

HUMAN RIGHTS IMPLICATIONS OF OBSTETRIC INTERVENTIONS

In the United States, reproductive rights have been traditionally considered to include such rights as the right to abortion, birth control, and comprehensive sex education. Childbirth and birthing rights, in contrast, are largely ignored in reproductive rights analyses. For example, the three leading textbooks on gender and the law fail to address childbirth as a human rights issue.¹ One commentator even posits that women's choices relating to childbirth merely involve their "interest in an aesthetically pleasing or emotionally satisfying birth" but do not involve their human rights.² This paper disputes this view of childbearing choices. It first argues that the prevalence of c-sections performed in the United States deprives women of their right to the highest attainable standard of health recognized in the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The paper next explores the requirement that informed consent be obtained prior to performing medical procedures on pregnant women. The paper then briefly considers preliminary data indicating that court-ordered obstetric interventions are disproportionately issued against minorities and women who do not speak English as a primary language, concluding that such data may evidence International Covenant on Civil and Political Rights (ICCPR) violations. The paper then considers the ethical considerations regarding pregnant woman's refusals to undergo procedures deemed medically necessary. Finally, this paper assesses the legality of court-ordered obstetric interventions targeting individual women with a particular emphasis on recent cases, in light of international human rights law and U.S. constitutional law.

¹ See Katherine T. Bartlett & Deborah L. Rhode, *Gender and Law: Theory, Doctrine, Commentary* (4th ed. 2006); D. Kelley Weisberg, *Feminist Legal Theory* (1996); and Herma H. Kay & Martha S. West *Cases and Materials on Sex-Based Discrimination* (6th ed. 2005). National Advocates for Pregnant Women.

² John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth* 69 Va. L. Rev. 405, 451 (1983).

A. Background on Cesarean Section Practice in the United States

Although the media infrequently report on restrictions on pregnant women's childbearing choices, evidence of their existence includes hospital bans on vaginal births after cesareans (VBACs)³, doctors' refusals to perform VBACs⁴, and the practice of seeking court orders to compel cesareans,⁵ even if the cesarean is not medically necessary.⁶ One study reported that 46 percent of maternal-fetal medicine fellowship program directors believe that it is acceptable to detain noncompliant pregnant women in hospitals and force them to submit to medical treatment deemed beneficial to their fetuses.⁷ A more recent study, however, determined that four percent of directors have such beliefs.⁸

The U.S. cesarean rate is itself evidence of a violation of international human rights law, irrespective of whether individual cesareans are forced. The ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁹ Although the U.S. has signed (but not ratified) the treaty, it has taken important steps to achieve the "full realization of this right" as enumerated in Article 12, ¶ 2.¹⁰ The U.S. may therefore be fairly characterized as willing to advance this right for its citizens.

³ National Institutes of Health Consensus Development Conference Statement, *Vaginal Birth After Cesarean: New Insights* at 4 (March 11, 2010). One-third of hospitals have banned VBACs.

⁴ *Id.* One-half of physicians do not offer trial of labor.

⁵ See for example Elizabeth Cohen, *Mom Won't be Forced to Have C-Section*, CNN (Oct. 15, 2009), available at <http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/index.html>. Page hospital CEO told Joy Szabo, an Arizona woman who had had one prior c-section followed by a successful vaginal birth, that the hospital would not allow her to deliver vaginally there again because of the prior c-section. When Ms. Szabo expressed her desire to deliver vaginally, the CEO warned that she would obtain a court order to ensure a cesarean delivery.

⁶ Elizabeth Cohen, *Mom Fights, Gets the Delivery She Wants*, CNN (Dec. 17, 2009), available at <http://www.cnn.com/2009/HEALTH/12/17/birth.plan.tips/index.html>. Ms. Szabo opted to deliver at a hospital six hours away in Phoenix, rather than undergo the unnecessary cesarean at Page Hospital. She delivered a healthy baby vaginally, with no complications.

⁷ Veronika Kolder et al, *Court-Ordered Obstetrical Interventions*, 316 *New Eng. J. Med.* 1192 (1987).

⁸ Lloyd de Vries, *Debate Revived on Mother's Rights*, CBS News (May 19, 2004), available at <http://www.cbsnews.com/stories/2004/05/19/health/main618535.shtml>

⁹ International Covenant on Economic, Social and Cultural Rights, art. 12 (Feb. 23, 1967).

While many cesareans are medically necessary, for example, when labor does not progress appropriately or in cases of placental abruption or placenta previa,¹¹ the World Health Organization states that a cesarean rate should be no higher than 10-15 percent in any locale.¹² In contrast, the 2007 U.S. cesarean rate was 31.8 percent, denoting the 11th continuous year of increase.¹³ Rates may vary considerably within a given locale. For example, in Baltimore, the FY 2009 cesarean rates ranged from 21 percent at Maryland General Hospital to 45 percent at Greater Baltimore Medical Center.¹⁴ High rates may be attributable to several factors unrelated to providing optimal health care to women: convenience for doctors,¹⁵ doctors' desire to avoid malpractice liability,^{16,17} and hospitals' desire to avoid malpractice liability, and hospitals' desire to maximize profits.^{18,19,20} One way hospitals minimize costs (thus maximizing profits) is by banning VBACs.²¹

¹⁰ *Id.* For example, the U.S. has created executive agencies such as the Environmental Protection Agency and the Occupational Safety and Health Administration, which serve the purpose (delineated in ¶ 2(b)) of "improv[ing]... all aspects of environmental and industrial hygiene." On March 23, 2010, the U.S. enacted the Patient Protection and Affordable Care Act, which embodies the step delineated in ¶ 2(d) of "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."

¹¹ American Congress of Obstetricians and Gynecologists, *Cesarean Birth Patient Education Pamphlet* (2005); available at http://www.acog.org/publications/patient_education/bp006.cfm.

¹² Nils Chaillet et al, *Identifying Barriers and Facilitators Towards Implementing Guidelines to Reduce Cesarean Section Rates in Quebec*, 85 Bulletin of the World Health Organization 791-797, 791 (2007); available at <http://www.who.int/bulletin/volumes/85/10/06-039289.pdf>.

¹³ Hamilton et al, *Births: Preliminary data for 2007*, 57 National Vital Statistics Reports 12 (2009); available at http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf.

The National Institutes of Health (NIH) reports the 2007 cesarean rate even higher at 33%; see National Institutes of Health Consensus Development Conference Statement, *Vaginal Birth After Cesarean: New Insights* at 4 (March 11, 2010).

¹⁴ Baltimore Chapter of the International Cesarean Awareness Network.

¹⁵ Cesar G. Victora and Fernando C. Barros, *Beware: Unnecessary Cesarean Sections may be Hazardous*, 367 *The Lancet* 1796-1797, 1797 (2006). The authors observed that "[p]rivate doctors know that quick cesarean sections are less likely to interfere with their workload or leisure time than spending several hours in a hospital for a vaginal delivery."

¹⁶ 2009 ACOG Survey on Professional Liability, available at http://www.acog.org/from_home/publications/press_releases/nr09-11-09.cfm. The survey reported that 29 percent of survey respondents increased the number of cesareans performed as "a result of the risk or fear of professional liability claims or litigation." Twenty-six percent stopped performing VBACs for the same reason.

¹⁷ Molly M. Ginty, *As C-Section Rate Grows, So Does Resistance*, Women's E-news (Sept. 2, 2005). Jennifer Reid's physician required her to undergo a repeat cesarean rather than a VBAC because his malpractice insurance would not cover the reported one to four percent risk of uterine rupture.

¹⁸ *Id.* The Agency for Healthcare Research and Quality reports the average cost of a vaginal delivery to be \$5,574 and the average cost of a cesarean delivery to be \$11,361.

¹⁹ Irene Fraser, *Care of Women in U.S. Hospitals*, Agency for Healthcare Research and Quality Fact Book (2000). The Fact Book states that privately insured women have the highest c-section rate (24.4 percent), while uninsured

Cesareans may result in inflammation and infection of the endometrium (endometritis), greater blood loss than that resulting from a vaginal birth, urinary tract infection, decreased bowel function, reactions to anesthesia, blood clots, including life-threatening pulmonary embolisms, infection at the site of the wound, injury to neighboring organs, and increased risks in future pregnancies that include excessive bleeding, placenta previa, abnormal positioning of the fetus (which may necessitate additional cesareans), and uterine rupture.²² Although the death rate for cesareans is higher than that for vaginal births,²³ comparing the two rates may be misleading because women requiring cesareans may have accompanying risk factors that increase their mortality risk.²⁴ Nevertheless, data indicate that cesareans *are* inherently riskier than vaginal births.²⁵ In view of the risks women incur in undergoing medically unnecessary cesareans,²⁶ the relatively low risks associated with trial of labor (TOL),²⁷ and the doctor and hospital-centric reasons for performing medically unnecessary cesareans described *supra*, women subjected to unnecessary cesareans do not enjoy the “highest attainable standard of physical and mental health” described in the ICESCR.

women have the lowest c-section rate (18.6 percent); available at <http://www.ahrq.gov/data/hcup/factbk3/factbk3a.htm>. This discrepancy indicates that payment is a motivating factor for performing c-sections.

