
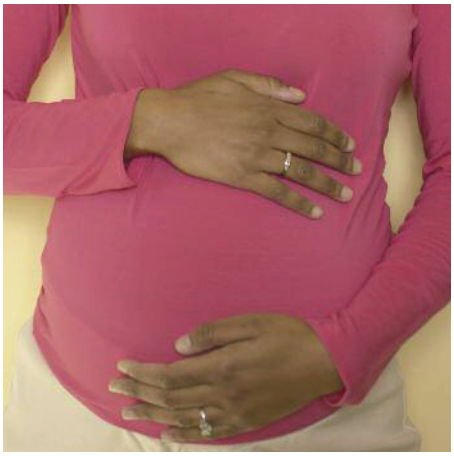


# A RIGHT TO REFUSE?

## The Legalities of a Pregnant Patient's Refusal of Medical Treatment

***By R. Rhett Owens***

On August 5, 2016, a Jefferson County, Alabama jury awarded $16 million to plaintiffs in a case involving claims arising from injuries that one of the plaintiffs sustained as a result of the birth of her fourth child. Plaintiffs alleged that defendants, a hospital and its employees, engaged in medical negligence and fraud by advertising that the hospital was open to facilitating "natural" births, but in plaintiffs' case (and against the plaintiff mother's will), the defendants compelled the mother to give birth in a manner different than she desired, and had planned with her obstetrician.

This verdict raises interesting questions about how medical providers should confront a situation in which an expectant mother's wishes and medical science diverge. For example, if a woman wants to deliver naturally, but her doctors determine it is medically necessary for her baby to be delivered by Cesarean section ("C-section"), are the woman's doctors obligated to honor her wishes, or are there legal interests that prevail over such wishes, thus authorizing the doctors to deliver the baby via C-section despite the woman's objections? As might be expected, the answer to this hypothetical is not entirely clear.

### The Right to Refuse Treatment

Medical providers are required to obtain informed consent from patients prior to performing a medical procedure, informed consent being defined as "the willing and un-coerced acceptance of a

medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention, its risks and benefits, as well as of alternatives with its risks and benefit."[1]

Importantly, a "logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[2] Following the lead of the U.S. Supreme Court, a number of state courts have acknowledged a patient's right to refuse medical treatment.[3] However, that an individual has the right to refuse medical treatment "does not end the inquiry: whether [] constitutional rights have been violated must be determined by balancing [] liberty interests against the relevant state interests."[4]

Predictably, in cases involving a pregnant woman's refusal of treatment, and specifically in cases where a woman refuses to give birth via a medically necessary C-section (a common situation confronted in applicable case law), courts have struggled to consistently balance a woman's constitutional right to refuse treatment and the state's interest in preserving life under circumstances where recommended treatment, including the performance of a C-section, is necessary to preserve either the woman's life or the life of her unborn fetus.

… courts have struggled to consistently balance a woman's constitutional right to refuse treatment and the state's interest in preserving life under circumstances where recommended treatment, including the performance of a C-section, is necessary to preserve either the woman's life or the life of her unborn fetus.

## Some Cases Hold State's Interest in Preserving Life Trumps Right to Refuse Treatment

In *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*,[5] the plaintiff (over her objection) was ordered by a Florida state court to submit to a C-section deemed necessary to avoid a "substantial risk" that her baby would die during delivery. Following the successful delivery of her baby, the plaintiff brought suit, claiming that her hospital and its physicians violated her constitutional rights via the compelled C-section. In granting the hospital's motion for summary judgment, the *Pemberton* court recognized the "important constitutional interests…implicated" by the situation, but nonetheless held that "[w]hatever the scope of [plaintiff's] personal constitutional rights…they clearly did not outweigh the interests of the State of Florida in preserving the life of the unborn child."[6] In support, the *Pemberton* court relied on a principle announced in *Roe v. Wade*, namely, that "by the point of viability–roughly the third trimester of pregnancy–the state's interest in preserving the life of the fetus outweighs the mother's own constitutional interest in determining whether she will bear a child."[7]

