# AUTONOMY AND PREGNANCY

## A COMPARATIVE ANALYSIS OF COMPELLED OBSTETRIC INTERVENTION

SAMANTHA HALLIDAY

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ROUTLEDGE

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## A Comparative Analysis of Compelled Obstetric Intervention

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*Denn nur durch Vergleichung unterscheidet man sich*
*und erfährt, was man ist, um ganz zu werden, was man sein soll.*

For only through comparison can one distinguish oneself
and discover who one is, in order to become all that one
should be.

(Thomas Mann, *Joseph in Ägypten*, 1933)

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# Foreword

This monograph by Samantha Halliday is based upon her doctoral dissertation "Constructing the Foetus as a Patient: A Comparative Analysis of Compelled Obstetric Intervention" submitted to the Faculty of Law at the Justus-Liebig University of Gießen, Germany. The thesis was graded as *summa cum laude* (outstanding) in January 2016. Samantha first visited the University of Giessen at the invitation of Professor Günter Weick, as part of the collaboration he nurtured between the Universities of Giessen and Warwick. The idea to undertake a comparative criminal law study of the variable conceptions of protection afforded to the foetus and the pregnant woman (above all where the performance of a blood transfusion, or a caesarean is indicated to save the foetus) arose in 2012. In 2014 she spent some time in my department, analysing the jurisprudence of the *Bundesverfassungsgericht* and the concept of a derivative crime of omission.

The results are surprising. Although the constitutional position of the foetus in German law appears to be strong, that counts for little in the case of a conflict of interests because the criminally relevant omission of the pregnant woman will only rarely give rise to criminal liability due to the criterion of reasonableness. The foetus has better prospects in the USA and England and Wales. In recognising a state interest in unborn life, the author argues that some American state courts have demonstrated a surprising willingness to disregard the refusal of a blood transfusion or a caesarean, even in the case of a *competent* pregnant woman. In England and Wales the woman's capacity is portrayed as the central issue. It is well recognised that medical treatment without consent will constitute a trespass to the person and that an individual with capacity has the right to refuse treatment. However, as Halliday argues, the courts appear to have been extremely willing to find women to lack the capacity to refuse a caesarean necessary to save the life of the foetus, thereafter designating the safe delivery of the foetus as the defining element of the woman's best interests. As a result of her comparative analysis Halliday argues that it is imperative to set the woman back in the centre of the discussion about the boundaries of prenatal diagnosis and therapy. She therefore advocates the use of an anticipatory pregnancy or birth directive by pregnant women, drafted at a time when their capacity is not in question, and the implementation of procedural safeguards to ensure that the woman remains part of, and the central focus of, decision-making.

This monograph is extremely topical; questions from doctors' circles are repeatedly addressed to lawyers as to whether, and if so which, interventions can be imposed upon a pregnant women in the interests of the unborn child, or her own health. More often than not, questions of liability are at the fore: could a doctor face liability for failing to act to protect the unborn child? The clarification provided by this work about when and to what extent the consent of a pregnant woman can be expected is of vital importance. Halliday's preferred approach, to relocate the decision-making from during birth to an earlier stage where the woman's capacity is undiminished, through the use of an advance pregnancy directive intended to take effect in the case of intervening incapacity, is admittedly not unproblematic. Such a directive is conceptually distinct from the more usual advance directive intended to set out the manner in which the patient would like to die. Whilst the refusal of treatment in a typical advance directive will inevitably lead to the patient's death, that is not necessarily the case in the context of a pregnancy directive. In this context it will be essential to undertake a detailed assessment of the woman's capacity and resort to the presumed will of the woman cannot be excluded.