²⁰ National Institutes of Health Consensus Development Conference Statement, *Vaginal Birth After Cesarean: New Insights* (March 11, 2010). VBAC rates of Medicaid patients enrolled in HMOs are higher at public than at private hospitals. *Id.* at 4. VBAC rates for the general population of women are lower at private hospitals than at public hospitals. *Id.* at 5.

²¹ *Id.* at 13-14. By choosing not to offer VBACs, hospitals are relieved from following ACOG’s costly recommendation of paying a surgical team to be “immediately available” in the event a woman requires an emergency c-section.

²² Mayo Clinic, *C-Section*, available at <http://www.mayoclinic.com/health/c-section/MY00214/DSECTION=risk>.

²³ Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA*, at 78; available at <http://www.amnestyusa.org/dignity/pdf/DeadlyDelivery.pdf>

²⁴ Pisake Lumbiganon et al, *Method of Delivery and Pregnancy Outcomes in Asia: the WHO Global Survey on Maternal and Perinatal Health 2007-08*, 375 *The Lancet* 490-499, 496 (Feb. 6, 2010).

²⁵ *Id.*

²⁶ *See supra* note 21.

²⁷ The National Institutes of Health Consensus Development Conference Statement reported the risk of uterine rupture, a particularly feared complication of trial of labor, to be less than 1 percent. *Id.* at 4. Perinatal death results from approximately 6 percent of uterine ruptures. *Id.* at 9.

B. The Consent Requirement

The requirement that a patient must consent to any medical treatment—even lifesaving medical treatment—is recognized under U.S. law.²⁸ International law recognizes this requirement as well. For example, the General Comment issued by the Committee on Economic, Social, and Cultural Rights, which monitors compliance with the International Covenant on Economic, Social, and Cultural Rights (ICESCR), clarifies the meaning of ‘right to health’ to include the right to control one’s health and body, the right to reproductive freedom, and the right to be free from forced medical treatment.²⁹ Similarly, the Report of the International Bioethics Committee (IBC) of the United Nations Educational, Scientific and Cultural Organization (UNESCO) on Consent requires practitioners to obtain informed consent before performing medical procedures, and urges “a collaborative relationship, rather than a paternalistic relationship” between a doctor and patient.³⁰ Furthermore, the level of formality of consent increases as the degree of invasiveness increases.³¹ While the IBC Report on Consent does not specifically address a woman’s right to refuse a cesarean, nor the propriety of states’ practice of assuming custody of a fetus to carry out forced cesareans, it fails to mention ‘the unborn’ as a class of persons without the ability to consent who require special protection.³²

The American Congress of Obstetricians and Gynecologists’ (ACOG) Committee on Ethics, however, states that “court-ordered intervention against the wishes of a pregnant woman is rarely if ever acceptable.” Although the Committee did not foreclose the potential for an

²⁸ See for example *Cruzan v. MO Dept. of Health*, 497 U.S. 261 (1990) (declining to allow termination of life support for a comatose car accident victim in light of the questionable reliability of the evidence that the victim would have wanted life support withdrawn under the circumstances of the case).

²⁹ U.S. Econ. & Soc. Council, Comm. On Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C. 12/2000/4 (Aug. 11, 2000)

³⁰ Report of the International Bioethics Committee of UNESCO (IBC) on Consent (2008) at 16.

³¹ *Id.* at 22. Cesareans are highly invasive because they constitute major abdominal surgery, involve more pain, and require longer recovery times than vaginal births.

³² *Id.* at 29 (while including neonates and children as members of this class). According to the IBC Report on Consent, court orders to provide for medical treatment when parents object is appropriate for children and neonates.

ethically permissible court order, it directed obstetricians to “respect the patient’s autonomy, continue to care for the pregnant woman, and not intervene against the patient’s wishes, regardless of the consequences.”³³ Other recommendations included: “The obstetrician’s response to a patient’s unwillingness to cooperate with medical advice ...should be to convey clearly the reasons for the recommendations to the pregnant woman, examine the barriers to change along with her, and encourage the development of health-promoting behavior,” “the obstetrician must keep in mind that medical knowledge has limitations and medical judgment is fallible,” and “obstetricians should consider the social and cultural context in which these decisions are made and question whether their ethical judgments reinforce gender, class, or racial inequality.”³⁴ This final recommendation is noteworthy, given the fact that a national survey reported that 81 percent of women subjected to court-ordered obstetrical interventions were black, Asian, or Hispanic.³⁵ Furthermore, about a quarter of the women did not speak English as their first language,³⁶ indicating a potential violation of Article 26 of the ICCPR, which prohibits discrimination on the basis of language.³⁷

C. Targeting of Racial Minorities for Court Orders and Minorities’ Lower TOL Rates May Demonstrate ICERD Violations.

In light of the survey findings with regards to race, as well as findings that “race and ethnicity are the strongest demographic predictors of vaginal delivery after TOL,”³⁸ the United States may be in violation of the International Convention on the Elimination of All Forms of

³³ ACOG Committee Opinion No. 321 at 5 (2005).

³⁴ *Id.*

³⁵ Kolder et al, *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987).

³⁶ *Id.* at 1197.

³⁷ International Covenant on Civil and Political Rights, art. 26 (Mar. 23, 1976).

³⁸ National Institutes of Health Consensus Development Conference Statement, *Vaginal Birth After Cesarean: New Insights* at 5 (March 11, 2010). Both Hispanic women and African American women have lower rates of vaginal delivery after TOL.

Racial Discrimination (ICERD).³⁹ Article 2 of the Convention provides that “States Parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races.” Subsection (a) directs public authorities and public institutions to act in accordance with Article 2. Furthermore, none of the reservations, declarations, or understandings (RDUs) accompanying the United States’ signature of the ICERD apply to racial discrimination regarding unnecessary or unwanted obstetrical interventions.⁴⁰ More recent studies are needed to confirm these findings in order to definitively prove violations of the ICCPR and the ICERD.

D. Ethical and Public Policy Considerations Regarding Pregnant Women’s Rejection of Treatment Deemed to be Medically Necessary Militate Against Court Orders.

1. People are not Legally Obligated to Undergo Treatment to Save Others.

In *McFall v. Shimp*,⁴¹ a patient afflicted with a rare and fatal bone marrow disease unsuccessfully sued to force a relative—the only acceptable bone marrow transplant donor—to become the plaintiff’s donor.⁴² Although the court morally objected to the defendant’s refusal, it observed that “the rule [that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue] is founded upon the very essence of our free society.”⁴³ Such a mentality reflects values common in American society, as well as the state of the law (at least regarding non-pregnant persons.) One may therefore question how *McFall* is distinguishable from court-ordered treatment of pregnant women.

³⁹ Convention on the Elimination of All Forms of Racial Discrimination, art. 2 (Jan. 4, 1969). The United States signed the Convention on Sept. 28, 1966 and ratified it on Oct. 21, 1994.

⁴⁰ See Convention on the Elimination of All Forms of Racial Discrimination, reservations, declarations, and understandings (Jan. 4, 1969). For example, the U.S. expressed concern that the Convention would interfere with freedom of speech, expression, or association.

⁴¹ 10 Pa. D. & C.3d 90, 1978 WL 255 Pa.Com.Pl (July 26, 1978).