A similar decision was issued by the Supreme Court of Georgia in *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*[8] There, a woman in her 39th week of pregnancy presented herself to the Griffin Spalding County Hospital for pre-natal care and was informed that she had a "complete *placenta previa*," i.e. the woman's afterbirth was lodged between the fetus and her birth canal, that there was a 99 percent probability that the fetus would not survive natural childbirth, that the chances of the woman surviving natural childbirth were no greater than 50 percent and that a C-section performed prior to delivery would have almost a 100 percent chance of preserving the life of the woman and her fetus.[9] Notwithstanding these opinions, the woman, citing religious beliefs, refused to submit to a C-section. Relying on its policy to treat any patient seeking emergency treatment, the hospital sought a court order to "administer medical treatment to [the woman] to save the life of herself and her unborn child."[10] In ordering the woman to submit to a C-section, the trial court held that Georgia had "an interest in the life of this unborn, living human being," and "that the intrusion involved into the life of [plaintiffs] is outweighed by the duty of the State to protect a living, unborn

human being from meeting his or her death before being given the opportunity to live."[11]

The woman and her husband moved for a stay of the order, which was denied by the Supreme Court of Georgia. Although no majority opinion was issued, the *Jefferson* Court did issue two concurring opinions. While the first of these concurring opinions recognized that a court's power to order a competent adult to submit to surgery was "exceedingly limited," it nonetheless indicated that the "unborn child's right to live" outweighed the mother's "right…to practice her religion and to refuse surgery on herself."[12] The second concurring opinion focused on the fact that the compelled C-section was the "least burdensome alternative" for preserving the state's "compelling interest in preserving the life of [the] fetus."[13]

A more recent decision, issued in 2010 by the Florida District Court of Appeals, presents a framework for balancing the interests implicated in a situation in which a pregnant woman refuses medical treatment. In *Burton v. State*,[14] a pregnant woman initially refused to submit to medically necessary treatment, including anticipated delivery via C-section. Operating under a procedure set forth in a 1994 decision, *In re Dubreuil*,[15] the State of Florida, having received notification of the woman's refusal of treatment, determined that a sufficient state interest was at stake and obtained an order to compel the woman to submit to the recommended medical treatment. Although the woman's appeal of the order was mooted by her eventual submission to the treatment, including delivery via C-section, the *Burton* court decided to exercise jurisdiction over the appeal, as the situation at issue–a medical situation requiring immediate resolution–was "capable of repetition yet evading review."[16]

In attempting to sum up Florida law on the issue, the *Burton* court held that "the test to overcome a woman's right to refuse medical intervention in her pregnancy is whether the state's compelling state interest[17] is sufficient to override the pregnant woman's constitutional right to the control of her person, including her right to refuse medical treatment."[18] The *Burton* court further held that where the state's "compelling interest" outweighed the woman's right to refuse treatment, the state had to show "that the method for pursuing that compelling state interest is narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual."[19]

# Some Cases Hold Treatment Decisions of Competent Woman Control

There is a body of common law holding contrary to the previously-discussed decisions, the rationale for which is set forth in two cases decided in the first half of the 1990s: *In re A.C.*[20] and *In re Baby Boy Doe*.[21]

In *A.C.*, the District of Columbia Court of Appeals vacated a trial court's order that a pregnant woman submit to a C-section. In summarizing its decision, the *A.C.* court held that a trial court's first task in a case involving a pregnant woman's refusal of treatment was "to determine…whether the patient is capable of making an informed decision about the course of her medical treatment."[22] A finding of competency ends the inquiry, as the woman's "wishes will control in virtually all cases."[23] Conversely, a finding that the woman is "incapable of making an informed consent (and thus incompetent)" forces the court to make a "substituted judgment" in which it must "ascertain as best it can what the patient would do if faced with the particular treatment question."[24]