The contribution to the literature made by this work is not only significant in the field of medical law; its contribution to comparative criminal law cannot be underestimated. The comparing and contrasting of common law and civil law is exceptionally successful. Whilst the analysis of the case law dominates the common law analysis, the author approaches the civil law by centring her analysis upon the abortion jurisprudence of the Federal Constitutional Court, before providing a sophisticated analysis of the German law in relation to derivative crimes of omission. Worthy of particular note is her analysis concerning the fundamental difference between the prohibition of the active termination of pregnancy and enforced acquiescence to an obstetric intervention in the context of a blood transfusion, a caesarean and other similarly invasive treatments. Halliday is capable of such high level analysis due to her outstanding knowledge of both the common law and the specific area of criminal liability for omissions in the German civil law system. This ability also enables the author to accurately develop her analysis, reasoning from the disproportionality of a forcible donation of blood in the so-called blood donor case, to the unlawfulness of obstetric treatment provided against the will of the pregnant woman.

In conclusion, Samantha Halliday has produced an innovative and groundbreaking contribution to the literature that will influence both German and European medical (criminal) law in the area of obstetrics.

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# Contents

# A. Introduction

## I. The context: the evolving status of the foetus, from non-person to patient, to adversary

This book is concerned with the permissibility of encroachment on the pregnant woman's autonomy in the interests of the foetus.[1] Although the foetus has not been accorded the status of person in any of the jurisdictions under consideration, it has increasingly been accorded the status of patient, an acquisition of status largely attributable to technology. Technology has effected a seismic shift in the relationship between the pregnant woman and the healthcare professionals treating her, reducing the reliance of professionals upon knowledge imparted by the woman, and indeed largely reversing the flow of information between the two. For example, doctors are no longer reliant upon women informing them that the foetus has quickened, or even when her last period was; rather, ultrasound scans are used to date the pregnancy and monitor foetal well-being. Technology has come to dominate the modern experience of pregnancy and childbirth, with professionals informing the woman of what is happening, both during the pregnancy, for example through the use of ultrasound, or during the birth through the use of electronic foetal monitoring, increasingly rendering birth a medical event, rather than a natural occurrence. The medicalisation of pregnancy has thus led to the situation where both pregnancy (the process) and birth (the outcome) are subject to oversight by a healthcare professional. This professional is, however, not a neutral observer; she[2] will have her own attitudes about what constitutes appropriate antenatal behaviour, attitudes often based to at least a degree upon clinical evidence, but those attitudes may not correspond with the pregnant woman's own views as to how she wishes to live, or indeed how she wishes to be treated during her pregnancy and labour.

1 Throughout this work I have followed the conventional usage in the literature, making reference to 'foetus' whenever referring to the developing human organism from conception to birth, unless a distinction needs to be drawn between an embryo (the developing organism up to the end of the 8th gestational week) and a foetus.

2 The use of feminine pronouns throughout this work is intended to encompass both genders.

Instead of empowering pregnant women, technology has been used to identify a second patient. As Mark Kilby recognised, 'One of the most significant advances in antenatal care has been the introduction of ultrasound. This has allowed the visualisation of our second patient, the fetus'.[3] Similarly, in 1971 one of the leading American obstetrics texts stated:

> Since World War II and especially in the last decade, knowledge of the fetus and his environment has increased remarkably. As an important consequence the fetus has acquired status as a patient to be cared for by the physician as he long has been accustomed to caring for the mother.[4]

As acknowledged by these excerpts, the use of techniques such as ultrasound and foetal surgery has led to the characterisation of the foetus as a second patient, a distinct entity separate from the pregnant woman, with its own needs and interests. Often, foetal and the woman's interests will be aligned and their care intertwined; nevertheless, in legal and medical discourses the two 'patients' are frequently framed as antagonists with conflicting interests, a trend graphically illustrated by the title of Jeffrey Phelan's article, 'The maternal abdominal wall: a fortress against fetal health care?'[5] Thus technology has transformed the relationship both between the pregnant woman and the foetus she carries and between the pregnant woman and her healthcare professionals. Within this triadic relationship, the role of foetal protector is therefore often ascribed not to the pregnant woman but to the healthcare professional who may intercede on its behalf to secure its well-being and/or treatment, if necessary by protecting it from the pregnant woman. Indeed, as Ingrid Zechmeister suggested, technology may shift the focus of antenatal care from caring to surveillance:

