with the mother's condition and options on her behalf."³¹ The court acknowledged that the decision may have cut short A.C.'s life span by a few hours.³²

The court began its discussion of the legal principles that would guide its decision by specifically noting that this was not a case about abortion—it was not a case like *Roe v. Wade*³³ in which a woman retains the right to timely terminate her pregnancy.

The court in *A.C. I* justified medical intervention for pregnant women who refuse medical treatment by relying on two established areas of law in deciding this case. First, as to A.C.'s rights, the court looked to the established right of competent patients to refuse medical care.³⁴ Central to the rights of personhood are rights to bodily integrity.³⁵ The courts are extremely reluctant to override a person's autonomy. Thus, the criminal and civil law redress battery, including battery done in the name of medicine.³⁶ The right to refuse treatment is protected even when such a choice will surely result in death, such as cerebral palsy sufferer Elizabeth Bouvia's decision to discontinue her nutrition and hydration through feeding tubes.³⁷ There have only been a handful of cases where the right to refuse

26. A.C. I, 533 A.2d at 613.

27. *Id.*

28. *Id.*

29. *Id.* at 617 (indeed the bulk of Judge Nebeker's opinion discussed the applicability of cases where courts have overridden parents' refusal of medical treatment for their children).

30. It is clear from the opinion of Judge Nebeker that the trial judge, Judge Sullivan of the District of Columbia Superior Court, did not ask A.C. for her consent before he made his decision. *Id.* at 613.

31. *Id.* ("The ordinary question of likelihood of ultimate success on the merits was deemed subsumed in the immediate necessity to balance the delicate interests of fetus survival with the mother's condition and options on her behalf.")

32. *Id.* at 613, 614.

33. *Id.* at 614 (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

34. *Id.* at 615. See also *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (upholding the discontinuation of a patient's respirator where patient, prior to becoming incompetent, requested not to have his life prolonged by medical means if there was no hope for recovery); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981) (holding that competent adult patients with incurable illnesses have the right to have life-support equipment disconnected even if this would result in death).

35. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 744, 745, 370 N.E.2d 417, 427 (1977); *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (holding that no right is more sacred than that of possession and control of one's own person).

36. See *Bartling*, 163 Cal. App. 3d at 197, 209 Cal. Rptr. at 224; see *Kristine C. Karnezis, Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R.3d 67 (1979).

37. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); see also *In re Osborne*, 294 A.2d 372 (D.C. 1972) (upholding the refusal of a blood transfusion on religious grounds).

treatment has not been honored. These are usually in the context of refusals of medical treatment for religious reasons, such as the Jehovah's Witnesses-type cases.³⁸

The courts have articulated three interests of the state which might override the autonomy of the patient: 1) a general interest in the preservation of life and prevention of suicide; 2) an interest in protecting third parties— particularly when the patient refusing treatment is the parent of young children; and 3) an interest in protecting the integrity of the medical profession.³⁹ The court in *A.C. I* found that there was no significant state interest preventing suicide or in the preservation of the integrity the medical profession.⁴⁰ However, the court did find that the state indeed held an interest in protecting an innocent third party, namely, A.C.'s fetus.⁴¹

This interest led the court to borrow from a second established area of law: child neglect cases.⁴² Here, the court considered the rights of the fetus. The law recognizes that a court may intervene and order life-saving medical care for a minor even where the child's parents have refused to consent to the treatment.⁴³ The court notes that this state interest in minors has been applied to fetuses both to order blood transfusions to pregnant women over their objections⁴⁴ and to order a Caesarean operation, as in the case of *Jefferson v. Spalding County Hospital Authority*.⁴⁵

The court then balanced the interests of A.C. and the fetus. The court made the following finding:

The Caesarean section would not significantly affect A.C.'s condition because she had, at best, two days left of sedated life; the complications arising from the surgery would not significantly alter the prognosis. The child, on the other hand, had a chance of surviving delivery, despite the possibility that it would be born handicapped. Accordingly, we con-

38. See, e.g., *In re President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir. 1964), cert. denied, 377 U.S. 978 (1964)(denying competent patient's refusal of blood transfusion).

39. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 431-33, 497 N.E.2d 626, 634 (1986); *Saikewicz*, 373 Mass. at 740, 741, 370 N.E.2d at 425.

40. A.C. I, 533 A.2d at 615, 616.

41. *Id.* at 616, 617.

42. *Id.* at 616 (citing *Jehovah's Witnesses v. King County Hosp. Unit No. 1*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968)(upholding law allowing courts to declare children dependents of the state for purposes of ordering blood transfusions); *Muhlenberg Hosp. v. Patterson*, 128 N.J. Super. 498, 320 A.2d 518 (1974)(ordering transfusion to prevent brain damage despite parent's objections); see also *In re Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978)(ordering chemotherapy for a child despite parental objections).

43. A.C. I, 533 A.2d at 616.

44. See, e.g., *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), cert. denied, 377 U.S. 985 (1964)(guardian appointed for fetus with power to order pregnant woman to undergo blood transfusion); *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (1985)(guardian for fetus appointed with right to force pregnant mother to undergo blood transfusion); *Crouse Irving Memorial Hosp., Inc. v. Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (1985)(pregnant woman ordered to receive blood transfusion to protect fetus); but see *Taft v. Taft*, 388 Mass. 331, 334, 335, 446 N.E.2d 395, 397 (1983)(court refused to order surgery to prevent potential miscarriage).

45. 247 Ga. 86, 274 S.E.2d 457 (1981)(mother at term and in labor, refused to consent to Caesarean; court ordered operation if necessary following additional diagnosis). One commentator distinguishes the transfusion cases from the Caesarean cases: "Whatever relevance these cases may retain in the context of transfusions, they provide little authority for the much more invasive, risky, and painful Caesarean sections and intrauterine procedures at issue today." Kolder, *supra* note 8, at 1195.

cluded that the trial judge did not err in subordinating A.C.'s right against bodily intrusion to the interest of the unborn child and the state. . . .⁴⁶

Further, the court noted that the medical procedure sought did not conflict with expressed medical judgment and that there were doctors willing to perform the surgery.⁴⁷ The balance of these many factors resulted in the denial of the motion for stay of the superior court's order.

Judge Nebeker filed his opinion four months after the appeals court initially denied the request for stay, thereby sending A.C. to the operating room. The opinion was issued despite A.C.'s lawyers' request that a formal decision not be issued because of the troubling precedent created by trading the mother's interest in her life and health against that of her unborn fetus.⁴⁸ Difficult facts at times make worrisome law. Nevertheless, Judge Nebeker did set out his analysis and reasons for decision. Interestingly, Judge Nebeker does not tell the reader in the opinion that the fetus lived only two hours after surgery and that A.C. died two days after the surgery. Her death certificate lists the Caesarean operation as a contributing cause of death.⁴⁹

B. *The Retelling: Judge Terry for the Majority; Subtext of Judge Belson's Dissent*

The Court of Appeals, *en banc*, on rehearing discussed at length the course of events following the trial judge's decision.⁵⁰ Judge Terry noted that the testimony of A.C.'s doctors indicated that she had regained consciousness and was particularly lucid. A.C. was in intensive care, flanked by her family. Her doctors, while expressing qualifications as to whether their conversations met the standards of informed consent, did state that A.C. was in contact with reality; could clearly understand the questions that were put to her; and clearly and distinctly mouthed the words, "I don't want it done."⁵¹

Though Judge Sullivan, the trial judge, never interviewed A.C., there is dispute over whether he found A.C. incompetent. The court of appeals decision on remand reflects this ambiguity.⁵² The majority opinion of Judge Terry found that Judge Sullivan erred by not making a determination of competency.⁵³ Judge Belson, in his opinion concurring in part and dissenting in part, disagreed. Judge Belson found that the trial judge's statement that "the court is still not clear what her intent is," was mitigated by the trial court's finding that "A.C. was 'heavily sedated' and that there could be no 'meaningful conversation with her at this point.'"⁵⁴

46. A.C. I, 533 A.2d at 617.

47. *Id.*

48. Lynn M. Paltrow, *Court Forces Dying Woman to Undergo Caesarean*, CIVIL LIBERTIES, Winter 1988, at 12 ("[T]he ACLU's Reproductive Freedom Project, together with . . . [A.C.'s] court appointed lawyer, asked the appeals court not to issue an opinion supporting its ruling.")

49. *Id.*

50. *In re A.C.*, 573 A.2d 1235, 1240-41 (D.C.App. 1990) (*en banc*) [hereinafter A.C. II].

51. *Id.* at 1241.

52. *Id.* at 1247.

53. *Id.* at 1252.

54. *Id.* at 1253.

Judge Belson determined that the trial court had found A.C. incompetent.⁵⁵ This was, of course, at odds with the testimony of A.C.'s doctors who described her as lucid, in touch with reality and able to understand the medical choice shortly after Judge Sullivan issued his order.⁵⁶ One can reasonably argue that A.C. was temporarily incapacitated during a period of sedation. If Judge Sullivan would have waited but a short time, he could have conversed with A.C. On rehearing, Judge Terry also stated that this was not a case about *Roe v. Wade*.⁵⁷ Judge Belson, in his opinion, reiterated this position, but, ironically, at the same time made it clear why this was a case about *Roe v. Wade*. Judge Belson argued, "when a woman has carried an unborn child to viability . . . the child becomes a party whose interests must be considered. . . . The balancing test should be applied in instances in which women become pregnant and carry an unborn child to the point of viability."⁵⁸ In *Roe v. Wade*, the Supreme Court made clear that the health of a pregnant woman always takes precedence over the welfare of the fetus, even in the third trimester.⁵⁹ Under the doctrine of *Roe v. Wade*, a woman's health is not to be traded against the welfare of her fetus.