Four years later, in *In re Baby Boy Doe*, the Illinois Court of Appeals affirmed a trial court's denial of a petition to compel a woman to submit to a C-section. In so holding, the *Baby Boy Doe* court emphasized that, consistent with Illinois law, "a woman's right to refuse invasive medical treatment…is not diminished during pregnancy" and that "potential impact upon the fetus is not legally relevant," i.e. the woman's rights were not subordinate to that of her unborn baby.[25]

The *Baby Boy Doe* court, citing the Supreme Court's opinion in *Thornburgh v. American College of Obstetricians and Gynecologists*,[26] also addressed the issue of balancing the interests in preserving the life of the mother and that of her unborn fetus. Specifically, in discussing *Thornburgh*, the *Baby Boy Doe* court noted the Supreme Court's characterization of the Pennsylvania statute as impermissibly requiring a "trade-off" between a woman's health and the survival of her fetus, and stressed that "the woman's health is always the paramount consideration, i.e. any degree of increased risk to the woman's health is unacceptable."[27] Thus, the *Baby Boy Doe* court held that a compelled C-section, which, "by its nature, presents some additional risks to the woman's health," when

"recommended solely for the benefit of the fetus… cannot pass constitutional muster."[28]

# Other Authorities Suggest Pregnant Woman's Wishes Control

The above-discussed decisions constitute the majority of what is a surprisingly sparse body of law on the issue of whether, and under what circumstances, a pregnant woman may be compelled to submit to medically necessary treatment. As can be seen, these cases provide support for both sides of the issue. Thus, we are forced to turn to other sources. The first such source is case law addressing whether a pregnant woman can be compelled to undergo other medically necessary treatment as part of her pre-natal care, for example, a blood transfusion. As could be expected, while certain jurisdictions hold that a competent patient's refusal of treatment carries the day, notwithstanding the likelihood that said refusal will jeopardize the patient's life and/or the life of her unborn fetus, other jurisdictions hold that the state has an interest in preserving the life of the unborn fetus and, thus, under certain circumstances, can compel a patient to undergo a blood transfusion.[29]

In light of this split in authority, the opinion of physicians most directly involved in these cases presents reliable authority which can influence an analysis of potential liability. A recent committee opinion issued by the American College of Obstetricians and Gynecologists establishes that the medical community is firmly in the camp of adhering to treatment decisions made by competent pregnant women:

> The most suitable ethical framework for addressing a pregnant woman's refusal of recommended care is one that recognizes the interconnectedness of the pregnant woman and her fetus but maintains as a central component respect for the pregnant woman's autonomous decision-making. This approach does not restrict the obstetrician-gynecologist from providing medical advice based on fetal well-being, but it preserves the woman's autonomy and decision-making capacity surrounding her pregnancy. Pregnancy does not lessen or limit the requirement to obtain informed consent or to honor a pregnant woman's refusal of recommended treatment.[30]

# What about the Father?

To add another complicating factor to this analysis, the father of the unborn fetus also has certain rights, though the Supreme Court's abortion-related decisions suggest these rights are very limited with respect to an unborn fetus.[31] Thus, if a man cannot compel a pregnant woman, even his wife, to consent to a C-section or other medical necessary treatment necessary treatment, what rights does he have in this complex situation? In sum, depending on the specific facts at issue and the jurisdiction in which he lives, the father can assert tort claims against the medical providers involved in the situation.

The first of these potential claims is a claim for "wrongful birth" of a fetus, which has been recognized by 18 states, including Alabama, and three federal circuit courts of appeal.[32] This claim seeks to impose tort liability on healthcare providers who negligently fail to apprise parents of material information relating to an unborn fetus.[33] Therefore, theoretically, a wrongful birth claim would be unsuccessful in cases where the provider fully and completely informs the mother of the fetus (or, if applicable, its parents) of all aspects of the medical situation, and the mother refuses treatment.