⁴² *Id.*

⁴³ *Id.*

2. Women's Motives Often Demonstrate Concern for Maternal or Fetal Wellbeing.

At first blush, women who reject medical advice may appear selfish or ignorant. In fact, they are often motivated by a genuine belief that the recommended procedure is unnecessary or unsafe. For example, Amber Marlowe feared undergoing a recommended c-section because a friend had died from one.⁴⁴ She also disputed doctors' contentions that the surgery was necessary.⁴⁵ Although doctors concluded from an ultrasound that the baby weighed 13 pounds—too large to deliver vaginally⁴⁶—it actually weighed 11 pounds, 9 ounces.⁴⁷ Furthermore, Ms. Marlowe had extensive experience delivering large babies, having already vaginally delivered six babies, each weighing nearly 12 pounds.⁴⁸ Nevertheless, a Luzerne County Court of Common Pleas judge granted Wilkes-Barre General Hospital's request to become a guardian of Ms. Marlowe's fetus and force her to undergo a c-section in the event she returned to the hospital.⁴⁹ Ms. Marlowe delivered a healthy baby vaginally at another hospital, describing the experience as “a piece of cake.”⁵⁰

Joy Szabo⁵¹ was motivated in part by fetal wellbeing in refusing a threatened court-ordered cesarean.⁵² Cesareans create risks to the baby that include premature birth, low Apgar scores (possibly due to anesthesia), breathing problems, and being cut from the uterine incision

⁴⁴ David Weiss, Court Delivers Controversy: *Mom Rejects C-sections; Gives Birth on own Terms*, Times Leader (January 16, 2004).

⁴⁵ *Id.*

⁴⁶ Judge Michael Conahan, *Motion for Special Injunction: Order and Appointment of Guardian* (Jan. 14, 2008) at 2.

⁴⁷ Lloyd de Vries, *Debate Revived on Mother's Rights*, CBS News (May 19, 2004), available at <http://www.cbsnews.com/stories/2004/05/19/health/main618535.shtml>

⁴⁸ *Id.*

⁴⁹ Judge Michael Conahan, *Motion for Special Injunction: Order and Appointment of Guardian* (Jan. 14, 2008).

⁵⁰ Lloyd de Vries, *Debate Revived on Mother's Rights*, CBS News (May 19, 2004), available at <http://www.cbsnews.com/stories/2004/05/19/health/main618535.shtml>

⁵¹ *See supra* notes 5-6.

⁵² Elizabeth Cohen, *Mom Won't be Forced to Have C-Section*, CNN (Oct. 15, 2009), available at <http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/index.html>.

being made too deeply.⁵³ Notably, both Ms. Szabo⁵⁴ and Laura Pemberton⁵⁵ (see discussion on pp. 9-19, *infra*) expressed gratitude at having undergone medically indicated cesareans prior to their respective threatened and actual court-ordered cesareans. Thus, the view that women refuse cesareans out of ignorance or lack of concern for their baby's wellbeing appear to be incorrect.

3. A Court Order May Not Necessarily Avert Harm.

Court orders are also inappropriate in light of medical uncertainty and error,⁵⁶ apparent in the order directed against Ms. Marlowe and the threatened order against Ms. Szabo,⁵⁷ both of whom delivered healthy babies vaginally. In addition, in a true medical emergency (when, for example, a fetus is severely oxygen deprived and requires an immediate cesarean delivery), it is unlikely that a court order would avert harm because court orders are not generally issued instantaneously.⁵⁸ Finally, women fearing forced treatment may opt to avoid the healthcare system altogether.⁵⁹

4. A Court is an Unsuitable Venue for Medical Decision-Making.

Court orders are often issued with little time to deliberate the facts and possible treatment

⁵³ Interview with Dr. Marsden Wagner, former director of Women and Children's Health at the WHO, Baltimore, MD (Apr. 29, 2010).

⁵⁴ Elizabeth Cohen, *Mom Won't be Forced to Have C-Section*, CNN (Oct. 15, 2009). Ms. Szabo remarked, "I'm grateful for that [prior] C-section. It saved [my son's] life."

⁵⁵ *Laura Pemberton: Speaking on Her Experience of a Court-ordered Cesarean Surgery* [hereinafter *Laura Pemberton: Speaking on her Experience*], available at http://advocatesforpregnantwomen.org/issues/court_ordered_interventions/laura_pemberton_speaking_on_her_experience_of_a_courtordered_cesarian_surgery.php. Ms. Pemberton remarked, "I had just had a c-section less than one year earlier. I had willingly and wisely chose that c-section."

⁵⁶ *See supra* note 34.

⁵⁷ *See supra* note 5-6.

⁵⁸ *See for example* Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999). The process of issuing the court order and retrieving the patient to undergo treatment in *Pemberton* took several hours. *See also* Helene Cole, *Legal Interventions During Pregnancy* 26 JAMA 2663, 2665 (Nov. 28, 1990). According to one study, only 19 percent of court orders were obtained in under one hour, while 88 percent were granted within six hours. *Id.*

⁵⁹ *Id.* For example, Ms. Pemberton chose to give birth at home when she learned that her physician would not allow her a trial of labor. *Laura Pemberton: Speaking on Her Experience.*

options, and to consider relevant legal authority.⁶⁰ Women are thus rendered susceptible to orders issued in haste.⁶¹ In addition, there is no opportunity for a meaningful appeal.⁶² For example, although the District of Columbia Court of Appeals overturned a lower court's decision allowing a hospital to perform a cesarean on an unwilling cancer patient, this legal victory was meaningless for the woman because she died hours after the cesarean.⁶³

Furthermore, the legal process of obtaining court orders is in many regards unfair to women. First, women may not have access to counsel, while a hospital may appoint an attorney to represent the fetus.⁶⁴ Second, women may not be capable of adequately expressing their rationale for treatment refusal due to their unique medical circumstances.⁶⁵ For example, Ms. Pemberton's hearing took place while she was in active labor.⁶⁶ She was also forced to advocate for her interests while dehydrated and hungry, as she could not eat or drink without vomiting.⁶⁷ Ms. Carder, in contrast, could not advocate for her interests at all because she fell in and out of consciousness (although she did mouth the words "*I don't want it done*" twice when asked if she would agree to undergo a cesarean.)⁶⁸

Finally, a woman may not be able to secure competent legal representation with little advance notice, and her attorney(s) may not have sufficient time to prepare her case.⁶⁹ For the foregoing reasons, it is clear that the legal process is not suited for resolution of medical decision-making disputes.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ See *In re A.C.*, 573 A.2d 1235 (D.C. App. 1990). Ms. Carder's baby also died shortly after the cesarean.

⁶⁴ Such was the scenario Laura Pemberton experienced. See p. 11, *infra*.

⁶⁵ Helene Cole, *Legal Interventions During Pregnancy* 26 JAMA 2663, 2665 (Nov. 28, 1990).

⁶⁶ *Laura Pemberton: Speaking on Her Experience*, *supra* note 55. Ms. Pemberton wryly commented that during her hearing, officials graciously allowed her to pause in between contractions.

⁶⁷ *Id.*

⁶⁸ *In re A.C.*, 573 A.2d 1235, 1241 (D.C. App. 1990).

⁶⁹ Helene Cole, *Legal Interventions During Pregnancy* 26 JAMA 2663, 2665 (Nov. 28, 1990).

5. There is No Logical Reason to Distinguish Foregoing Medical Advice to Submit to Treatment From Foregoing Other Medical Advice.

If a physician may secure a court order to force bed rest or a cesarean on a pregnant woman, there is nothing to prevent him/her from, say, securing orders to force women to undergo fetal surgery. While it may seem tempting to distinguish fetal surgery from cesareans on the grounds that fetal surgery is often performed earlier in a pregnancy than c-sections, both Ms. Carder's⁷⁰ and Ms. Burton's⁷¹ court-ordered cesareans were performed very early in the third trimester, possibly before fetal viability. (Both babies died upon delivery or shortly thereafter.)⁷² Thus, court-ordered cesareans are indistinguishable from other interventions, such as fetal surgery.

They are also indistinguishable from securing orders to prohibit a woman from harming her fetus in other ways. For example, if she chooses to ignore medical advice against eating soft cheeses, deli meat, and sushi, she may become infected with *listeria monocytogenes*, resulting in miscarriage, premature delivery, infection in the newborn, or death in the newborn.⁷³ Similarly, cleaning a cat's litter box may result in toxoplasmosis, an infection that can severely damage a baby's brain and eyes.⁷⁴ If a woman can be legally compelled to follow doctor's orders to undergo a cesarean or bed rest, it follows that court orders preventing women from engaging in certain activities deemed unsafe for the unborn child are a real possibility.

⁷⁰ In re A.C., 573 A.2d 1235, 1240 (D.C. App. 1990).

⁷¹ Susan Donaldson James, *Pregnant Woman Fights Court-Ordered Bed Rest*, ABC News (Jan. 14, 2010).

⁷² *Id.*; In re A.C., 573 A.2d 1235, 1241 (D.C. App. 1990).

⁷³ American Pregnancy Association, *Listeria and Pregnancy* (Oct. 2008); available at <http://www.americanpregnancy.org/pregnancycomplications/listeria.html>. Approximately 22 percent of perinatal listeriosis cases lead to fetal death or stillbirth.