II. A GENDER CRITIQUE

A. *Pregnant Women as Persons with Autonomous Rights*

A gender critique of the tragic case of A.C. might begin with the question: "Who's story is being told?"⁶⁰ The story Judge Nebeker tells is a tragedy of conflicting rights—the rights of a mother and the rights of an unborn child.⁶¹ The language of conflict misrepresents the maternal fetal relationship.⁶² Couching the debate in terms of woman against fetus is counterproductive and fails to recognize the autonomy of the woman and the unique relationship of woman and fetus.⁶³ Judge Nebeker was confronted with a notion of autonomy that was at odds with the traditional conceptions of individuality.⁶⁴ The court did not view A.C. as an individual but as two persons. Because of this perception, the court's opinion ques-

55. *Id.*

56. *Id.* at 1241.

57. *Id.* at 1245 n.9.

58. *Id.* at 1255-56.

59. 410 U.S. at 165 (the state cannot proscribe abortions which are "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.").

60. See generally *Symposium on Legal Storytelling*, 87 MICH. L. REV. 2073 (1989); Milner S. Ball, *The Legal Academy and Minority Scholars*, 103 HARV. L. REV. 1855, 1859 (1990) (recognizing the transformative power of narrative for minority legal scholars); see also James R. Elkins, *The Stories We Tell Ourselves in Law*, 40 J. LEG. EDUC. 47, 53 (1990).

61. A.C. I, 533 A.2d at 617.

62. Note, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Child-birth Decisions and Women of Color*, 26 HARV. C.R.-C.L. L. REV. 523, 543 (1991).

63. See Cheryl E. Amana, *Maternal-Fetal Conflict: A Call for Humanism and Consciousness in a Time of Crisis*, 3 COLUM. J. GENDER & L. 351 (1992).

64. Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1 (1988) (arguing that feminist theory poses a new conception of "human being," not as a physically bound individual, but as an uniquely relationship bound entity); Carol Gilligan, *Remapping the Moral Domain: New Images of Self in Relationship*, reprinted in *Mapping the Moral Domain* 5 (Carol Gilligan et al. eds., 1988) ("the identification of attachment or interdependence as a primary dimension of human experience ties the psychology of love to the representation of moral growth and self-development.").

tions the very humanness of women when they are pregnant.⁶⁵ An alternative approach might begin by viewing this not as a conflict between mother and child, but an adjudication about who should have the power to make decisions on behalf of the fetus.⁶⁶

A gender critique would continue with the court's legal premise. The court states that this is not a case about abortion—not about *Roe v. Wade*.⁶⁷ Was *Roe v. Wade* really only a case about abortion? Emphatically, no. *Roe* was a case about the autonomous rights of pregnant women.⁶⁸ A.C. had the right to abort her fetus during the first two trimesters of her pregnancy and she could have chosen to abort her fetus at the time of the court's decision if continuing the pregnancy would adversely affect her health. To argue that she lost that right because she had not yet exercised it is absurd. Pregnant women do not waive their right to the primacy of their own health by their decision to engage in the reproductive process for as long as possible.⁶⁹ To find otherwise would encourage peremptory abortion for any woman who's health might eventually be threatened.⁷⁰

65. The two-person concept is supported by the medical profession's acceptance of the fetus as a second patient. See *supra* note 7. Additionally, as explained by Lisa Ikemoto in *The Code of Perfect Pregnancy*, 53 OHIO ST. L. J. 1205, 1294 (1992):

Relationships in our society are only dimly understood in terms of power and . . . domination . . . and are more often described in terms of conflict and a balance of interests. . . . This cultural understanding prescribes the perception that in a woman-fetus relationship, the woman is in a position of power relative to the fetus, and that the fetus must be protected from harm caused by the woman's abuse of this power.

For example, Judge Belson, dissenting on rehearing, addresses the humanness of pregnant women when he notes what is undoubtedly true: "[T]he expectant mother has placed herself in a special class of persons who are bringing another person into existence, and upon whom that other person's life is totally dependent." A.C. II, 573 A.2d at 1256. It is the way Judge Belson characterizes that relationship in terms of conflict that is disturbing: "Also, uniquely, the viable unborn child is literally captive within the mother's body." *Id.* Apparently it is too conceptually disturbing to view a pregnant woman as one living entity. See also Marc Lipsitch, *Genetic Tug-of-War May Explain Many of the Troubles of Pregnancy*, N.Y. TIMES, July 20, 1993, at C3, col. 1 (evolutionary biologist Dr. David Haig maintains that many of the aspects of pregnancy are an evolutionary struggle between the woman and fetus. Dr. Haig describes several biochemical processes such as insulin production where there is a battle between the woman and her fetus); but see Abby Lippman, *What's Behind Odd Idea of War in the Womb*, N.Y. TIMES, Aug. 7, 1993, at 20, col. 4 (calls Dr. Haig's assumption that a woman and fetus are in conflict a patriarchal interpretation of pregnancy, fetuses are not fighting for their survival, rather mother and fetus cooperatively coexist).

66. Amana, *supra* note 63, at 351.

67. A.C. II, 533 A.2d at 614 (citing *Roe v. Wade*, 410 U.S. 113 (1973))(discussion of opinions in A.C. II by majority and dissent also take this position).

68. See generally *Roe*, 410 U.S. at 113.

69. See *Thornburgh v. Am. College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986)(striking statute that required doctor performing an abortion to deviate from treatment in the best interests of the pregnant woman in order to preserve the possible viability of a fetus).

70. This is not an insignificant risk. Estimates are that 1 out of every 118 women who have cancer will also be pregnant. Harry L. Ioachim, *Non-Hodgkin's Lymphoma in Pregnancy*, 109 ARCHIVES OF PATHOLOGY & LABORATORY MED. 803 (1985). While cancer during pregnancy is rare, when a malignancy occurs only in 1 out of 1,000 pregnancies, it is significant. Lanie Jones, *Cancer & Pregnancy: Dilemma Sometimes Pits Survival Against Abortion*, L.A. TIMES (Orange County Edition), Nov. 6, 1990, at E1, col. 4. In any given year over 3,400 women who have cancer will also be pregnant. Ioachim, *supra* at 803. Further, pregnant women face health choices other than cancer, and some women have different religious belief systems. When confronted with the possibility that their health or beliefs might be sacrificed, women may avoid medical care altogether. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Caesareans*, 74 CAL. L. REV. 1951, 2011 (1986).

More importantly, altruistic accommodation is not the relationship most women have with the fetus. It is a relationship of love.⁷¹ It is a human relationship that is fundamentally different than the relationships—even love relationships—between individuals who are biologically distinct.⁷² This relationship of love and hope existed between A.C. and the developing life within her.⁷³ The court was wrong when it stated that this was not a case about *Roe v. Wade*.

The court was also wrong when it characterized the case as one about the right to refuse treatment.⁷⁴ In all of the cases where the courts have ordered medical care over a person's objections, the courts were ordering life-saving treatments.⁷⁵ It is a far different matter to override a patient's objections to life-threatening, or perhaps terminal, medical care. In relying on this body of law, the court cited the *Jefferson*⁷⁶ case, where a Georgia court ordered a Caesarean section.⁷⁷ As the *A.C. I* opinion notes, however, in the *Jefferson* case the attending physicians testified that there was a fifty percent chance that the mother would die and a ninety-nine percent chance that the fetus would die if surgery were not performed.⁷⁸ The case of *A.C.* is much different; no one could claim that the surgery would benefit A.C.

A gender critique should also examine the hidden message the court sends regarding A.C.'s competency to decide her fate, and the competency of women in general to make fundamental reproductive choices.⁷⁹ The power of all women to make medical choices is different from that of men. A study of appellate court rulings revealed several major gender differ-

71. Gilligan, *supra* note 64, at 5.

72. Rhoden, *supra* note 70, at 1979 (despite the consistent refusal by the courts to order bone marrow donation, Caesarean cases seem different, and seem to elicit a difficult emotional response which results in different outcomes in the cases. Professor Rhoden argues that despite this emotional difference, the law should treat the cases as alike.)

73. Laurie Abraham, *Debate Follows Ruling for Fetus Over Mother*, 31 AM. MED. NEWS 1, 19 (1988) ("A.C. had realized, her obstetrician, Lewis Hamner, M.D., testified, that the pregnancy might bring back her dormant cancer, but she very much wanted to be a mother. At the same time, she did not want to sacrifice her own health during pregnancy, Dr. Hamner testified, and several times decided to take medication even though it posed some risk to the fetus."). See also Marie Ashe, *Zig-Zag Stitching and the Seamless Web: Thoughts on "Reproduction" and the Law*, 13 NOVA L. REV. 355, 380-82 (describing A.C.'s love for the child she might have, and also eloquently noting that, "legally-endorsed violations of women's bodies in the name of 'life'—hateful legal constructs that impose 'love' and 'self-sacrifice' upon women as our duties—are perverse. That in its alienation from nature law works harms far more destructive than the deaths that arise out of nature or out of the natural limitations of women.").