The second of the father's potential claims is a claim for "wrongful life," a cause of action "brought by or on behalf of a defective child who claims that but for the defendant doctor's negligent advice to or treatment of its

Pregnancy does not lessen or limit the requirement to obtain informed consent or to honor a pregnant woman's refusal of recommended treatment.

parents, the child would not have been born."[34] However, only four states recognize this cause of action.[35]

Conversely, a majority of jurisdictions in the United States recognize the third potential claim that could be asserted by a father, a cause of action for wrongful death of a fetus.[36] In these jurisdictions, a claim for the wrongful death of an unborn fetus is treated in the same manner as is a claim for wrongful death of a person who has been born, i.e. the elements are a defendant's duty to the fetus; defendant's breach of such duty via breach of the applicable standard of care; and proximate causation of the fetus's death by defendant's breach. Whether the fetus was viable at the time of its death will also be considered, as the majority of jurisdictions recognizing a cause of action for wrongful death of a fetus, absent legislative action to the contrary, require the fetus to have reached "viability" as a condition to maintaining a claim.[37] Damages will be determined largely in accord with applicable state law, though it should be noted that an increasing number of jurisdictions allow for the award of both economic and non-economic losses damages in fetal wrongful death cases.[38]

# Conclusion

Based on the above, liability arising from a situation in which a pregnant patient refuses treatment turns in large part on whether the medical provider has informed the patient of all information material to her refusal of treatment, and has documented both the patient's competency to refuse treatment, and the refusal itself. Ideally, such choices are made by an undeniably competent patient in a controlled environment well in advance of the time that such treatment will be administered. If, as is more likely, such choices are being made quickly due to medical necessity, the medical provider must nonetheless take steps to inform the patient of all material information relating to her refusal of treatment, and her competency to refuse such treatment must be determined and documented. In such cases, a recording of the applicable proceedings may be necessary to erase ambiguity as to what information was communicated and what decisions were made. If the woman's legal competency cannot be determined, i.e. she literally cannot express a decision, and/or is impaired to a degree that her decision cannot be afforded credibility, the provider should have in place specific policies for relying on third-party sources to determine the patient's wishes. However, in implementing such policies, absent a contrary law or regulation, the provider should avoid policies requiring it to inform state officials of the patient's refusal of treatment. To do otherwise could subject the provider to liability, as a plaintiff in a resultant suit could argue that but for the medical provider's provision of information to the state, the state would not have been aware of the treatment refusal, and the

losses associated with the state's attempts to override such refusal would not have occurred. ▲