⁷⁴ American Academy of Family Physicians, *Toxoplasmosis and Pregnancy* (Dec. 2009); available at <http://familydoctor.org/online/famdocen/home/women/pregnancy/illness/180.html>

E. Legal Interventions Targeting Individual Women

a. Laura Pemberton

Despite longstanding U.S. and international human rights law protecting patients from non-consensual medical treatment, U.S. courts have compelled pregnant women to submit to c-sections. In one case, Laura Pemberton sought an IV at a hospital because she was feeling dehydrated while in labor at home.⁷⁵ Ms. Pemberton saw a family practice physician who also treated obstetrics patients, but the physician declined to administer the IV and informed Ms. Pemberton that a cesarean was necessary,⁷⁶ as Ms. Pemberton had undergone a prior cesarean performed using a vertical incision that extended into the thickened myometrium.⁷⁷ This type of incision is associated with a higher risk of uterine rupture (and resulting fetal death) than the more commonly used horizontal incision.⁷⁸ After Ms. Pemberton refused the cesarean, the physician informed hospital officials of the situation, and it actuated a previously devised process “to deal with patients who refuse to consent to medically necessary treatment.”⁷⁹ Ms. Pemberton secretly left the hospital during this process⁸⁰ after a nurse who was sympathetic to her desire for a VBAC confirmed that the fetus’s heart rate was normal, unbeknownst to the hospital.⁸¹ The hospital’s attorney called the State Attorney, who appointed a special assistant state attorney to handle the matter.⁸² The special assistant state attorney called a judge, who held a hearing at the hospital—in which neither Ms. Pemberton nor a legal representative acting on her behalf was present—and heard testimony supporting the contention that “vaginal birth would pose a

⁷⁵ Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999).

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

⁸² *Pemberton*, 66 F. Supp. 2d at 1249.

substantial risk of uterine rupture and resulting death of the baby.”⁸³ One physician witness for the hospital later stated at trial that the risk of rupture if Ms. Pemberton gave birth at a hospital was four to six percent, with a consequence of “almost certain death,”⁸⁴ while Ms. Pemberton’s witness stated that the uterine rupture risk was two to 2.2 percent, resulting in a 50 percent risk of fetal death in the event rupture occurred.⁸⁵ Thus, the risk of fetal death on the basis of this evidence ranged from one percent⁸⁶ to about six percent,⁸⁷ assuming a hospital birth.⁸⁸

The hearing at the hospital resulted in an order compelling Ms. Pemberton to return to Tallahassee Memorial Regional Medical Center.⁸⁹ An armed sheriff went to her home to ensure that she complied with the transportation order.⁹⁰ Her legs were strapped together,⁹¹ ostensibly to prevent her from giving birth vaginally en route to the hospital. Once she arrived, the hearing continued, resulting in a court order compelling a c-section.⁹² Ms. Pemberton subsequently sued the hospital, alleging it violated her substantive constitutional rights and her right to procedural due process, and she alleged common law theories of negligence and false imprisonment.⁹³

1. The Court Erred by Employing a Balancing Test

In granting summary judgment in favor of the hospital, the court employed a test that balanced Ms. Pemberton’s constitutional rights to refuse a c-section against the state of Florida’s

⁸³ *Id.*

⁸⁴ *Pemberton*, 66 F. Supp. 2d at 1253.

⁸⁵ *Id.*

⁸⁶ According to Ms. Pemberton’s witness

⁸⁷ According to the hospital’s witness

⁸⁸ While a home birth may increase the odds of fetal death in the event of rupture, Ms. Pemberton’s obstetrician told her the odds of uterine rupture were greatest at the onset of labor. At the time Judge Padovano issued the court order, Ms. Pemberton’s labor was well underway, indicating the risk of rupture may have been diminished. Before being forced into the ambulance, she could feel the baby’s head in the birth canal. See *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

⁸⁹ *Pemberton*, 66 F. Supp. 2d at 1250.

⁹⁰ Lynn Paltrow, *Can There be Justice for Pregnant Women if the Unborn Have “Human Rights”?* (Oct. 23, 2008); available at <http://www.rhrealitycheck.org/blog/2008/10/22/can-there-be-justice-pregnant-women-if-unborn-have-human-rights>

⁹¹ *Id.*

⁹² *Pemberton*, 66 F. Supp. 2d at 1250.

⁹³ *Id.* at 1249.

interest in preserving the life of her fetus.⁹⁴ U.S. courts have criticized the use of balancing tests in such circumstances. For example, the court in *In re Baby Boy Doe*⁹⁵ held that a balancing test was improper, even when foregoing a c-section would harm a woman's fetus.⁹⁶ In so concluding, the court cited *Thornburgh v. American College of Obstetricians and Gynecologists*,⁹⁷ which invalidated a Pennsylvania statute that required physicians to use the abortion method that would most likely result in a fetus being born alive because doing would result in an impermissible "trade-off" between a woman's health and fetal life.⁹⁸

In *In re A.C.*,⁹⁹ the court also rejected the use of a balancing test that weighed the patient's rights against state interests.¹⁰⁰ It acknowledged four instances when courts determined that the right to reject medical treatment was not absolute: (1) preserving life, (2) preventing suicide, (3) maintaining the ethical integrity of the medical profession, and (4) protecting third parties.¹⁰¹ The *A.C.* court deemed the second and third considerations irrelevant and implied that it did not find the interest in preserving life to be "truly compelling."¹⁰² It did not explicitly address why the aim of protecting third parties did not apply.¹⁰³ In contrast, the

⁹⁴ *Id.* at 1251.

⁹⁵ 632 N.E.2d 326, 326 (Ill. App. 1 Dist. 1994) (holding that a woman had a right to refuse a cesarean, even though doctors concluded that the chances of the baby surviving a vaginal delivery were close to zero and that if the baby survived, it would almost certainly be mentally retarded). Ms. Doe ultimately gave birth vaginally, and the baby was "normal and healthy." *Id.* at 329.

⁹⁶ *Id.*

⁹⁷ 476 U.S. 747 (1986).

⁹⁸ This legal conclusion in *Thornburgh* may not remain valid in light of *Gonzales v. Carhart*, which upheld a federal ban on a second-trimester abortion procedure known as intact dilation and evacuation, even though the procedure was shown to be the safest abortion option in certain circumstances and even though the ban contained no exception for preserving a woman's health. 550 U.S. 124 (2007). The changing nature of U.S. constitutional law thus provides justification for applying international human rights law to unwanted obstetric interventions because that latter is less subject to any one country's political whims.

⁹⁹ 573 A.2d 1235, 1247 (D.C. App. 1990). See pp. 8-9 *supra*.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 1246-47.

¹⁰² *Id.*

¹⁰³ *Id.*

court in *In re Baby Boy Doe*¹⁰⁴ found the first two considerations irrelevant, asserted that the fourth concerned only people already born, and averred that the third militated in the pregnant woman's favor because the medical profession decried legal interventions during pregnancy on ethical grounds.¹⁰⁵ As in *In re A.C.* and *In re Baby Boy Doe*, the court in *In re Brown*¹⁰⁶ also rejected a balancing test and viewed the four factors in essentially the same manner as the court in *Doe*.¹⁰⁷ Therefore, it is evident that while courts are in disagreement over the meaning and application of the four factors that may undermine a woman's right to refuse medical treatment, courts have also rejected balancing tests that weigh a pregnant woman's right to refuse treatment against state interests of promoting fetal life.

In invoking a balancing test in *Pemberton*, the court cited *Roe v. Wade*, which allows states to outlaw abortion after fetal viability,¹⁰⁸ and considered the defendant's witness estimation of four to six percent uterine rupture risk.¹⁰⁹ However, even assuming an equivalent risk of fetal death, such risk hardly demonstrates unqualified necessity of a c-section. First, Ms. Pemberton stated that she could feel her baby's head in her vagina¹¹⁰ when the sheriff came to her home,¹¹¹ indicating the process of birth was already well underway. Additionally, because there was no sign of rupture at any point in the process, particularly the beginning stages of labor

¹⁰⁴ 632 N.E.2d 326, 334 (Ill. App. 1 Dist. 1994). As stated *supra*, the court in *In re Baby Boy Doe* also determined that a balancing test was improper.

¹⁰⁵ *Id.*

¹⁰⁶ 689 N.E. 2d 397 (Ill. App. 1 Dist. 1997) (holding that a Jehovah's Witness could not be forced to undergo a blood transfusion to save the life of her viable fetus).

¹⁰⁷ *Id.* at 403-04.