74. See *A.C. I*, 533 A.2d at 615-16.

75. See *supra* notes 38, 44 and 45.

76. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

77. *A.C. I*, 533 A.2d at 614 n.2.

78. *Id.*

79. Janet Gallagher, *The Fetus and the Law - Whose Life Is It Anyway?*, 13 MS. MAGAZINE, Sept. 1984, at 62, 66 (reproductive rights lawyer Gallagher notes that there is an "unspoken assumption that pregnancy renders a woman legally incompetent to make decisions." This assumption means recent medical advances are "laced with threat as well as promise" for pregnant women). Professor Lisa Ikemoto notes that "courts may . . . be, in fact, applying the stereotype - that pregnant women are subject to the whims of their ever-changing hormonal imbalance and are incapable of knowing their own minds. . . ." *Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 504. See also Lawrence J. Nelson, *Compulsory Treatment of Pregnant Women*, 1 CLINICAL ETHICS REP. 1 (May 1987) (asserting that the mental capacity of a pregnant woman to refuse treatment should be determined as it would for any other adult).

ences in how courts weigh a competent individual's preferences.⁸⁰ One difference is the courts' view that a man's opinions are rational but a woman's opinions are unreflective, emotional, or immature.⁸¹ Additionally, women's moral agency in relation to medical decisions is often not recognized.⁸² Another gender distinction is found in the way courts apply different evidentiary standards to men's and women's preferences.⁸³ Finally, life-support dependent men are seen as subjected to medical assault; women are seen as vulnerable to medical neglect.⁸⁴

Judicial reasoning concerning men stresses the role of personal autonomy while judicial reasoning concerning women examines their roles as caregivers.⁸⁵ To illustrate how gender influences the courts, let us return to the *Jefferson*⁸⁶ case. The *A.C. I* court relies on this case for its moral approach as well as legal approach. The thinly disguised question is: "What kind of crazy woman, despite her religious beliefs, would refuse a Caesarean if there was a ninety-nine percent certainty that her baby would die and a fifty percent chance that she would die?" What the *A.C. I* court does not tell the reader is that in *Jefferson*, despite the dire predictions, the baby was born vaginally.⁸⁷ Both mother and child were fine. However, the judge gave greater weight to the doctor's opinion than to Ms. Jefferson's.⁸⁸

There are only a few cases where a court refused to grant a hospital's petition for an order.⁸⁹ In one case, Judge Margaret Taylor refused to order that a Caesarean section be performed on a woman who had a strong belief in natural childbirth and who's intuition told her that everything would be fine. As predicted, both mother and child were indeed fine.⁹⁰

After A.C.'s death, Lynn Paltrow, the ACLU attorney for A.C.'s parents, was left with the task of telling A.C.'s view of the case:

A.C.'s doctors told her that she had only days or perhaps months to live. They also determined that the fetus was too small to survive Nevertheless, when the hospital administration learned of A.C.'s situation, it contacted the hospital's attorney in the mistaken belief that the law mandated intervention on behalf of the fetus. In response to a call from the hospital's attorney, a judge arrived unannounced at the hospital and convened an emergency hearing to determine what medical care should be performed for the benefits of the fetus Despite the unequivocal

80. See Steven H. Miles & Allison August, *Courts, Gender and "The Right to Die"*, 18 *LAW, MED. & HEALTH CARE* 85, 87 (1989).

81. *Id.* at 87.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.* at 91.

86. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

87. Rhoden, *supra* note 70, at 1959-60.

88. Professor Ikemoto examined the court's opinion in-depth and found that one long paragraph is devoted to the doctors' assessment of the risk whereas the position of Ms. Jefferson and her husband are summarized in three sentences. Ikemoto, *supra* note 79, at 501. Professor Ikemoto concludes 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." *Id.* at 502.

89. Alice M. Noble-Allgire, *Court-Ordered Caesarean Sections: A Judicial Standard for Resolving the Conflict Between Fetal Interests and Maternal Rights*, 10 *J. LEG. MED.* 211, 235 (1989).

90. Rhoden, *supra* note 70, at 1959.

testimony of Angie's family, her doctors and the entire hospital obstetric staff, and her own adamantly articulated wishes (she repeatedly told doctors, "I don't want it done"), the judge ordered that the Caesarean be performed. "She's going to die," he said.⁹¹

The impact of the Caesarean section on A.C. was discounted by the court.⁹² Likewise, the impact of Caesarean operations are discounted generally.⁹³ There is a Caesarean epidemic in this country. Nationally, Caesarean sections account for twenty-three percent of all births; a rate that has more than quadrupled since 1970.⁹⁴ About one-third of Caesarean opera-

91. Paltrow, *supra* note 48, at 12.

92. *Terminally Ill and Pregnant*, *supra* note 17, at 626-27.

93. *See, e.g.*, A.C. II, 573 A.2d at 1259 n.14 (Belson, J., dissenting in part).

94. In an egregiously circular argument, Judge Belson, dissenting in part on rehearing, argues:

An additional factor, which is difficult to assess but probably deserves some consideration, is that caesarean deliveries are quite common. According to the Bureau of the Census, the Department of Commerce, 24.1 per cent of all births were by caesarean section in the year 1986 . . . Without detracting from the seriousness of the caesarean procedure, its invasiveness, and the somewhat greater risk it entails, it seems reasonable to consider the fact that nearly a quarter of all births are caesarean not only in the substituted judgment analysis but also in the balancing analysis that should resolve a conflict between mother and unborn child.

Id. at 1259 n.14. Judge Belson argues that because women are butchered frequently, there is justification for butchering them frequently. Even if Caesareans are common they are still major surgery. Nancy W. Cohen and Lois J. Estner include this description of a Caesarean section in their book *SILENT KNIFE*:

With one strong and definite motion [the surgeon] creates a crescent-shaped incision along the woman's pubic hairline. As the skin is cut, the subcutaneous tissue bulges upward as though it had been straining to get through all the time. . . . With scalpel and forceps . . . the surgeon cuts deeper beneath the subcutaneous tissue, to a thick layer of fibrous tissue that holds the abdominal organs and muscles of the abdominal wall in place. Once reached, this fibrous layer is incised and cut along the lines of the original surface incision while the muscles adhering to this tissue are scraped off and pushed out of the way. The uterus is now visible under the peritoneum, . . . which covers most of the internal organs The peritoneum is lifted away from the uterus, and an incision is made in it, leaving the uterus and bladder easily accessible. The bladder is peeled away from the uterus [T]he obstetrician extends the initial cut either by putting two index fingers into the small incision and ripping the uterus open or by using blunt-ended scissors and cutting in two directions away from the initial incision. If the membranes are still intact, they are now punctured by toothed forceps, and the fluid spills out onto the table. In the normal position, the baby's head is down and under the incision, so the obstetrician places one hand inside the uterus, under the baby's head, and with the other hand exerts pressure on the upper end of the uterus to push the baby through the abdominal incision. . . . The rest of the surgery is more difficult for the woman. There is more pain and women often vomit and complain of difficult breathing as we handle their organs [T]he uterus can be brought out of the abdominal cavity and rested on the outside of the woman's abdomen, thus adding both visibility and room in which to work [L]arge circular needles and thick thread . . . [are] used to sew closed the hole in the uterus. [S]mall sutures are used to tie . . . bleeding blood vessels. [S]paces in the abdominal cavity are cleared of blood and fluid. The uterus is then placed back in the abdominal cavity. The bladder is sewn back onto the surface to the uterus, and then finally the peritoneum is closed [T]he closure of the abdominal wall begins. Muscles overlying the peritoneum are pushed back in place, and are sometimes sewn with loose stitches. Fascia, the thick fibrous layer, is the most important one, since it holds all the abdominal organs inside and keeps them from coming through the incision Therefore this layer is closed with heavy thread and many individual stitches. The subcutaneous tissue is closed in loose stitches [S]kin, the final layer, is closed with silk or nylon thread or metal staples. . . . [A] dry bandage is placed over the woman's incision and then taped to her skin. NANCY W. COHEN & LOIS J. ESTNER, *SILENT KNIFE* 27-28 (1983) (*quoting* MICHELE HARRISON, M.D., *WOMAN IN RESIDENCE* 81-84 (1982)).

