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“A Critical Examination of *R v Collins* and the Pregnant Woman’s Right to Refuse Treatment”

Thesis submitted for the degree of Master of Jurisprudence

1999

Abstract

In this thesis I aim to provide a balanced, unbiased analysis of the materno-fetal conflict as expressed by the caesarean section scenario. A second aim is to examine the legal balance of the woman’s rights against the fetus’ and to determine whether the law could be altered to increase its protection of the fetus without unacceptably infringing the woman’s rights.

In *R v Collins*, the Court of Appeal has strongly affirmed the right of the competent pregnant woman to refuse consent to medical treatment regardless of any detrimental effect either to herself or her fetus. Likewise, *Re MB* holds that the interests of the fetus have no bearing on the woman’s right to self-determination. However, despite its powerful affirmation of the primacy of autonomy I show that the Court of Appeal has left significant leeway for the concerned physician - or judge - to circumvent the woman’s decision by finding her temporarily incompetent. The subjective nature of the current competence assessment tests and the use of temporary factors - such as pain, drugs and labour itself - allows backdoor paternalism.

The failure of the courts to assess the public policy implications of the situation, and the obvious judicial sympathy for the fetus, suggest that the legal balance may be weighted too heavily in favour of the woman. However, analysis of statute law, common law and government publications suggests that society would not support the protection of the fetus at the expense of the woman. This is confirmed by European human rights law. Likewise, I argue that the moral value of the fetus is insufficient to allow it to trump the woman’s rights. Finally, I argue that neither criminal nor tort liability are justified in trying to protect the fetus against the woman’s refusal of consent to treatment.

**A Critical Examination of R v Collins and the
Pregnant Woman's Right to Refuse Treatment**

Alasdair Rhuairidh Maclean

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**Thesis submitted for the degree of
Master of Jurisprudence**

The University of Durham

Department of Law



23 MAY 2000

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Declaration

None of the material in this thesis has previously been submitted for a degree in this or any other university. None of the material is the result of joint research.

Statement of Copyright

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Introduction

In October 1992 the 'caesarean section debate'¹ crossed the Atlantic when, in *Re S*,² the High Court considered whether doctors could lawfully perform a caesarean against the will of a competent woman. This aspect of the maternal-fetal conflict first emerged in the U.S. more than ten years previously. *Jefferson*,³ in which the Supreme Court of Georgia upheld the compulsory caesarean order made by the lower court, was the first officially reported case.⁴ The conflict raged in America for almost ten years until *Re AC*.⁵ This case concerned an unfortunate woman in the latter stage of terminal cancer who was 26 weeks pregnant when doctors estimated her life expectancy as only 24 to 48 hours.⁶ The District of Columbia Court of Appeals, in reversing the original compulsory caesarean order, held that the trial judge was wrong to balance AC's rights against those of the state and that a competent refusal of consent must be respected in 'virtually all cases'.⁷ Sadly, we were destined to play out the same judicial farce that had already been reconciled in America.

In *Re S*, a 30 year old woman, in her third pregnancy, was admitted post-term with ruptured membranes and a transverse fetal lie. S refused consent to a caesarean for religious reasons. The situation was described as a matter of 'life and death'⁸ with both mother and fetus at risk. In under an hour Sir Stephen Brown P held that - on the basis of *Re T*⁹ and *Re AC*¹⁰ - a non-consensual caesarean was lawful (figure 1).

¹ Thorpe, LJ. 'The Caesarean Section Debate' [1997] 27 *Fam. Law* 663.

² *Re S* [1993] 1 FLR 26.

³ *Jefferson v Griffin Spalding County Hospital Authority*, 274 SE 2d 457 (Ga 1981).

⁴ Rhoden, NK. 'The Judge in the Delivery Room' [1986] *California Law Review* 1951.

⁵ *Re AC*, 573 A 2d 1235 (1990).