¹⁰⁸ 410 U.S. 113 (1973). The court in *Pemberton* reasoned that because proscribing post-viability abortion (a constitutionally permissible option for states) is a greater rights violation than restricting the manner a woman gives birth, the latter is necessarily also constitutional. One counterargument is apparent when acknowledging that preventing a woman from aborting a pregnancy is not equivalent to requiring her to take the affirmative step of submitting to a surgery that lowers risk of fetal death.

¹⁰⁹ See *supra* note 84.

¹¹⁰ See *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

¹¹¹ Transcript of Keynote Address, *What to Expect: legal Developments and Challenges in Reproductive Justice*, 15 Cardozo J.L. & Gender 503, 509 (Spring, 2009).

when risk of rupture was highest,¹¹² the hospital failed to prove an immediate need for the c-section.^{113,114} The court thus did not balance Ms. Pemberton's desire to avoid a c-section against her baby's interest in living, as it claimed.¹¹⁵ Rather, it balanced Ms. Pemberton's desire to avoid a c-section against her baby's interest in *lowering its risk of death*, in this case, from six percent¹¹⁶ to its risk of death from a cesarean birth.

2. The Court Mischaracterized Ms. Pemberton's State of Knowledge, Compared to that of the Doctors.

The WHO defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." This broad definition of health transcends the biomedical paradigm, in which judgments of medical experts are considered to be infallible.¹¹⁷ Mainstream medical groups have indicated willingness to question this presumption of infallibility. Recall, for example, ACOG Committee Opinion No. 321, described *supra*, in which obstetricians are urged to "keep in mind that medical knowledge has limitations and medical judgment is fallible"¹¹⁸ when encountering patients who refuse treatment deemed necessary to their fetus.

Furthermore, one commentator noted a societal bias of "the fantasy of omniscience and omnipotence, as embodied in the doctor who commands the wondrous apparatus of modern science, [and] the fantasy of ignorance and weakness, as embodied in the uncertain, dependent patient."¹¹⁹ This fantasy is apparent in *Pemberton*. The court dismisses Ms. Pemberton's

¹¹² *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

¹¹³ *See Id.*

¹¹⁴ *See supra* note 49 (describing the normal fetal heart rate measured at the hospital).

¹¹⁵ *Pemberton*, 66 F. Supp. 2d at 1252.

¹¹⁶ Assuming that the risk was not lowered due to the fact that Ms. Pemberton's labor at the time of the c-section was beyond the point of highest risk of rupture.

¹¹⁷ Prof. Janet Lord, *Basic Concepts of Human Rights Power Point Slides* (Slide 3).

¹¹⁸ *See supra* note 34.

¹¹⁹ Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y.L. Sch. L. Rev. 59, 64 (2010).

research and genuine desire for a vaginal birth in stating that “[t]he medical evidence belies Ms. Pemberton’s bravado.”¹²⁰ It further declared that the “hospital and these physicians would surely have been pleased not to be involved.”¹²¹ Given the zeal with which the hospital pursued the court-ordered cesarean, even after Ms. Pemberton left the hospital premises, this observation appears disingenuous. Despite the doctors’ “credentials,” “competence,” and “board-certified” status¹²² to which the court repeatedly referred to justify its reliance on the defendant’s assertion that Ms. Pemberton could not safely give birth vaginally due to her prior cesarean, Ms. Pemberton subsequently gave birth to four children—including a set of twins—vaginally.¹²³

3. The Hospital May Have Violated Ms. Pemberton’s Right to Privacy Under the ICCPR.

The court neglected to consider Ms. Pemberton’s right to privacy as provided by the International Covenant on Civil and Political Rights (ICCPR),¹²⁴ which the United States ratified June 8, 1992. Article 17 provides that “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation” and that “[e]veryone has the right to the protection of the law against such interference or attacks.”¹²⁵ The hospital breached Ms. Pemberton’s expectations of medical privacy by involving its attorney and the State Attorney, who involved a special assistant state attorney and a judge in the matter. These people were not only informed of her private medical history, they were present during her “hearing” in her hospital room. As a result of the state’s retrieval of Ms. Pemberton from her home, neighbors could see what was taking place.¹²⁶

¹²⁰ *Pemberton*, 66 F. Supp. 2d at 1252.

¹²¹ *Id.* at 1257.

¹²² *Id.* at 1256.

¹²³ Transcript of Keynote Address, *What to Expect: legal Developments and Challenges in Reproductive Justice*, 15 *Cardozo J.L. & Gender* 503, 509 (Spring, 2009).

¹²⁴ International Covenant on Civil and Political Rights, art. 17 (Mar. 23, 1976).

¹²⁵ *Id.*

¹²⁶ See *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

Furthermore, the state agent entered Ms. Pemberton's home, watched her as she moved about her bedroom, and even followed her into the closet.¹²⁷ Most importantly, the matter concerned Ms. Pemberton as she labored and gave birth, arguably one of the most private moments of a woman's life. Therefore, the hospital and its employees, as well as the judge who conducted the hearing in the presence of extraneous persons, may well have violated Article 17 of the ICCPR.

4. The Hospital May Have Violated Ms. Pemberton's Right to Liberty Under the ICCPR.

The court held that Ms. Pemberton's theory of false imprisonment "add[ed] nothing to her claims"¹²⁸ because she necessarily must have been transported to the hospital for the hospital to carry out a lawful court order. While tempting, this reasoning is faulty in light of *Enhorn v. Sweden*¹²⁹ (holding that an HIV positive man's hospital detention in accordance with Sweden's 1988 Infectious Diseases Act constituted a violation of the right to liberty and security of the person). The Swedish government detained Mr. Enhorn after he failed to keep his appointments with the county medical officer, who was entrusted with ascertaining Mr. Enhorn's compliance with a protocol designed to minimize the risk that he would infect others. The government asserted that Mr. Enhorn was "likely to have sexual relations...without thinking of the consequences," and noted that he had already infected another man with HIV and that he failed to inform medical workers of his HIV status, as required by the county medical officer's protocol. The European Court of Human Rights held that in detaining Mr. Enhorn, Sweden violated Article 5 § 1(e) of the Convention for the Protection of Human Rights and Fundamental Freedoms.¹³⁰ Article 5 provides that "[e]veryone has the right to liberty and security of person.

¹²⁷ *Id.*

¹²⁸ *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1257 (N.D. Fla. 1999).

¹²⁹ *Enhorn v. Sweden*, 41 Eur. Ct. H.R. 633 (2005).

¹³⁰ *Id.*

No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law[.]”¹³¹ The court noted the similarity between the language in Article 5 of the Convention for the Protection of Human Rights and Fundamental Freedoms and Article 9 of the ICCPR.¹³² Article 9 establishes that “[e]veryone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.” Moreover, the United States Supreme Court has cited the European Court of Human Rights directly,¹³³ signaling a willingness to view the latter (and, by inference, the European Convention on Human Rights) as sources of authoritative law.

In finding an Article 5 violation, the court explained that detention is acceptable only when “less severe measures have been considered and found to be insufficient to safeguard the individual or the public interest.” In *Pemberton*, one less severe option could have been to allow Ms. Pemberton a trial of labor at the hospital, and perform a cesarean only when it was clearly necessary (for example, in the event she showed signs of uterine rupture, or if the fetus showed signs of distress.) In fact, Ms. Pemberton expressed approval when her obstetrician had told her earlier in her pregnancy that a trial of labor at the hospital was a possibility, and chose to attempt to give birth at home only when the obstetrician reversed course and she could find no other obstetrician to fill in.¹³⁴ Furthermore, she was not opposed to undergoing a cesarean that was truly medically necessary, as she had willingly done so in a previous pregnancy.¹³⁵ Therefore, it

¹³¹ Convention for the Protection of Human Rights and Fundamental Freedoms (Sept. 21, 1970). Section 1(e) explains that one may be detained “for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants[.]”

¹³² *Enhorn v. Sweden*, 41 Eur. Ct. H.R. 633 (2005).

¹³³ See *Lawrence v. Texas*, 539 U.S. 558, 573 (2003) (citing *Dudgeon v. United Kingdom*, 45 Eur. Ct. H.R. (1981) in holding that a law prohibiting homosexual sodomy was unconstitutional).

¹³⁴ *Laura Pemberton: Speaking on Her Experience*, *supra* note 55.

¹³⁵ *Id.*

is likely that use of the less extreme measure of trial of labor at the hospital, followed by a possible emergency c-section, would have been a viable option.

Importantly, the court in *Enhorn* also noted that national law provides, by itself, insufficient grounds to justify detention, and that the detention must be necessary under the particular circumstances of the case. The *Pemberton* court, in contrast, justified its finding that Ms. Pemberton was not falsely imprisoned solely on the basis that a lawful court order was issued. As stated *supra*, the c-section was not absolutely necessary. Therefore, the court erred in evaluating the merits of Ms. Pemberton's false imprisonment assertion.