Professor Annas best characterizes the attitude of Judge Belson when writing about the judicial ordering of Caesarean operations, and in particular, the order in the A.C. case: "The ultimate rationale for the decision may be purely sexist: this situation could never apply to males

tions result in infection or other complications.⁹⁵ The risk of death is four times greater from Caesarean sections than from vaginal delivery. Caesarean sections affect future child-bearing and may cause sterility.⁹⁶ Most importantly, they fundamentally alter the birthing process.⁹⁷

The emotional impact of a Caesarean section should not be discounted. Caesarean mothers are likely to feel disappointed, angry, frustrated, guilty, helpless, and depressed. They may also experience a sense of failure.⁹⁸ In studying women who have had Caesarean sections, Cohen and Estner found that "[the] Caesarean mother grieves for her healthy body, . . . for the enforced separations from spouse and newborn. . . . She grieves for the loss of control . . . and her self-esteem; . . . for her energy, stamina, and strength; . . . for her femininity and for a feeling of trust and confidence in her body. . . ."⁹⁹ Letters from women who experienced Caesarean sections express the following feelings:

"I've been physically bisected and emotionally dissected."¹⁰⁰

"[I]t has made me feel less than a total woman. I felt like I had failed It's been almost a year and I believe I'm starting to be able to sort out my feelings; however, it has been a long hard year. . . ."¹⁰¹

"All the Caesarean mothers I see are frustrated, scared and sad."¹⁰²

"The times I try to explain to others the depths of my disappointment and heartache over my c/section, the words just won't come out right. After months of trying to push these feelings aside, I no longer can. I always felt guilty thinking I was just feeling sorry for myself, that I was ungrateful for my healthy child."¹⁰³

"I feel cheated in a way and am still blaming myself and feeling like I did something wrong."¹⁰⁴

A.C.'s last days were not spent in a struggle to survive a few more weeks and perhaps give her fetus a better chance at life.¹⁰⁵ She was wheeled off to an operating room. Though there were doctors willing to

like these judges; they are unable to identify with the pregnant woman and thus need not concern themselves about the future application of their decision to themselves." George Annas, *She's Going to Die: The Case of Angela C.*, 18 HASTINGS CENTER REP. 23, 25 (1988).

95. At least one-third of Caesarean patients will suffer from some form of post-operative infection. NATIONAL INSTITUTE OF HEALTH, U.S. DEPT. OF HEALTH AND HUMAN SERV., CAESAREAN CHILDBIRTH: REPORT OF A CONSENSUS DEVELOPMENT CONFERENCE 16 (1981).

96. Denise Grady, *Too Many Caesareans*, SELF, April 1990, at 218.

97. See generally Ashe, *supra* note 73 (Professor Ashe provides a moving description of childbearing in different settings by offering her own reproductive experiences).

98. COHEN & ESTNER, *supra* note 94, at 33.

99. *Id.* at 63.

100. *Id.*

101. *Id.* at 41.

102. *Id.* at 50.

103. *Id.* at 51.

104. *Id.* at 52.

105. Dr. Moscow, A.C.'s oncologist disagreed with the prognosis that she had only 24 to 48 hours of life remaining. See *Terminally Ill and Pregnant*, *supra* note 17, at 630 n.78 (Dr. Moscow felt that another treatment option would significantly alter her prognosis and prolong her life). See also, Paltrow, *supra* note 48, at 12 ("[A.C.'s] doctors told her that she had only days or perhaps months to live."). In the words of A.C.'s mother, Nettie Stoner: "After the surgery and after they told her the baby was dead, I think [A.C.] just gave up." *Drama In The Womb: A Matter Of Life And Death Winds Up In Court*, L.A. TIMES, Dec. 25, 1987, sec. 5A, at 5, col. 1.

perform the surgery, they were not her doctors.¹⁰⁶ Her pregnancy, begun in intimacy,¹⁰⁷ with the hope that her struggle with disease was over, ended under the direction of strangers. Neither the legal nor the medical establishments listened to A.C.

B. *Sacrifice for Others: Stereotypes of "Good" Women/Mothers*

As the court fails to recognize the competency of women to make their own decisions, it proceeds to impose its own image of motherhood. A gender critique must also examine the stereotypes which affect the results of forced Caesarean cases.

The ideal of the mother as the "supreme nurturer and a sacrificial being who willingly experiences hardship to better her child, pervades our society."¹⁰⁸ Underlying Judge Nebeker's balancing of the A.C.'s interests with those of her fetus is a set of assumptions—"that a normal woman would do anything for the sake of her unborn child even if it endangered her own life;" and that there must be something wrong with the woman who refuses to risk her life for her fetus.¹⁰⁹ Many women faced with Caesarean sections or other treatment decisions choose to jeopardize their own health for the sake of the fetus; however, these decisions are not challenged. Courts and doctors do not prevent a woman from endangering her life to save that of her child because such decisions meet our expectations of how a good mother should behave.¹¹⁰

At best, women who do not adhere to the ideal of motherhood are thought to have improper motives, be of poor character, or simply thought of as bad mothers.¹¹¹ At worst the trust these women placed in their doctors is betrayed, their fate is decided quickly by a judge, and they are forced to have major surgery—all in an attempt to reinforce the belief that a mother should act selflessly.¹¹²

106. A.C. I, 533 A.2d at 617 (noting only that there were doctors willing to operate and not that these doctors were not A.C.'s treating physicians). In fact, A.C.'s own doctors would not perform the surgery. *Terminally Ill and Pregnant*, *supra* note 17, at 631.

107. Richard Delgado, *Euthanasia Reconsidered: The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474, 477 (1975) (arguing that intimacy should be the touchstone for judicial determinations on the boundaries of constitutionally protected zones of privacy).

108. Andrea Goetze, *Court-Ordered Caesarean Sections: Probing the Wound*, 1 TEX. J. WOMEN & L. 59, 92 (1992). For an indepth discussion of the ideology of motherhood and how such stereotypes enforce subordination of women, see Ikemoto, *supra* note 65, at 1205.

109. Ikemoto, *supra* note 65, at 1245.

110. *Id.* at 1238.

111. *Id.* Doctors have described women who refused Caesareans as unreasonable or irrational. Ikemoto, *supra* note 79, at 502. Refusal may also be attributed to depression or mental disability. Joel J. Finer, *Toward Guidelines for Compelling Caesarean Surgery*, 76 MINN. L. REV. 239, 276 (1991). Such characterizations are an example of the prevailing attitude that a "normal", loving mother would gladly risk her health for that of her fetus, and that something must be wrong with a woman who chooses not to do so.

112. The judicial and medical interference in the lives of women who refuse Caesareans may even continue after the surgery. A medical case study of an extremely obese woman who refused to submit to a Caesarean and was ordered to have the surgery reports the following: After the delivery, the physicians, nurses, social workers, and consultants from the Department of Psychiatry met on a regular basis to discuss concerns about the woman's relationship with her newborn infant. Though the patient initially demonstrated caring behavior toward the infant, several months later all three of her children were assigned to foster care when there was evidence of

Forced Caesareans are justified on the grounds that pregnant women have a unique physical capacity to harm children. They may instead "reflect the view that pregnant women have a unique social obligation to protect children."¹¹³ In fact, forced Caesarean sections do not provide any degree of real protection for fetuses: A.C.'s child died shortly after it was delivered, and Ms. Jefferson delivered naturally. Likewise, in two other cases where court orders for Caesarean operations were obtained, the mothers had their babies vaginally, despite the dire predictions of the doctors.¹¹⁴ Court-ordered Caesareans may do more harm than good. For example, in order to perform a Caesarean section, a Nigerian woman had to be physically restrained and her husband was forced to leave the hospital. Several weeks after the operation the husband committed suicide.¹¹⁵ What becomes clear is that these interventions are a way of forcing women to conform to the cultural stereotype of the perfect mother.¹¹⁶

III. THE RACE CRITIQUE

It is tempting to lump the experiences of all women together. The assumption is that since all women suffer discrimination their stories are the same.¹¹⁷ They are not.¹¹⁸ But by concentrating only on gender, the focus tends to be on the experience of white, middle class women.¹¹⁹ Such

neglect. That these health care professionals continued to meet after the woman was no longer under their care suggests that they felt the refusal to undergo a Caesarean connoted deficient maternal feelings, and the possibility that the woman was a bad mother. The inclusion of this data in the case report may also have been provided to justify the decision to override the woman's refusal of treatment. Goetze, *supra* note 108, at 86-87. Similarly, another woman who was forced by court order to have a Caesarean section was "followed closely by social service agencies" to ensure she was functioning appropriately in relation to her infant. Elkins, *supra* note 10, at 151.

113. Reva Siegel, *Reasoning from the Body*, 44 STAN. L. REV. 261, 342 (1992).

114. Rhoden, *supra* note 70, at 1959-60. However, in one of these cases, the woman had to go into hiding. In the other, the woman left the hospital and had her baby at home. Forcing women to these extremes does nothing to ensure the health of the fetus. *Id.*

115. Ikemoto, *supra* note 65, at 1250; Kolder, *supra*, note 8, at 1193. Further evidence that fetal protection is more about regulating women and imposing a view of motherhood than about protecting children is found in the way men are held to lesser standards for protecting children than are women. See Siegel, *supra* note 113, at 342-43. For example, many states now require liquor sellers to post signs warning pregnant women not to drink, yet there is no requirement to warn men of the vast array of other harms drinking may pose to family members and strangers alike. *Id.* at 342. Additionally, men may abandon the children they father, or they may fail to "participate in their care or economic support in a fashion that compromises a child's welfare just as surely as any act of maternal neglect." Yet this conduct does not elicit the same social rage of the sort faced by pregnant women judged neglectful. *Id.* at 343. See also Jeffrey A. Parness, *Arming the Pregnancy Police: More Outlandish Concoctions*, 53 LA. L. REV. 427, 446 (1992) (based on the fact that drug use by men may affect sperm and pose an increased risk to children, the author advocates regulating men as well as women).