> The growing foetus which had always been hidden in the uterus has become visible, a development which, without doubt, has made pregnancy much less mysterious for the medical profession. This, on the other hand, poses the danger that antenatal care no longer emphasises, as the name might suggest, caring but that the focus shifts from caring to technical surveillance. Hence, women become the object of medical surveillance. What inevitably follows as another consequence is that because technique of visualisation opens up the new possibility of seeing the foetus, the focus of surveillance will be less on the mother but increasingly on the foetus. For the profession it becomes 'their' patient rather than the mother's baby. There might be two patients in pregnancy, however, as Overall ... suggests, 'the fetus is medically and technically

3 M. D. Kilby, 'Prenatal Diagnosis: The Way Ahead? (1998) 59(10) *Hospital Medicine* 752.

4 J. W. Williams; L. M. Hellman and J. A. Pritchard (eds) (1971) *Williams Obstetrics*, 14th edn, New York: Appleton-Century Crofts, at 199.

5 J. Phelan, 'The Maternal Abdominal Wall: A Fortress against Fetal Health Care?' (1986) 65 *Southern California Law Review* 461.

> by far the more interesting one'. Women solely function as environment and space to be explored in the interests of science.[6]

The recognition of the foetus as a separate patient has severed the unitary construction of the pregnant woman and her foetus, emphasising that it may be necessary to protect the foetus from its host, the pregnant woman. Foetal protection policies may be pursued at a state level – for example, through the statutory recognition of the foetus as a separate entity capable of being the victim of child abuse – or by healthcare institutions seeking court orders to override a woman's refusal of consent to treatment believed to further the best interests of the foetus or to be necessary to safeguard its life. Notably, these policies construct the foetus not only as separate but as an innocent third party or victim in need of protection; the uterus ceases to be a place of safety and is portrayed instead as a place of danger. In this manner an adversarial relationship may be created between the woman and the foetus, pitting each against the other, despite the fact that there is only one person involved because at most the foetus can only be characterised as a potential person. As McLachlin J recognised in *Winnipeg Child and Family Services (Northwest Area) v G (DF)*,[7] the concept of

> the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation ... is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by birth... . Judicial intervention ... ignores the basic components of women's fundamental human rights – the right to bodily integrity, and the right to equality, privacy, and dignity... . The foetus's complete physical existence is dependent on the body of the woman. As a result, any intervention to further the foetus's interests would necessarily implicate, and possibly conflict with, the mother's interests.

As McLachlin J noted, the concept of the foetus as a separate patient is belied by its location – whilst the foetus may be regarded as a patient in its own right, it is not an independent being; it is located within the woman's uterus and thus a unique situation arises whereby access to patient A (the foetus) must be gained through the body of patient B (the woman). While most women will willingly accept medical advice about what is best for the foetus, a dilemma arises when the wishes, or indeed interests, of a pregnant woman conflict with the perceived interests of the foetus. As will be seen from the cases discussed in the following chapters, women have rejected treatment that could benefit the foetus, or even save its life, for a number of reasons, including fear, religious beliefs, cultural practices or simply because they disagree with the doctor's prognosis. In all other

6 I. Zechmeister, 'Foetal Images: The Power of Visual Technology in Antenatal Care and the Implications for Women's Reproductive Freedom' (2001) 9 *Health Care Analysis* 387, at 391.

7 (1997) 3 B.H.R.C. 611, at 620–2 (Canadian Supreme Court).

areas of medical law, patient autonomy has become the gold standard, the principal determination of medical care of an adult with capacity, but the addition of a foetus into the equation, particularly a viable foetus, has posed a potent challenge to the autonomy of pregnant women. In many of the cases discussed below, the courts in England and Wales and in the United States of America have been prepared to authorise, or indeed order, medical treatment to be given for the benefit of the foetus, notwithstanding the woman's refusal of consent. Moreover, in some states of America child abuse statutes have been extended to cover the foetus so that the pregnant woman's lifestyle may be restricted.[8]

## II. The general principle that consent is a prerequisite to medical treatment

There is a general principle that everyone's body is inviolate, as Cardozo J stated in *Schloendorff v Society of New York Hospital*:[9]

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body.