## Endnotes

1. *Bankert by Bankert v. U.S.*, 937 F. Supp. 1169, 1173 (D. Md. 1996).
2. *Cruzan by Cruzan v. Director, Missouri Dept. of Health,* 497 U.S. 261, 270 (1990).
3. *See e.g., Sekerez v. Rush University Medical Center*, 954 N.E. 2d 383, 394 (Ill. App. Ct. 2011) ("A corollary to the requirement that a patient's consent must be obtained prior to the performance of a medical procedure is that a patient is entitled to refuse medical treatment. In fact, absent consent, a patient cannot be compelled to submit to a medical procedure even where the patient's life is in jeopardy.") (quoting *Curtis v. Jaskey*, 759 N.E. 2d 962, 965 (Ill. App. Ct. 2001)); *Powers v. Floyd*, 904 S.W. 2d 713, 717 (Tex. App. 1995) ("In Texas a physician must make reasonable disclosure of the risks of medical treatment and must secure the authority or consent of the patient to legally perform a medical procedure. This duty is based on the right of every normal adult to determine what shall be done to his or her own body and a recognition that the patient needs adequate information to make an intelligent decision whether to consent to or refuse the treatment.").
4. *Cruzan*, 497 U.S. at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).
5. 66 F. Supp. 2d 1247 (N.D. Fla. 1999).
6. *Id.*, at 1251.
7. *Pemberton*, 66 F. Supp. 2d at 1251 (citing *Roe v. Wade*, 410 U.S. 113 (1973)).
8. 274 S.E. 2d 457 (Ga. 1981).
9. *Id.*, at 458.
10. *Id.*
11. *Id.*, at 460.
12. *Id.*, at 460 (Hill, J., concurring).
13. *Id.*, at 461 (Smith, J., concurring).
14. 49 So. 3d 263 (Fla. Dist. Ct. App. 2010).
15. 629 So. 2d 819 (Fla. 1994). In *Dubreuil*, the Florida Supreme Court held, in a case in which a patient refused a blood transfusion on religious grounds (in contravention of a consent form she had previously signed), that "[w]hen a healthcare provider, acting in good faith, follows the wishes of a competent and informed patient to refuse medical treatment, the health care provider is acting appropriately and cannot be subjected to civil or criminal liability." 629 So. 2d at 823-24. The court further held that a state actor could only get involved when the healthcare provider desired to override the patient's refusal: "*a health care provider wishing to override a patient's decision to refuse medical treatment* must immediately provide notice to the state attorney presiding in the circuit where the controversy arises, and to interested third parties known to the healthcare provider." *Id.*, at 824 (emphasis added). Thus, under *Dubreuil*, as long as the medical provider has fully informed a patient of the consequences associated with her refusal of treatment, and has documented the competency of the patient to refuse treatment, and the refusal itself, a state actor has no grounds to intervene, as *Dubreuil* suggests that a condition precedent to state intervention is the medical provider's desire for the state to become involved.
16. 49 So. 3d at 264.
17. *Burton*, like *Pemberton*, emphasized that a state's interest in preserving the life of an unborn baby became compelling at the point of viability, i.e. when "the fetus becomes capable of meaningful life outside the womb, albeit with artificial aid." *Burton*, 49 So. 3d at 265 (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973) and *In re T.W.*, 551 So. 2d 1186, 1193 (Fla. 1989); see also FLA. STAT. § 390.0111(4) (defining "viability" as "that stage of fetal development when the life of the unborn child may with a reasonable degree of medical probability be continued indefinitely outside the womb.").
18. 49 So. 3d at 266.
19. *Id*.
20. 573 A. 2d 1235 (D.C. 1990).
21. 632 N.E. 2d 326 (Ill. Ct. App. 1994).
22. 573 A. 2d at 1252.
23. *Id*.
24. *Id.*; *see also Doe v. District of Columbia*, 206 F. Supp. 3d 583, 630-31 (D.D.C. 2016) (holding that the "substituted judgment test" requires courts to consider treatment decisions made by the patient when he or she was competent and, if the patient was never competent to make a treatment decision, a parent or guardian's consent is required).
25. 632 N.E. 2d at 332 (citing *Stallman v. Youngquist*, 531 N.E. 2d 355 (Ill. 1988)).
26. 476 U.S. 747 (1986) (holding as unconstitutional a Pennsylvania statute requiring physicians, in performing post-viability abortions, to utilize the procedure most likely to result in the fetus being aborted alive).
27. 632 N.E. 2d at 403.
28. *Id*.
29. *See*, *e.g.*, *In re Brown*, 689 N.E. 2d 397, 405 (Ill. App. Ct. 1997) (holding that the State of Illinois could not override a pregnant woman's competently-made decision to refuse a blood transfusion to potentially save the life of a viable fetus); *but see In re Jamaica Hospital*, 491 N.Y.S. 2d 898 (N.Y. App. Div. 1985) (appointing a physician as guardian *ad litem* over unborn fetus and granting physician discretion in this capacity to compel pregnant woman to undergo all treatment necessary to save fetus's life, including a blood transfusion, which the pregnant woman had refused on religious grounds); *accord Crouse Irving Memorial Hosp., Inc. v. Paddock*, 485 N.Y.S. 2d 443 (N.Y. App. Div. 1985); *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 201 A. 2d 537 (N.J. 1964).
30. *See* American College of Obstetricians and Gynecologists, Committee Opinion Number 664 (June 2016); *see also In re Baby Boy Doe*, 632 N.E. 2d at 335 (noting the American Medical Association's Board of Trustee's recommendation that if a pregnant woman refuses treatment, "the appropriate response is not to attempt to force the recommended procedure upon her, but to urge her to seek consultation and counseling from a variety of sources.").
31. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 69 (1976) (holding that states could not require a woman to obtain spousal consent before having an abortion); *accord Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 897 (1992) (plurality opinion of O'Connor, Kennedy, and Souter, JJ.); *but see In re Matter of Raquel Marie X.*, 559 N.E. 2d 418, 424 (N.Y. 1990) (relying on U.S. Supreme Court precedent in holding that "in an adoption proceeding by strangers, an unwed father who has been physically unable to have a full custodial relationship with his newborn child is [] entitled to the maximum protection of his relationship, so long as he promptly avails himself of all the possible mechanisms for forming a legal and emotional bond with his child.").
32. *See* Catherine Palo, J.D., LL.M, *Cause of Action for Wrongful Birth or Wrongful Life*, 23 CAUSES OF ACTION 2D 55 at § 4 (2003) (listing jurisdictions recognizing cause of action for wrongful birth).