116. See Ikemoto, *supra* note 65, at 1294.

117. Ikemoto, *supra* note 79, at 509; see Paulette M. Caldwell, *A Hair Piece*, 2 DUKE L.J. 365 (1991); Kimberle Williams Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, U. CHI. LEGAL F. 139 (1989); Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581 (1990).

118. See Pamela J. Smith, *We are not Sisters: African-American Women and the Freedom to Associate and Dissociate*, 66 TUL. L. REV. 1467 (1992) (discussion of how the experiences of African American women are quantitatively and qualitatively different from those of white women).

119. Ikemoto, *supra* note 79, at 509.

a focus neglects the stories of women whose lives are based on an inseparable combination of race and class as well as gender.

A race critique¹²⁰ of the case of A.C. again poses the questions of who's story is being told. Who are these women forced onto the operating table? The reported appellate court cases are about A.C., who is white and disabled, or about Jessie Mae Jefferson, a Jehovah's Witness. Most of the court orders for Caesarean section operations, however, are issued by lower courts with no written opinion to create precedent.¹²¹ These lower court orders primarily affect women of color. In 1987, the Kolder study, published in the *New England Journal of Medicine*, analyzed court ordered Caesareans. The study found that in eighty-one percent of the cases, the women were black, Hispanic or Asian, and twenty-four percent of these women did not speak English as their primary language.¹²² All of the women in these cases were treated in a teaching hospital or were receiving public assistance. The Kolder survey concluded that there was discrimination in the court ordering of Caesarean sections on the basis of race and resources.¹²³ Poor women can't afford an appeal through the court system.

More is going on here than the usual case of no one listening to poor colored women or their families.¹²⁴ Poor women may not look at a Caesarean section as an inconvenience, but as an equally viable means of birth. A Caesarean section is therefore a more burdensome decision for the poor.¹²⁵ More expensive hospital bills and the longer recovery required by Caesarean section are crucial concerns for women who work. Many not have medical insurance or have pressing family responsibilities.

Historically, there has been little respect for the reproductive rights of women of color. For example, prior to *Roe v. Wade*,¹²⁶ there was access to therapeutic abortion in many states.¹²⁷ Thousands of abortions were performed in hospitals for white women.¹²⁸ The system of therapeutic or psychiatric abortion, however, institutionalized:

economic and social discrimination against one group, the ward patients. In large cities the poor, particularly Negroes and Puerto Ricans, are virtually denied the same medical care as the privileged few. Of hospital abortions performed in New York City during 1960-62 only 7 per cent were non-whites, as compared with 93 per cent whites. . . . In a survey of 60 leading hospitals across the country, the rate of abortions for private pa-

120. I am using the term "race critique" in reference to the body of legal scholarship that utilizes race or ethnic status as a basis for the analysis of law. See, e.g., Randall L. Kennedy, *Racial Critiques of Legal Academia*, 102 HARV. L. REV. 1745 (1989); Colloquy, *Introduction: Choosing Sides in the Racial Critiques Debate*, 103 HARV. L. REV. 1844 (1990); Richard Delgado, *When a Story is Just a Story: Does Voice Really Matter?*, 76 VA. L. REV. 95 (1990).

121. *Terminally Ill and Pregnant*, *supra* note 17, at 619 n.2 ("One of the difficulties with these cases is that the crisis nature of maternal-fetal conflicts often leads to shotgun court orders, which then go unreported and are rarely appealed.").

122. Kolder, *supra* note 8, at 1192.

123. *Id.*

124. See generally Harris, *supra* note 117; Crenshaw, *supra* note 117.

125. See COHEN & ESTNER, *supra* note 94, at 39, 33-34 (describing the emotional burdens of a Caesarean section).

126. 410 U.S. 113 (1973).

127. LAWRENCE LADER, *ABORTION* (1966) (in 1950 at least 30,000 hospital abortions were performed; this number decreased to approximately 8,000 by 1965).

128. *Id.* at 29.

tients proved to be almost four times greater than for ward patients. . . .¹²⁹

As a consequence of this discrimination, poor women of color were driven in large numbers to attempt self abortion or to turn to the poorest trained and most dangerous of the criminal abortionists.¹³⁰ In New York City, for example, twice as many deaths caused by abortion occurred among non-whites as among whites.¹³¹

In addition, the few therapeutic abortions available to the poor were often conditioned upon the woman consenting to sterilization.¹³² Unfortunately, following *Roe v. Wade*, poor women armed with a legal right but without money, found themselves again being coerced into sterilization as a condition of abortion.¹³³

An important part of the denial of reproductive freedom is the devaluation of women of color as mothers.¹³⁴ The meaning of motherhood is molded on the basis of race as well as gender. Black and white motherhood is not treated the same. The image of the black mother has always diverged from, and often contradicted, the image of the white mother.¹³⁵ The good mother model as applied to all women is one of middle class, white motherhood; it denies the social reality in which women of differing status and cultures live.¹³⁶

Race and gender cannot be neatly separated. It seems all women who refuse doctors' recommendations are treated as bad mothers—black or

129. *Id.* ("The disparity between ward and private patients is even greater in the case of psychiatric abortions. At Sloane Hospital for Women, for example, private patients receiving psychiatric abortions outnumbered ward patients more than 10 to 1.")

130. Proceedings of an International Conference Convened in Hot Springs, Virginia, November 17-20, 1968, by the Association for the Study of Abortion, Volume II, *Abortion and Poverty*, in 2 ABORTION IN A CHANGING WORLD, 25 ASSOC. FOR THE STUDY OF ABORTION (1970). See also LADER, *supra* note 127, at 2 ("In 1957 a conference of experts sponsored by the Planned Parenthood Federation estimated that U.S. abortions could run from 200,000 to 1,200,000 annually. Dr. Christopher Tietze, of the National Committee on Maternal health, who headed this statistical panel, considers 1,200,000 the most accurate figure today.")

131. Harvey L. Ziff, *Recent Abortion Law Reforms (Or Much Ado About Nothing)*, 60 J. CRIM. L., CRIMINOLOGY & POLICE SCI. 3, 11 (1969)(indicating that the nonwhite death rate due to abortions in California was also much higher).

132. LADER, *supra* note 127, at 30; see also BETTY SARVIS & HYMAN RODMAN, *THE ABORTION CONTROVERSY* 176-78 (1973)(indicating that sterilization as a condition of abortion was racially motivated and a form of black genocide).

133. See, e.g., *In re Primus*, 436 U.S. 412 (1978) (holding solicitation of clients allowable by legal services lawyer bringing class action suit on behalf of women coerced into sterilization); *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977)(regarding civil rights action brought against attending obstetrician at a county hospital for sterilizing women solely on account of their race); *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974), *on remand sub nom. Relf v. Mathews*, 403 F. Supp. 1235 (D.D.C. 1975), *vacated sub nom. Relf v. Weinberger*, 565 F.2d 722 (D.C. Cir. 1977) (court found 100,000 to 150,000 poor women were sterilized annually under federally funded programs).

134. Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies*, 104 HARV. L. REV. 1419, 1436 (1991). Professor Roberts shows that sterilization, prosecution for drug use, and the removal of black children from their families are a way of enforcing society's determination that black women do not deserve to be mothers and that such methods are an attempt to discourage black women from having children. *Id.*; see Dorothy E. Roberts, *Racism and Patriarchy in the Meaning of Motherhood*, 1 AM. U. J. GENDER LAW 1, 14 (1993).

135. Roberts, *supra* note 134, at 6.

136. See Ikemoto, *supra* note 65, at 1304. These maternal standards are not sex-based norms which black women happened to fail. They are created out of race as well as gendered components. Roberts, *supra* note 134, at 15-16.

white. But there is still a distinction. Women of color as a group are defined as bad mothers where it is only the individual white woman who refuses medical treatment who is considered bad.

The assumption is that certain women will be good mothers and certain women will not. Stereotypes of black women as sexually promiscuous, domineering matriarchs, or lazy welfare mothers portray women of color as undeserving of motherhood.¹³⁷ Such images are used to legitimize government intrusion and the practices of health care providers.¹³⁸ For example, one study found that while the rates of drug use among black and white pregnant women are similar, eighty-seven percent of the women reported to authorities for exposing their fetuses to illegal substances were black.¹³⁹ This means that a black woman is ten times more likely to be tested for drug usage during pregnancy than a white woman.¹⁴⁰ Discrimination by hospitals and the courts in ordering Caesarean section operations continues a long and tragic history of the oppression of women of color.

IV. PROBLEMS WITH INFORMED CONSENT DOCTRINE AS A SOLUTION TO COERCED CAESAREANS

A. *Informed Consent Failed A.C.*

In March of 1988, the District of Columbia Court of Appeals vacated its order in the *A.C. I* case and ordered a rehearing *en banc*.¹⁴¹ The case was reargued on September 22, 1988, but a new decision was not issued until April 26, 1990. The opinion of Judge Terry 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 fetus."¹⁴² Judge Terry further noted that if the patient is incompetent or otherwise cannot exercise informed consent, then the doctors, hospital and courts should apply

137. Roberts, *supra* note 134, at 1437. See Comment, *Idea Woman*, *NEW YORKER*, June 14, 1993, at 4. During Lani Guinier's nomination for Assistant Attorney General for Civil Rights, the *Wall Street Journal* ran an op-ed piece on April 30, 1993, labeling Lani Guinier as a "quota queen." The *New Yorker* criticizes this characterization "with its echo of 'welfare queens,' " as having "a touch of raw racism not reflected in the article."