Therefore, consent will generally be a prerequisite to any medical treatment; without it the doctor may be liable in negligence or battery. Moreover, it is well recognised that generally in each of the jurisdictions under consideration every patient with the requisite capacity has the right to refuse medical treatment, even that which may save his or her life.[10] Nevertheless, an exception to this general

8 See, for example, *Whitner v State* 528 U.S. 1145 (1998) and *In re Baby Boy Blackshear* No. 99CA00018, 1999 Ohio App. LEXIS 4274 (Sept. 7, 1999). As at 1 July 2015, 'One state allows assault charges to be filed against a pregnant woman who uses certain substances [Tennessee]. 18 states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes, and 3 consider it grounds for civil commitment'. Guttmacher Institute *State policies in brief: substance abuse during pregnancy*, available at www.guttmacher.org/statecenter/spibs/spib_SADP.pdf (accessed 13 August 2015). For discussion of this, see, for example, J. Ehrlich, 'Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women' (2008) 32 *N.Y.U. Review of Law & Social Change* 381; R. Roth, *Making Women Pay: The Hidden Costs of Fetal Rights*, Ithaca, NY: Cornell University Press, 2000; L. Paltrow, 'Pregnant Drug Users, Fetal Persons, and the Threat to *Roe v Wade*' (1999) 62 *Albany Law Review* 999; M. Mills, 'Fetal Abuse Prosecutions: The Triumph of Reaction over Reason' (1998) 47 *DePaul Law Review* 989; K. Moss, 'Substance Abuse during Pregnancy' (1990) 13 *Harvard Women's Law Journal* 278; S. Balisy, 'Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus' (1987) 60 *Southern California Law Review* 1209; C. R. Daniels, *At Women's Expense: State Power and the Politics of Foetal Rights*, 1993, Cambridge, MA: Harvard University Press.

9 105 NE 92 (1914), at 93.

10 *Re T (An Adult) (Consent to Medical Treatment)* [1993] Fam 95; *Airedale NHS Trust v Bland* [1993] 1 All ER 821; *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); *BGHSt* 11, 111 at 113;

principle appears to have been developed in the US and to some extent in England and Wales and Germany, in relation to pregnant women, particularly where the foetus is viable.

Given that the courts in the US and England and Wales have refused to accord the foetus a right to life, it is rather surprising that they have been prepared to override a woman's refusal of consent to medical intervention deemed necessary for the foetus. By contrast there are no reported decisions of cases concerning court-authorised obstetric intervention in Germany. This may be due to the low level of reporting in such cases, or simply due to the fact that no case has been brought to court, but it is significant given the fact that the *Bundesverfassungsgericht* has held that the foetus has a constitutionally protected right to life from implantation and that the foetal right to life operates even against the pregnant woman.[11] Moreover, under German law both the woman and her attending doctor are classified as guarantors, owing a duty to protect the life of the foetus. As discussed below, this means that German law imposes a *prima facie* duty upon doctors to operate to save the life of the foetus, notwithstanding the woman's objection, and that women have a duty to accept treatment needed to save the life of the foetus.

## III. The focus of this book

This book will focus upon that tension between the pregnant woman's autonomy and actions taken to protect the foetus. It will address the circumstances in which courts have declared medical treatment lawful in the face of the pregnant woman's refusal of consent, considering first the English and American case law relating to court-authorised caesareans and blood transfusions. Thereafter, the duties imposed by German law upon the pregnant woman and her doctor with regard to safeguarding foetal life will be considered, assessing to what extent the pregnant woman's duty to protect the foetal life gives rise to an obligation to accept medical treatment for its benefit. Finally, it will comparatively analyse the way in which courts and healthcare professionals, relying upon technology, have enabled the foetus to displace the woman as the primary patient, restricting or even overriding her autonomy, in the name of protecting the entity that will only gain the status of person after live birth.

*BGHSt* 11, 111 at 113; *BGHZ* 154, 205; *BGHZ* 163, 195; *Cruzan v Director, Missouri Dept of Health* 111 L ed 2d 224 (1990).

11 Art. 2 II GG; *BVerfGE* 39, 1 (1975); *BVerfGE* 88, 203 (1993).