33. *See, e.g. Keel v. Banach*, 624 So. 2d 1022, 1029 (Ala. 1993) ("The nature of the tort of wrongful birth has nothing to do with whether a defendant caused the injury or harm to the child, but, rather, with whether the defendant's negligence was the proximate cause of the parents' being deprived of the option of avoiding a conception or, in the case of pregnancy, making an informed and meaningful decision either to terminate the pregnancy or to give birth to a potentially defective child."); *Provenzano v. Integrated Genetics*, 22 F. Supp. 2d 406, 414 (D.N.J. 1998) ("a wrongful birth cause of action is brought by parents who claim that "negligent medical advice or treatment deprived them of the choice of avoiding conception or...of terminating the pregnancy.") (internal citation omitted).

34. *Provenzano*, 22 F. Supp. 2d at 413 (internal citation omitted).

35. *See* Palo, *Cause of Action for Wrongful Birth or Wrongful Life*, 23 Causes of Action 2d 55 at § 10 (identifying California, Colorado, New Jersey and Washington as the only jurisdictions recognizing cause of action for wrongful life).

36. *See* 19 Am. Jur. Proof of Facts 3d 107 § 1 (1993) (identifying 36 states permitting a wrongful death action to be maintained on behalf of an unborn child).

37. *See, e.g., Brown v. Contemporary OB/GYN Associates*, 794 A.2d 669, 701 (Md. 2002) (holding that "a cause of action for wrongful death may not be maintained on behalf of a nonviable fetus that is stillborn"); *Coveleski v. Bubnis*, 571 A.2d 433, 435 (Pa. Super. Ct. 1990) ("Where the wrongful death and survival statutes are not explicit regarding the rights of an unborn child, it is sound statutory interpretation to limit the right to assert such an action to a viable fetus."); *but see* Ala. Code § 13A-6-1(a)(3) (defining "person," for purposes of the wrongful death statute, as "a human being, including an unborn child in utero at any stage of development, regardless of viability"); *accord Stinnett v. Kennedy*, —So. 3d—, No. 1150889, 2016 WL 7488255, at *10 (Ala. Dec. 30, 2016) (reaffirming its previous holding that Alabama's Wrongful Death Act permitted claims arising from the death of a pre-viable fetus); *cf. Connor v. Monkem Co., Inc.*, 898 S.W. 2d 89, 92 (Mo. 1995) ("[W]e cannot avoid the conclusion that the legislature intended the courts to interpret 'person' within the wrongful death statute to allow a natural parent to state a claim for the wrongful death of his or her unborn child, even prior to viability.").

38. *See* 65 Am. Jur. Trials 261 § 12 n. 57 and n. 58 (1997) (identifying jurisdictions that, by common law decision and statutory provision, have expanded available damages in wrongful death actions involving children to include both economic and non-economic damages, including punitive damages).


**R. Rhett Owens**

Rhett Owens practices with Hall Booth Smith PC in the firm's Birmingham office. His practice focuses on the representation of medical providers in various types of professional liability matters, including medical malpractice and elder abuse cases.