138. Roberts, *supra* note 134, at 1444; see also Mary Cantwell, *Coercion and Contraception*, *N.Y. TIMES*, Jan. 27, 1991, at 16E, col. 1 (California Judge Howard Broadman conditioned probation of Darlene Johnson on insertion of a new long-lasting birth control device, Norplant, in her arm); Jonathan Alter, *One Well-Read Editorial: A Bitter Debate About Race and Birth Control*, *NEWSWEEK*, Dec. 31, 1990, at 65 (recounting controversy over editorial in the Philadelphia Enquirer linking a study that one-half the nation's black children live in poverty and recent government approval of Norplant; then arguing that welfare mothers be offered an increased benefit if they agreed to use Norplant).

139. Helaine Olen, *Racial Tinge to Drug Testing of New Moms*, *CHI. TRIB.*, Dec. 19, 1991, Section 3, at 14 (study of 2,000 pregnant women in Illinois by the National Association for Perinatal Addiction Research and Education); see also Ron Winslow, *Black Pregnant Women Far More Likely Than Whites to Be Reported for Drug Use*, *WALL ST. J.*, Apr. 27, 1990, at 7.

140. Olen, *supra* note 139, at 14.

141. *A.C. II*, 573 A.2d 1235.

142. *Id.* at 1237. The Supreme Court recently denied a request for emergency intervention when an Illinois woman refused to have a Cesarean section at the 37th week of pregnancy. The Court's denial let stand the Illinois Supreme Court decision not to order the woman to have a Cesarean section. The lower court judge stated he could find no precedent for forcing a woman to have surgery only for the benefit of a fetus. *Justices Reject Action On Birth*, *Boston Globe*, Dec. 19, 1993, at 2.

the doctrine of substituted judgment.¹⁴³ This procedure would attempt to ascertain what the patient would have done had she been competent.¹⁴⁴

The reversal of Judge Nebeker's decision by the District of Columbia Court of Appeals acting *en banc* is significant. It formally recognizes that pregnant women are persons who have a right of autonomous decision-making regarding medical care during their pregnancies. In reality, however, this formal right may provide limited protection to the women who are most at risk of court intrusion.¹⁴⁵

For example, the George Washington University Medical Center, which brought the original *A.C.* case, revealed a new policy to resolve "maternal-fetal" conflicts.¹⁴⁶ The policy was part of a settlement of the tort claims arising out of the *A.C. I* case.¹⁴⁷ Unfortunately, unlike the nearly absolute right for the mother to decide course of treatment which Judge Terry set forth, the Medical Center's policy states that it is "rarely" justified for the hospital to go to court to seek to override a pregnant woman's medical decision. "Rarely" was chosen because the doctors at the Medical Center saw a greater likelihood of the need for future court orders to override a pregnant woman's treatment decision.¹⁴⁸ "Rarely" is an important step away from Judge Terry's "virtually never."¹⁴⁹ The hospital's policy fosters the stereotype that women who disagree with their doctor's reproductive decisions are not competent. In a thorough examination of *The Policy on Decision-Making With Pregnant Patients at The George Washington University Hospital*, Professor Ikemoto found that the hospital explicitly worried that the decision making capacity of these women might be impaired by "emotional or psychological difficulties".¹⁵⁰ The policy further suggests "additional counseling" by the obstetrician and by pediatric and other appropriate specialists and the physician is "encouraged to bring such matters to the attention of the hospital ethics committee."¹⁵¹ The problem with this policy, according to Professor Ikemoto, is that "it assumes a woman's choice is wrong to begin with."¹⁵²

143. *A.C. II*, 573 A.2d at 1237.

144. *Id.* at 1249.

145. It is also unclear whether this holding would apply to cases where a Caesarean section would benefit both the mother and fetus. The court did not overrule *In re Madyun* where a Caesarean section that was deemed beneficial to mother and fetus was authorized. Rosa H. Kim, *Reconciling Fetal/Maternal Conflicts*, 27 IDAHO L. REV. 223 (1991).

146. Sherman, *supra* note 8, at 16. One lawyer criticized the decision as not providing any practical assistance to doctors, hospital administrators, lawyers or judges. *Letter to Editor*, 324 NEW ENG. J. MED. 272 (1991).

147. Sherman, *supra* note 8, at 16. Interestingly, while hospitals rely on the rhetoric that they fear torts claims to justify court intervention, in *A.C. I* this does not make sense. Indeed, "[e]xactly who would have filed a lawsuit is unclear, since all parties opposed the Caesarean. . . ." Abraham, *supra* note 73, at 20.

148. Sherman, *supra* note 8, at 16.

149. *Id.*; see also Brent T. Stanyer, *Court Ordered Caesarean Sections: An Example of the Dangers of Judicial Involvement in Medical Decision Making*, 28 GONZ. L. REV. 121, 136 (1993) ("The word rarely also does not provide adequate protection for women's decisions because the policy fails to state the exceptions in which intervention is appropriate. Such vague language leaves room for arbitrary enforcement.")

150. Ikemoto, *supra* note 65, at 1239.

151. *Id.*

152. *Id.*

While advocating informed consent as the solution to this dilemma, the *A.C. II* court actually emphasizes just how problematic informed consent can be. A.C. had cancer many years before she became pregnant. She had lost a leg to cancer. She and her doctor knew pregnancy might bring the cancer out of remission. She had discussed the possibility of a Caesarean section at twenty-eight weeks. But the question remains—why was there no discussion as to what should be done if problems developed before the twenty-eighth week of pregnancy? The information regarding A.C.'s directives is conflicting—Richard Love & Beverly Burke, D.C. Corporation Counsel, stated “no one specifically had discussed with her what her choice would have been had she known she could not reach that goal [of twenty-eight weeks].”¹⁵³ On the other hand, in an *amici curiae* brief filed by several medical groups, the chairman of obstetrics and gynecology at George Washington testified, “the obstetrics staff had made it clear to A.C. that the earliest we would feel comfortable in intervening should there be indication as to either maternal or fetal grounds, would be 28 weeks. Much prior to that the prognosis was poor enough that we would be extremely uncomfortable intervening.”¹⁵⁴ The brief also maintains that A.C.'s attending physicians had “clearly stated that they had recommended against any intervention . . . at that time.”¹⁵⁵

No matter what was or was not discussed with A.C. regarding a Caesarean before twenty-eight weeks, this is clearly an example of communication gone all wrong. What is particularly troubling is that A.C.'s doctors may have discussed an earlier Caesarean with her—made it seem like there would be no intervention; then in a sense went back on their word. Such a betrayal of the confidences and trust between A.C. and her doctors is in some ways even worse than not discussing the situation at all.

Informed consent did not work for A.C.¹⁵⁶ If informed consent fails for a middle class, white woman supported by her family and doctor, and known to be a high risk pregnancy, how can one expect such a policy to protect poor women of color who have little or no access to prenatal care?¹⁵⁷ The case of *In re A.C.* is not only about the failure of the legal and

153. Richard S. Love & Beverly J. Burke, *A Court-Ordered Caesarean Birth*, WASH. POST, Dec. 21, 1987, at A22, col. 3.

154. Gianelli, *supra* note 25, at 3, col. 4.

155. *Id.*

156. In a more recent case, a nurse with three children told her doctor she did not want a Caesarean section for her fourth pregnancy unless it was medically necessary. The doctor agreed she was a good candidate for a vaginal birth. However, two weeks before her due date the doctor decided to schedule a Caesarean section despite her protestations. Though she went into labor before the scheduled surgery, a Caesarean section was still performed. She suffered severe complications and was awarded \$990,000. Mark A. Cohen, *Woman Awarded \$990K for Unwanted C-Section*, 21 MASS. L. WKLY. 2919 (June 28, 1993).

157. For 1991, the U.S. Center for Disease Control and Prevention found that the mortality rate for white infants during their first year was 7.3 per 1,000 births. But among African Americans the rate was 17.6 infants per 1,000 births. Robert L. Jackson, *Panel Calls for U.S. to Curb Infant Deaths*, L.A. TIMES, Dec. 16, 1993, at A37, col. 1. Additionally, 27% of all American mothers receive inadequate prenatal care. Ray Moseley, *Among Rich Nations, U.S. has Highest Child-Poverty Rate*, CHI. TRIB., Sept. 23, 1993, at 4. However, 10.7% of black mothers receive little or no prenatal care compared to only 3.2% of white mothers. Myron E. Wegman, *Annual Summary of Vital Statistics - 1992*, 92 PEDIATRICS 743, 750 (1993).

medical communities to allow women to make their own decisions, it is also about their failure to communicate with women.