5. The Hospital May Have Subjected Ms. Pemberton to Degrading Treatment Under the CAT.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)¹³⁶ is also relevant in evaluating cases of forced medical treatment, including cesareans. Like the ICERD and the ICCPR, the CAT carries the force of law because the United States ratified it.¹³⁷ While forced confinement or medical treatment may not rise to the level of torture, it may arguably constitute cruel, inhuman or degrading treatment or punishment in Ms. Pemberton's circumstances.¹³⁸ The CAT provides that:

Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article

¹³⁶ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 16 (Dec. 10, 1984).

¹³⁷ Signature date: Apr. 18, 1988; ratification date: Oct. 21, 1994.

¹³⁸ *Laura Pemberton: Speaking on Her Experience*, *supra* note 55. Ms. Pemberton stated, "I began hysterically pleading with the state attorney, please don't let them take me in. I was told there was nothing they could do. I couldn't believe what was happening. Was this a nightmare? I want to wake up. No way does anybody have this right—total invasion of my home, family, emotions, and person...I asked if I could at least get dressed... The EMT gave me permission to get a robe on. But they followed me wherever I went. I went in the closet, they came with me...If I was left alone in the room, the state attorney was peeking in to make sure that I was not going to flee. And they never examined me as they promised. After putting me in the stretcher, strapping me down, and wheeling me into the ambulance I felt total humiliation. Neighbors were watching, and I knew that what was happening to me was wrong, very wrong...I asked if I could have my legs unstrapped, as being strapped down made the contractions more unbearable..."

I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.¹³⁹

Moreover, the single RDU associated with the United States' ratification of the CAT does not appear to apply to unnecessary or unwanted obstetrical interventions.¹⁴⁰ While the United States limits applications of the ICCPR's Article 7 prohibitions on torture, inhuman, or degrading treatment to only those recognized as such under the 5th, 8th, and/or 14th amendments to the constitution,¹⁴¹ the United States does not express this reservation with respect to the CAT.¹⁴² Thus, the binding nature of the CAT, coupled with evidence indicating that the forced cesarean constituted degrading treatment, indicate that the hospital may have violated the CAT.

b. Samantha Burton

Samantha Burton was in her 25th week of pregnancy¹⁴³ when she experienced symptoms of premature labor and checked in to Tallahassee Memorial Hospital on the advice of her physician.¹⁴⁴ Although the symptoms constituted a false alarm, the physician urged Ms. Burton to remain in the hospital indefinitely and quit smoking to avert a possible miscarriage.¹⁴⁵ She refused, explaining she had two toddlers at home who needed her supervision.¹⁴⁶ Two days later, Ms. Burton's doctor and hospital attorneys entered her room with a telephone and contacted a

¹³⁹ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 16, ¶ 1.

¹⁴⁰ The U.S. expressed the understanding that communications claiming that a State Party violates CAT must come from a State Party that recognizes the competence of the Committee Against Torture.

¹⁴¹ International Covenant on Civil and Political Rights, RDUs.

¹⁴² Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, RDUs.

¹⁴³ Pregnancy generally lasts 39-40 weeks; See <http://www.plannedparenthood.org/health-topics/pregnancy/stages-pregnancy-23953.htm>

¹⁴⁴ Bill Kaczor, *Fla. Woman Fights Ruling That Kept Her in Hospital*, ABC News (Jan. 26, 2010); available at <http://abcnews.go.com/US/wireStory?id=9662262>

¹⁴⁵ *Id.*

¹⁴⁶ Susan Donaldson James, *Pregnant Woman Fights Court-Ordered Bed Rest*, ABC News (Jan. 14, 2010); available at <http://abcnews.go.com/Health/florida-court-orders-pregnant-woman-bed-rest-medical/story?id=9561460>

circuit court judge.¹⁴⁷ The judge denied Ms. Burton’s request to be transferred to another hospital for a second opinion, and granted an order authorizing treatment “*including but not limited to* restricting [her] to bed rest, administering appropriate medication, postponing labor, taking appropriate steps to prevent and/or treat infection, and/or eventually performing a cesarean section delivery of the child at the appropriate time.”¹⁴⁸ (emphasis added).

Interestingly, the state attorney involved in seeking the court order was also involved in seeking the court order against Ms. Pemberton.¹⁴⁹ Days after the issuance of the order, Ms. Burton delivered a stillborn baby by cesarean section.¹⁵⁰ Distraught over her treatment and the order, Ms. Burton later appealed to the Florida First District Court of Appeal.¹⁵¹

1. The Hospital, the Doctors, and the State May Have Violated Ms. Burton’s Rights to Liberty and Privacy Under the ICCPR and Her Right to Be Free From Degrading Treatment Under the CAT.

Ms. Burton’s potential claims under international human rights law overlap in many respects with those of Ms. Pemberton. For example, she may assert violations of her liberty under the ICCPR. As was the case in *Pemberton*, Ms. Burton was detained in the hospital when less restrictive alternatives were available. Crucially, bed rest has been shown to be ineffective¹⁵² for the prevention of premature delivery and miscarriage, and ACOG has warned against its inappropriate use outside of strict research guidelines.¹⁵³ Even if bed rest were

¹⁴⁷ Letitia Stein and Curtis Krueger, *Pregnant Woman’s Involuntary Hospitalization Raises Legal, Ethical, Medical Questions*, St. Petersburg Times (Jan. 27, 2010); available at <http://www.tampabay.com/news/health/pregnant-womans-involuntary-hospitalization-raises-legal-ethical-medical/1068455>

¹⁴⁸ The Honorable John C. Cooper, Circuit Court Judge, *Order Authorizing Medical Treatment—In re Unborn Child of Samantha Burton*, Case No. 2009 CA 1167 (Mar. 27, 2009).

¹⁴⁹ See *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999); *Pregnant Woman’s Involuntary Hospitalization Raises Legal, Ethical, Medical Questions*.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* See discussion *infra* on page 26.

¹⁵² Telephone interview with Dr. Dayna Finkenzeller, Assistant Professor of Obstetrics and Gynecology at Johns Hopkins Bayview Medical Center (April 21, 2010). Dr. Finkenzeller dismissed bed rest as a means to prevent miscarriage or premature birth as “voodoo medicine.”

¹⁵³ ACOG Committee Opinion Number 352 at 3, *Innovative Practice: Ethical Guidelines* (2006); available at http://www.acog.org/from_home/publications/ethics/co352.pdf

effective, Ms. Burton could have been subjected to such less restrictive measures as remaining on bed rest at a nursing home or other facility equipped to provide medical care in the context of a less restrictive environment.¹⁵⁴ A friend who lived in the hospital vicinity also offered Ms. Burton a temporary place to stay.¹⁵⁵ As explained *supra*, detainment is not justified under Article 5 under the European Convention on Human Rights, even in accordance with national law, when less restrictive measures exist. Furthermore, Article 5 language mirrors that of Article 9 of the ICCPR, which carries the force of law.¹⁵⁶ Thus, Ms. Burton may assert that the hospital and physicians violated her right to liberty under the ICCPR.

Ms. Burton may also assert an Article 17 violation of privacy, although she did not experience an invasion of her home, as was the case in *Pemberton*. Finally, depending on whether she suffered treatment that rose to the level of being cruel, inhuman, or degrading, she may also assert that the hospital, the doctors, and the state violated the CAT.¹⁵⁷ However, in view of Ms. Burton's earlier stage of pregnancy, the court order authorizing *any* medical treatment deemed necessary (even treatment not yet considered by the court), and of her confinement being justified in part by her smoking,¹⁵⁸ Ms. Burton's circumstances allow for additional claims:

2. The Hospital, the Doctors, and the State may have Violated Ms. Burton's Right to Privacy Under the U.S. Constitution Because the Fetus May Not Have Been Viable.

¹⁵⁴ Susan Donaldson James, *Pregnant Woman Fights Court-Ordered Bed Rest*, ABC News (Jan. 14, 2010). Ms. Burton's attorney, a trained nurse, asserted that these alternatives were appropriate.

¹⁵⁵ *Id.*

¹⁵⁶ The United States ratified the ICCPR on June 8, 1992.

¹⁵⁷ News reports and court filings do not specify the nature of Ms. Burton's treatment in detail, although one report stated that she described her physician as "brusque and overbearing." See Bill Kaczor, *Fla. Woman Fights Ruling That Kept Her in Hospital* (Jan. 26, 2010).