B. *Doctors Emasculate Informed Consent*

The gender critique illustrated how judges defer to physicians at the expense of women's views. This problem is further compounded by the fact that many doctors do not believe in informed consent. The Kolder study in the *New England Journal of Medicine* found that forty-six percent of doctors surveyed thought mothers should be detained if they refused medical advice and thereby endangered the life of the fetus.¹⁵⁸ Forty-seven percent felt that "precedent set by the courts in cases requiring emergency Caesareans for the sake of the fetus" should be extended to include other lifesaving procedures for the fetus.¹⁵⁹ Overall, only twenty-four percent consistently upheld a competent woman's right to refuse medical advice.¹⁶⁰ Though patients' values are emphasized in theory, there is increasing evidence that physician values may be the deciding factor.¹⁶¹ It seems patients' choices are respected only if the doctors think the choice is the best decision.¹⁶² If the physician disagrees with the wisdom of the patient's choice then it is likely the patient's decision will be overridden.¹⁶³

Doctors' values, beliefs, and preferences also affect the information patients receive.¹⁶⁴ Patients' choices depend in part on the way information is presented to them.¹⁶⁵ The physician who believes the proposed treatment is the better choice may describe it in a way that emphasizes the benefits and minimizes the risks.¹⁶⁶

Furthermore, physicians' beliefs and preferences shape patients' decisions.¹⁶⁷ Even without a court order, doctors may have a great deal of power to pressure women into consenting to recommended surgery.¹⁶⁸ For example, a recent study of women's treatment choices following breast cancer surgery found that women were strongly influenced by their physicians

158. Kolder, *supra* note 8, at 1193.

159. *Id.*

160. *Id.* at 1194.

161. For example, the presence of advance directives in patients' charts have been found not to increase the likelihood that the patients' wishes will be followed. Marion Danis et al., *A Prospective Study of Advance Directives for Life Sustaining Care*, 324 *NEW ENG. J. MED.* 882, 885 (1991); see also David Orentlicher, *The Illusion of Patient Choice in End-of Life Decisions*, 267 *JAMA* 2101 (1991).

162. Orentlicher, *supra* note 161, at 2101.

163. *Id.*

164. *Id.* at 2102.

165. *Id.*

166. Ikemoto, *supra* note 65, at 1237. Professor Ikemoto explains:

In the early 60's doctors recommended DES to diabetic pregnant women, had pregnant women x-rayed, limited their weight gain to thirteen pounds, and prescribed diuretics to them. Doctors made these recommendations in good faith, but did so despite their lack of complete information about the risks these therapies posed. Women who refused to follow these recommendations were treated as problems.

Id. at 1237-38.

167. Orentlicher, *supra* note 161, at 2102.

168. Katherine A. Knopoff, *Can a Pregnant Woman Morally Refuse Fetal Surgery?*, 79 *CAL. L. REV.* 499, 535 (1991).

to select a particular treatment option.¹⁶⁹ In fact, the physicians recommendations were the strongest factor in determining the women's choice—eighty percent of the women followed their doctor's recommendation.¹⁷⁰

The cornerstone of informed consent is communication between doctor and patient.¹⁷¹ However, many doctors do not communicate effectively with their patients. A study of 336 encounters between doctors and patients found that doctors tended not to ask patients what they understood about their illnesses, often did not take a social history, tended not to inquire about the patients' emotional responses to illness and frequently did not explain the nature of the patients' problems.¹⁷²

Even though patients almost always want as much information as possible,¹⁷³ doctors spend very little time giving information to their patients—a little more than one minute in encounters lasting about twenty minutes.¹⁷⁴ One reason doctors may devote so little time to sharing information, is that they inaccurately assess their patients' need for information. The same study discovered that doctors underestimated their patients desire for information sixty-five percent of the time.¹⁷⁵ A sample of 110 pregnant women and their obstetricians illustrates how severely doctors misjudge their patients' desires for information.¹⁷⁶ Over ninety percent of the women sampled wanted information about Caesarean sections, but only fourteen percent of the doctors believed a majority of the women wanted this information.¹⁷⁷ In fact, this misattribution of the desire for information has been called "one of the most common errors in clinical practice."¹⁷⁸

Not only do physicians fail to recognize the patient's need for information, but as illustrated in the Carder case, they also do a poor job of eliciting patient preferences. A study of do not resuscitate orders (DNR) found that only eleven percent of the patients were mentally impaired when admitted to the hospital, and thus unable to make medical choices.¹⁷⁹ How-

169. Carol S. Weisman & Martha A. Teitelbaum, *Women & Health Care Communication*, 13 *PATIENT EDUC. & COUNS.* 183, 189 (1989).

170. *Id.*

171. Effective communication is essential not only to informed consent, but also for the delivery of health care services, maintenance of good health, proper diagnosis and treatment, and patient compliance. Mary Frances Lowe, *Women & Their Health Care Providers*, *PUB. HEALTH REP.* 140 (1987) Supplement to July/Aug. Issue; see also Howard Waitzkin, *Doctor-Patient Communication*, 252 *JAMA* 2441 (1984).

172. Waitzkin, *supra* note 171, at 2442.

173. A study of normal patients and patients suffering from cancer found that the great majority wanted accurate information about their illnesses. Similarly, a study of patients with seizures also found that most wanted to be informed of all benefits and risks associated with medication including rare side effects. *Id.* at 2442.

174. *Id.*

175. *Id.*

176. See M.C. Shapiro et al., *Information Control & the Exercise of Power in the Obstetrical Encounter*, 17 *SOC. SCI MED.* 139, 140, 145 (1983).

177. *Id.* at 142; Similarly, a study of 289 persons with AIDS, found that although seventy-two percent of the patients wanted to discuss their preferences for life-sustaining treatment with their doctors, only thirty-eight percent had actually done so. Jennifer S. Haas et al., *Discussion of Preferences for Life-Sustaining Care by Persons with AIDS*, 153 *ARCH. INTERN. MED.* 1241, 1244 (1993).

178. Waitzkin, *supra* note 171, at 2442.

179. Orentlicher, *supra* note 161, at 2102.

ever, seventy-six percent of the patients were unable to discuss their preferences at the time DNR decisions were made.¹⁸⁰ The above studies show that doctors often do not communicate with their patients. However, few studies have been conducted for the express purpose of studying how gender affects doctor/patient communication. Only very recently has there been a growing awareness of how badly women are treated by their physicians and the American health care system.¹⁸¹ Discrimination is rife. Women are often excluded from medical and drug research. Their medical problems are trivialized or treated primarily as psychosomatic, and are more likely to be misdiagnosed or mistreated.¹⁸² The results of the few studies done on communication between doctors and female patients are contradictory. For example, while several studies found that women receive more doctor time and/or explanations¹⁸³ the same studies also found that doctors were less attentive to female patients;¹⁸⁴ women were interrupted more often;¹⁸⁵ and the explanations given to women were short answers tending to contain less technical information.¹⁸⁶ Inattentiveness, interruptions and inadequate explanations are not effective communication. Thus, the mere fact that doctors spend more time with female patients does not presume that greater understanding is achieved or that rational decision making occurs.¹⁸⁷

Anecdotal evidence also indicates that doctors do not listen to women patients. One woman said “[a]nytime I ask my doctor a question with a little bit of medical knowledge on my part he gets intimidated and ignores me.”¹⁸⁸ Another woman reported that when she asked her doctor for information about a surgical procedure he said she needed, he gave a “cold arrogant response” and threatened that he would no longer be her doctor if she did not go along with his recommendation.¹⁸⁹ Such experiences reflect the power structure of the medical profession and highlight the need not

180. *Id.* The goal of promoting patient self-determination is not really being implemented in resuscitation decisions. The vast majority of decisions not to resuscitate were made without either patient or family input. Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 JAMA 2236, 2238 (1985).

181. JOHN M. SMITH, *WOMEN & DOCTORS* at 1 (1992).

182. An examination of thirty-eight studies revealed major differences in the medical care women receive. Women are less likely than men to receive dialysis or kidney transplants; and they are less likely to be properly diagnosed and treated for cardiac disease and lung cancer. Council Report, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559, 559-60 (1991).

183. Ludwien Meeuwesen et al., *Verbal Analysis of Doctor-Patient Communications*, 32 Soc. Sci. Med. 1143, 1147 (1991); see also Weisman & Teitelbaum, *supra* note 169, at 187; Waitzkin, *supra* note 171, at 2442.

184. Meeuwesen, *supra* note 183, at 1147.

185. Waitzkin, *supra* note 171, at 2444-45.

186. Weisman, *supra* note 169, at 187.

187. *Id.* at 189. Weisman hypothesizes that doctors who spend more time giving explanations to women may not just be communicating information, but may also be attempting to persuade the women of a particular outcome or point of view. *Id.*

188. COHEN & ESTNER, *supra* note 94, at 55.

189. Aurora Mackey, *Ms. Treatment*, L.A. TIMES, April 2, 1992, at J8, col. 1. For additional anecdotal evidence see Smith, *supra* note 181. Dr. Smith, a gynecologist, writes of many instances where women have been misdiagnosed and mistreated by their doctors.

only for more effective communication, but also the need to better understand the affects of gender in the doctor/patient context.¹⁹⁰

C. *Race Discrimination By Doctors Vitiates Informed Consent*

Class, race, and cultural differences affect how doctors communicate with their patients. While there is no difference between lower income patients and higher income patients in their desire for information, upper or upper middle class patients receive more doctor time and more explanations.¹⁹¹ Similarly, a national telephone survey conducted in 1986 found that blacks were more likely than whites to report that their physician did not inquire sufficiently about their pain, did not tell them how long it would take for prescribed medicine to work, did not explain the seriousness of their illness or injury, and did not discuss test and examination findings.¹⁹²

In 1990, twenty percent of Americans were racial and ethnic minorities. The typical physician is an English-only speaking, U.S. born, white male who is upper middle class or higher. Cross-cultural issues concerning traditional practices, attitudes towards doctors, and healthcare systems are certain to arise. In many cases, however, physicians are not aware of the most basic political or geographic facts regarding patients. An inability to identify such issues will affect physician-patient communication and consequently patient care.¹⁹³

Many physicians neglect the language barriers that can arise when English is a patient's second language. An interpreter relates the following story:

A pregnant Mexican woman was prescribed sitz baths to relieve swelling and pain in her hands and arms. Since she spoke a little English no interpreter was used. During a subsequent visit the physician and dietician became concerned about the woman's unexpected weight loss and called me [the interpreter] in to help find the cause. The patient asked me to tell the physician that her hands were still hurting, but she proudly added that she had been very good about doing her sitz baths. She also remarked that they are very tiring, but she was still doing them for twenty minutes twice a day. I asked the woman to tell me what she was doing since I couldn't understand why a bath would be so tiring. The woman explained that she would fill the bathtub with water and get in and sit

190. In *WOMEN & DOCTORS*, Dr. Smith maintains that the attitudes and behaviors of doctors are at the root of the problems that plague the healthcare system. SMITH, *supra* note 181, at 1.