¹⁵⁸ Susan Donaldson James, *Pregnant Woman Fights Court-Ordered Bed Rest*, ABC News (Jan. 14, 2010).

Under current abortion jurisprudence, the state may not legally prohibit a woman from terminating a pre-viable pregnancy.¹⁵⁹ While viability is thought to occur at about 24 weeks' gestation,¹⁶⁰ the precise point at which a fetus reaches viability differs in each pregnancy, and is to be determined by the attending physician, as opposed to a legislature or court.¹⁶¹ For example, 26 percent of 24-week-old fetuses are viable, while 44 percent of 25-week-old fetuses are viable.¹⁶² Thus, Ms. Burton's 25-week-old fetus may not have reached viability, evidenced by its death prior to being delivered by c-section.¹⁶³

If Ms. Burton could have legally obtained an abortion at the time the judge issued the order for her confinement and forced medical treatment, it follows that the order violated her constitutional right to privacy. In other words, if her fetus did not enjoy a legal right to life the day the order was issued, it certainly did not enjoy the right to medical treatment that would supposedly enhance¹⁶⁴ its chances of survival.

3. The Hospital, the Doctors, and the State may have Violated Ms. Burton's Right to Equal Protection Under the ICCPR, CEDAW, and the U.S. Constitution Because her Smoking was a Basis for Seeking the Court Order.

Article 26 of the ICCPR provides that:

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on

¹⁵⁹ See *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Gonzales v. Carhart*, 550 U.S. 124 (2007) (acknowledging that a ban the Court upholds on a particular abortion method does not extend to *all* second trimester abortion methods).

¹⁶⁰ British Medical Association, *Abortion Time Limits* (June 17, 2005); available at http://www.bma.org.uk/ethics/reproduction_genetics/AbortionTimeLimits.jsp?page=6

¹⁶¹ *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 63-64 (1976) (holding that fixed gestational limits on abortions are unconstitutional).

¹⁶² British Medical Association, *Abortion Time Limits* (June 17, 2005); available at http://www.bma.org.uk/ethics/reproduction_genetics/AbortionTimeLimits.jsp?page=6

¹⁶³ See *supra* note 106.

¹⁶⁴ See discussion *supra* on p. 16-17 on the ineffective nature of bed rest for preventing premature birth and miscarriage.

any ground such as race, colour, *sex*, language, religion, political or other opinion, national or social origin, property, birth or other status.¹⁶⁵ (emphasis added.)

Because the order compelled Ms. Burton to remain in the hospital so that she could not expose her fetus to cigarette smoke—but did not even inquire as to whether her husband smoked—the order may violate her Article 26 right to equal protection on the basis of sex. Article 15 of CEDAW further clarifies that “States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity.”¹⁶⁶ While the United States has not yet ratified CEDAW, it is a useful tool for elucidating rights already established in ratified treaties; in this case, Article 26 of the ICCPR. Ms. Burton did not enjoy legal capacity on equal footing with that of men not merely because she was targeted as a smoker, but because she was targeted as a pregnant person. Because men cannot be pregnant, they cannot conceivably be ordered confined under the same circumstances, whether or not they smoke.

Under the Equal Protection Clause of the United States Constitution, gender-based classifications are subject to intermediate scrutiny, a form of heightened scrutiny which requires that a regulation serve important government interests and be substantially related to achieving the regulation’s objectives. *Craig v. Boren*, 429 U.S. 190 (1976) (holding that an Oklahoma statute prohibiting the sale of certain alcoholic beverages to males under 21 years of age and to females under 18 years of age violated the Equal Protection Clause because doing so was not substantially related to the statute’s stated objective of enhancing traffic safety.) While preventing cigarette smoke exposure may fairly be termed an important government interest, the state does not target parents who smoke in the presence of born children, even infants. Nor does

¹⁶⁵ International Covenant on Civil and Political Rights, art 26 (Mar, 23, 1976).

¹⁶⁶ Convention on the Elimination of All Forms of Discrimination Against Women, art. 15, ¶ 2 (Dec. 18, 1979).

the state target pregnant women's husbands or boyfriends who smoke. Importantly, the order issued against Ms. Burton expired once she gave birth, at which point the court did not seek to prevent her from smoking in the presence of the child once it was born. Hence, the court order is not substantially related to achieving the objective of preventing people from cigarette exposure and may be unconstitutional under the Equal Protection Clause.

4. The Florida First District Court of Appeal Held the Court Order Violated Ms. Burton's Constitutional Right to Privacy.

In August, 2010, the Florida First District Court of Appeal declared Ms. Burton's court-ordered treatment and confinement an unconstitutional violation of her right to privacy, which includes the "right to determine what shall be done with [her] own body."¹⁶⁷ In adopting the reasoning in *Roe v. Wade*¹⁶⁸ that a state's interest in protecting fetal life becomes compelling at viability,¹⁶⁹ the court held that the trial court did not employ the correct legal test.¹⁷⁰ The court also cautioned that the party seeking to compel medical treatment has the burden to demonstrate fetal viability.

c. J.D.S.

J.D.S. was a 22-year old woman who was impregnated in 2003¹⁷¹ as a result of a rape committed by the husband of the director of the group home in which J.D.S lived.¹⁷² She suffered from cerebral palsy, autism,¹⁷³ and seizure disorder,¹⁷⁴ had the mental capacity of a

¹⁶⁷ *Burton v. State of Florida*, ---So.3d---, 2010 WL 3168124 (Aug. 12, 2010).

¹⁶⁸ 410 U.S. 113 (1973).

¹⁶⁹ *Id.* at 163.

¹⁷⁰ *Burton*, 2010 WL at 3. The trial summarily concluded that the state's interests overrode Ms. Burton's privacy interests.

¹⁷¹ *In re Guardianship of J.D.S.*, 864 So. 2d 534 (Fla. App. 5 Dist. 2004).

¹⁷² Anthony Colarossi, *Court Fight Ahead Over Who'll Speak for J.D.S.*, *Orlando Sentinel* (Jan. 21, 2004); available at http://articles.orlandosentinel.com/2004-01-21/news/0401210087_1_jarrell-guardian-disabled-woman

¹⁷³ *Id.*

¹⁷⁴ *J.D.S.*, 864 So. 2d 534 at 536.

young child,¹⁷⁵ and could not speak.¹⁷⁶ Because she could not make decisions for herself, including how to manage her pregnancy, a Florida trial court determined that a plenary guardian for J.D.S. should be designated.¹⁷⁷ Meanwhile, a woman by the name of Jennifer Wixtrom petitioned to be designated guardian of J.D.S.'s fetus, even after J.D.S.'s plenary guardian determined that J.D.S. would not undergo an abortion. Ms. Wixtrom claimed that a fetal guardian was necessary to ensure fetal welfare, as certain aspects of J.D.S.'s medical care had the potential to harm her fetus:¹⁷⁸

Furthermore, J.D.S. is taking psychotropic medications that may be jeopardizing the welfare of the unborn child. In addition, future medical procedures, tests and medications will be required of J.D.S. that may detrimentally affect the unborn child's welfare. Matters such as whether to obtain a sonogram, use of anesthesia for any medical procedure, the type of vitamins, choice of delivery, medications, and other pre-natal "dilemmas" will have a profound impact on the well-being of the unborn child. These issues alone create a conflict of interest that a court-appointed guardian over J.D.S. cannot resolve, as the guardian owes a fiduciary duty to J.D.S., not to the unborn child...

To resolve this "dilemma," the Court must appoint a guardian for the unborn child.¹⁷⁹

The trial court refused to appoint Ms. Wixtrom as fetal guardian on the narrow grounds that a fetus is not a legal person, and that Chapter 744, Florida Statutes,¹⁸⁰ contains no

¹⁷⁵ Anthony Colarossi, *Court Fight Ahead Over Who'll Speak for J.D.S.*, Orlando Sentinel (Jan. 21, 2004); available at http://articles.orlandosentinel.com/2004-01-21/news/0401210087_1_jarrell-guardian-disabled-woman

¹⁷⁶ *J.D.S.*, 864 So. 2d 534 at 536.

¹⁷⁷ *Id.* at 537.

¹⁷⁸ *Id.* at 536.

¹⁷⁹ Brief of Amici Curiae, In re Guardianship of J.D.S. at pp. 14-15, quoting Appellant Jennifer Wixtrom's brief at pp. 28-29.; available at <http://www.aclu.org/files/FilesPDFs/ACF28A5.pdf>. (Wixtrom's brief is not available through Lexis or Westlaw.)