191. Waitzkin, *supra* note 171, at 2442; Orentlicher, *supra* note 161, at 2102 (patients who seem more intelligent and better educated receive more time and explanations from their physicians).

192. Robert J. Blendon et al., *Access to Medical Care for Black & White Americans*, 261 JAMA 278, 280 (1989) (survey of 10,130 people). Likewise, a study of 289 AIDS patients found that while the desire to discuss life-sustaining treatment preferences did not vary by race, only twenty-six percent of the black patients had discussed such preferences with their doctors versus forty-two percent of the white patients. Haas, *supra* note 177, at 1244. Blacks also report more general difficulties getting into the health care system and greater dissatisfaction with medical care services. Council Report, *Black-White Disparities in Health Care*, 263 JAMA 2344, 2345 (1990).

193. Charlene Marmer Solomon, *A World of Difference*, AM. MED. NEWS 27, 28 (Nov. 1992). A special issue of *The Western Journal of Medicine* on cross-cultural medicine provides an in-depth look at the ways culture can affect medical care. 157 W. J. MED. 213-390 (1992).

down. Then she would stand up, sit down, stand up, sit down—for twenty minutes at a time.”¹⁹⁴

The interpreter goes on to say that while the image of a pregnant woman doing deep-knee bends in the bathtub is comical, if the woman had fallen she could have been seriously injured. Once again the interpreter realized “how important good communication is and how risks can be increased by faulty communication.”¹⁹⁵

Further, the court ordering of a particular medical procedure demonstrates lack of respect by the medical establishment for different belief structures and cultural differences. Unfortunately, many of the court ordered Caesarean cases demonstrate many doctors’ disrespect for differing cultural beliefs. For example, in the case of *In re Madyun*,¹⁹⁶ cited by the A.C. I court,¹⁹⁷ the pregnant woman was a Muslim. Mr. and Ms. Madyun did not believe surgery was necessary. Ms. Madyun had been in labor for some time; her water had broken forty-eight hours earlier. The court ordered the Caesarean because the medical testimony indicated that there was a fifty-to-seventy-five percent chance of fetal sepsis.¹⁹⁸ Mr. Madyun complained that the hospital refused to let Mrs. Madyun stand up or walk around, activities which would aid in delivery.¹⁹⁹ Mr. Madyun also explained to the court that under Muslim law a woman confronted with a life and death situation has the right to decide whether to risk her own health in order to save the fetus.²⁰⁰ Ignoring both the medical bullying by the hospital and the religious beliefs of the Madyuns, the court ordered surgery.²⁰¹

Another example is found in the case of Chau Lee. In December of 1990 Chau Lee, a pregnant Hmong woman, was ordered to undergo a Caesarean operation despite her objections. Her doctors went to court before her labor began and told the court that “any attempt at delivery posed an 80 percent to 90 percent chance of death to the child and a 50 percent risk of death to the mother.”²⁰² Despite the court’s order, Ms. Lee subsequently went to a high risk pregnancy specialist who advised her that a vaginal delivery could be attempted. Ms. Lee then agreed to a Caesarean if complications arose.²⁰³ As one commentator noted: “Better communica-

194. See Linda Haffner, *Translation is not Enough*, 157 W. J. MED. 255, 258 (1992).

195. *Id.* at 258.

196. 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 26, 1986). The A.C. II court included the Madyun decision as Appendix A. A.C. II, 573 A.2d at 1259. All cites to the Madyun case will be to the Appendix.

197. A.C. I, 533 A.2d at 613 (the court misspelled “Madyun,” as “Maydun”).

198. A.C. II, 573 A.2d at 1259-61. The risk of sepsis was also greatly increased because Mrs. Madyun had been subjected to ten vaginal examinations since admission to the hospital. *Id.* at 1261 n.9.

199. *Id.* at 1260.

200. *Id.* at 1260.

201. Rhoden, *supra* note 70, at 2029. Rhoden states: “But in this area, it is irrational to fail to provide prenatal care to all, thus risking many mothers and babies, and at the same time make women with atypical religious or medical beliefs choose between accepting care that violates their most cherished beliefs and foregoing care altogether.” *Id.*

202. Sherman, *supra* note 8, at 16.

203. *Id.*

tion may have kept the courts from getting involved in the case of Chau Lee"²⁰⁴

D. *Informed Consent Allows Coercion*

The informed consent process is structured to allow or even facilitate pressuring the woman into changing her mind.²⁰⁵ It is ethically permissible for a physician "to try to persuade a pregnant woman refusing medically indicated treatment to change her mind."²⁰⁶ A woman is likely to give in when the doctor whom she has trusted tells her she is wrong and opposes her.²⁰⁷ The physician may also attempt to persuade the pregnant woman to change her mind in ways that amount to coercion.²⁰⁸ In the emergency Caesarean context the woman is close to delivery, in pain, and undoubtedly worried about the health of the fetus. In such a weakened and desperate condition she may be unable to withstand the pressure on her to give in.²⁰⁹ Such consent is far from voluntary. If women are unable to assert their preferences in the face of pressures from the medical profession, then informed consent is meaningless. A judicial standard dependent on listening to and respecting the opinions of women and particularly women of color, is not much solace to those concerned about honoring the medical choices of pregnant women. Despite the precedent setting opinion by Judge Terry, the reality is that courts are far too willing to peremptorily dictate major surgery for pregnant women. The courts do not listen to women.²¹⁰ The decision making power remains in the hands of the medical and legal communities.

CONCLUSION

The judicial system has encouraged court intervention. The cases involving court ordered Caesarean operations present situations which try the ability of any court to adjudicate. Too often there is a difference of medical opinion. How can a court give proper deference and respect to a woman who may share little world view or experience with the judge? Perhaps she has what may seem to the court strange beliefs. Even if she were

204. *Id.*

205. Ikemoto, *supra* note 65, at 1239.

206. Lawrence J. Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 JAMA 1060, 1061 (1988). "Neither patient autonomy nor the doctrine of informed consent requires physicians to accept patient refusal passively and without inquiry, protest or argument."

207. Knopoff, *supra* note 168, at 533.

208. Ikemoto, *supra* note 65, at 1239. Professor Chervenak, director of Obstetric Ultrasound and Ethics for the New York Hospital-Cornell Medical Center, and Professor McCullough, professor of medicine and ethics, advocate using the pregnant woman's beliefs "as the basis for negotiation" and call for "respectful persuasion." However, should these efforts fail, they believe a court-order forcing the woman to comply is justified. Chervenak & McCullough, *supra* note 10, at 14. It is difficult to imagine how respectful persuasion in the delivery room would not become coercive.

209. Knopoff, *supra* note 168, at 533.

210. Carrie Menkel-Meadow, *Excluded Voices: New Voices in the Legal Profession Making New Voices in the Law*, 42 U. MIAMI L. REV. 29 (1987)(stating that the viewpoints of women have been systematically excluded from law); CATHERINE MACKINNON, *FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW* 36 (1987)(stating that men define the structure and values of American society).

not in labor, she often would have difficulty articulating to a judge the basis for her medical decisions.²¹¹

We do not know enough about the reality of court ordered Caesareans—what happens at the hospital, what happens in the truncated, emergency hearings in the trial courts. We do know that A.C. was disabled. Her disability led Judge Nebeker to view her interests as less than the interests of other persons. Judge Nebeker's perspective caused him to approach the situation by considering whether A.C. should undergo a Caesarean section operation. This approach in turn led the court to place a value on A.C.'s life and weigh it against the value of the life of her fetus. Judge Nebeker treated A.C. as if she were already dead, and the fetus as if it were already born.

A view from a different vantage might pose the questions a little differently. Who should decide whether A.C. is going to have a Caesarean operation? This would avoid the valuation of one person's life by another. In a society where the lives of women, minorities and the disabled too often come cheaply, such a perspective is essential.

211. Kolder, *supra* note 8, at 1192 (noting that many of the women subjected to forced Caesarean operations did not speak English as their primary language).