¹⁸⁰ Chapter 744 governs guardianships.

mechanism through which the court could appoint a fetal guardian.¹⁸¹ The Fifth District Court of Appeal affirmed.¹⁸²

By rejecting Ms. Wixtrom's petition on such narrow grounds, the court neglected to consider relevant bases for rejecting the petition that would have explicitly affirmed J.D.S.'s human rights. Moreover, focusing solely on whether a fetus is a person in deciding the legality of fetal guardianship exposes the decision to the potential for being overruled in the event fetuses attain the status of legal personhood. The U.S. has indicated a willingness to grant fetuses such a status when, for example, it revised state child health insurance coverage to include "individuals under the age of 19 including the period from conception until birth"¹⁸³ and when it adopted the Unborn Victims of Violence Act (UVVA),¹⁸⁴ which made it a federal crime to cause death or injury to a fetus at any gestational stage, during the commission of other specified federal crimes. UVVA does not recognize death or injury to a pregnant woman as a federal offense, a testament to its focus on fetal rights.¹⁸⁵ International human rights law, in contrast, is *ipso facto* less susceptible to political trends in any one country. Several treaties may be applicable to J.D.S.'s case:

1. Appointing a Fetal Guardian Would Deprive J.D.S. of her right to Equal Protection of the Law.

Article 26 of the ICCPR designates *all persons* as equal before the law¹⁸⁶ and while disabled people are not included in Article 26's list of protected groups, the list is not meant to

¹⁸¹ *J.D.S.*, 864 So. 2d 534 at 536. The court also rejected Ms. Wixtrom's petition because she failed to include her address on the guardianship application and certify that she provided proper notice to parties involved.

¹⁸² *Id.*

¹⁸³ ACOG Committee Opinion Number 321: *Maternal Decision Making, Ethics, and the Law* at 3 (November 2005).

¹⁸⁴ ACOG Committee Opinion Number 321: *Maternal Decision Making, Ethics, and the Law* at 4 (November 2005).

¹⁸⁵ *Id.*

¹⁸⁶ International Covenant on Civil and Political Rights, art. 26 (Mar. 23, 1976).

be exhaustive. (Emphasis added.) (Article 26 prohibits “discrimination on any ground *such as* age, color, . . .”).¹⁸⁷ (Emphasis added.) Furthermore, Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD) clarifies that “persons with disabilities have the right to recognition everywhere as persons before the law”¹⁸⁸ and that “persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.”¹⁸⁹ While the United States has not yet ratified the CRPD, and thus it does not carry the force of law in the strictest sense, some commentators explained that “although several articles might seem to embody newly created rights, these rights were included in order to direct the means by which other Convention rights are realized.”¹⁹⁰ The CRPD is therefore a useful tool in evaluating compliance with the ICCPR, which the U.S. has ratified.¹⁹¹

Because courts do not generally appoint fetal guardians for non-disabled women in circumstances otherwise comparable to J.D.S.’s, Ms. Wixtrom’s petition, if granted, would likely have violated J.D.S.’s right to equal protection. J.D.S.’s guardian was appointed to “act on behalf of [her] person or property or both.”¹⁹² In other words, the guardian was appointed to determine the course of care J.D.S. would have chosen for herself had she been of sound mind. Therefore, any concern over pre-natal “dilemmas,” such as those cited in Ms. Wixtrom’s brief,¹⁹³ are irrelevant; J.D.S.’s guardian was in the position to resolve any such dilemmas. In this respect, Florida statutory law providing for appointment of an incapacitated person’s guardian conforms to the CRPD’s stipulation in Article 12, ¶ 4 that “measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest

¹⁸⁷ *Id.*

¹⁸⁸ Convention on the Rights of Persons with Disabilities, art. 12 ¶1 (Dec. 13, 2006).

¹⁸⁹ Convention on the Rights of Persons with Disabilities, art. 12 ¶2 (Dec. 13, 2006).

¹⁹⁰ Janet E. Lord and Michael Ashley Stein, *The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities*, 83 Wash. L. Rev. 449, 462 (2008).

¹⁹¹ The U.S. ratified the ICCPR on June 8, 1992.

¹⁹² *J.D.S.*, 864 So. 2d 534 at 538.

¹⁹³ *See supra* note 116.

and undue influence.” Had Ms. Wixtrom’s petition been granted, Article 12, ¶ 4, as well as Article 26 of the ICCPR, may have been violated.

2. Appointing a Fetal Guardian Would Deprive J.D.S. of her right to Autonomy

Article 3 of the CRPD sets forth several principles—including “individual autonomy including the freedom to make one’s own choices”—that shape the goals of the Convention.¹⁹⁴ This goal is inherent in Article 26 of the ICCPR, as non-disabled persons and men enjoy the right to make their own medical choices. Therefore, on the basis of equal protection, a disabled woman also has the right to make her own medical choices. In this case, J.D.S.’s court-appointed guardian has the right to effectuate the choices J.D.S. would have made for herself, without a fetal guardian interfering.

3. Appointing a Fetal Guardian Would Deprive J.D.S. of her Right to Freedom from Exploitation.

Ms. Wixtrom did not explicitly admit to ulterior motives, or assert that she targeted J.D.S. on the basis of her disability, yet there is no doubt that she did so. (Otherwise, Ms. Wixtrom presumably would have petitioned to be named guardian of J.D.S. *before* she became pregnant, or petitioned to become guardian of a *non-disabled* woman’s fetus at some point. There is no evidence that either occurred.) As a disabled woman with no familial support, J.D.S. was in no position to hire her own attorney to fight Wixtrom’s petition, or otherwise advocate for her own rights, perhaps by speaking to the press or fleeing the state. Although Ms. Wixtrom’s request to be appointed fetal guardian purported to be a “special case,” had the court approved the request, there would have been nothing to stop the state from appointing fetal guardians for *all* woman.

¹⁹⁴ Convention on the Rights of Persons with Disabilities, art. 3 (Dec. 13, 2006).

As the concurrence stated,

[i]f a fetus has rights, then all fetuses have rights. And, if a fetus is a person, then all fetuses are people, not just those residing in the womb of an incompetent mother. If we recognize a fetus as a person, we must accept that the unborn would have the rights guaranteed persons under the Constitutions of the United States and the State of Florida. While it is inviting to view this case as narrowly as Wixtrom suggests, it would be dangerous to do so when the potential for state intrusion into the lives of women is so significant.¹⁹⁵

Undoubtedly, Ms. Wixtrom and the amici curiae supporting her were using J.D.S.—who did not choose to become a party to the suit—as a tool to advance their cause of undermining a woman’s right to abortion. Ms. Wixtrom and the amici curiae were in effect exploiting J.D.S. in violation of Article 16 of the CRPD.

4. Appointing a Fetal Guardian Would Deprive J.D.S. of her Right to the Highest Attainable Standard of Health.

Under Article 12 of the ICESCR, everyone has the right to enjoy “the highest attainable standard of physical and mental health.”¹⁹⁶ “Everyone” includes disabled persons and pregnant women. Likewise, the CRPD specifies that “persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.”¹⁹⁷ Appointing a fetal guardian who has the authority to nullify determinations made by J.D.S.’s guardian to advance J.D.S.’s interests *necessarily* would result in J.D.S. being deprived of her right to the highest attainable standard of health, unless of course J.D.S.’s guardian makes a mistake in her determinations. (Recall that Ms. Wixtrom sought to make decisions regarding “whether to obtain a sonogram, use of anesthesia for any medical procedure,

¹⁹⁵ In re Guardianship of J.D.S., 864 So.2d 534, 541 (Fla. App. 5 Dist. 2004) (Orfinger, J., concurring and concurring specially).

¹⁹⁶ International Covenant on Economic, Social and Cultural Rights, art. 12 (Feb. 23, 1967).

¹⁹⁷ Convention on the Rights of Persons With Disabilities, art. 25 (Dec. 13, 2006).

the type of vitamins, choice of delivery, medications, and other pre-natal ‘dilemmas’¹⁹⁸).

Therefore, appointing a fetal guardian would violate Article 12 of the ICESCR and Article 25 of the CRPD.

F. Conclusion.

A competent woman’s right to informed refusal of medical treatment deemed necessary for her fetus, while presenting ethical dilemmas, is ultimately embodied in U.S. constitutional law and international human rights law. International law is an important tool for securing human rights domestically because it is less prone than domestic law to capricious changes resulting from political trade-offs. While not every treaty cited in this paper has been ratified by the U.S., the treaties to which the U.S. is bound provide sufficient legal basis to conclude that treatment performed without informed consent, including court-ordered treatment, violates international law.

¹⁹⁸ These were the decisions regarding J.D.S.’s medical care that Ms. Wixtrom sought to control, according to her brief. *See supra* note 176.