⁶ Noble-Allgire, AM. 'Court-Ordered Cesarean Sections' (1989) 10 *The Journal of Legal Medicine* 211.

⁷ *Op cit.* n.5 at 1249.

⁸ *Op cit.* n.2 at 27.

⁹ *Re T (Adult: Refusal of Medical Treatment)* [1992] WLR 782.

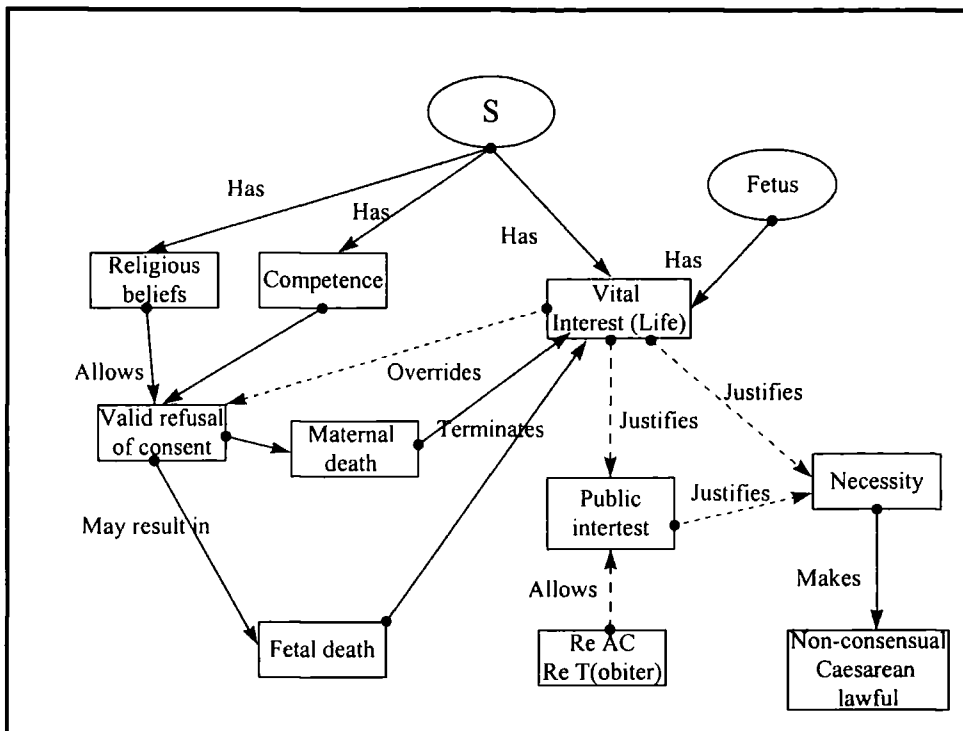


Figure 1: Interpretation of the possible basis for the decision in *Re S*. The dashed lines represent contentious arguments criticised as not having a good legal basis.

The decision provoked strong criticism with the consensus that *Re S* was wrongly decided¹¹. Thomson states: ‘...the decision in *Re S* appears to ignore what seemed to be a settled requirement for consent to medical treatment when the individual is conscious and mentally competent. ...it also appears to run counter to the view that the fetus in English law does not have a legal personality until it is born alive’.¹² As Montgomery noted: ‘Although the decision was made by the President of the Family Division ...its hurried nature means that it must be treated warily. The basis of the court’s jurisdiction to make the order was barely discussed, nor was any clear explanation given of the reasons for the decision’.¹³ Stern,

¹⁰ Op cit. n.5.

¹¹ Plomer, A. ‘Judicially Enforced Caesareans and the Sanctity of Life’ (1997) 26 *Anglo-American Law Review* 235 at 236.

¹² Thomson, M. ‘After *Re S*’ [1994] 2 *Med. Law Rev.* 127 at 130.

¹³ Montgomery, J. *Health Care Law* (1997) at 404.

interprets the decision as based on the public interest in the fetus and believes: 'the decision in *re S* represents a worrying policy preference for the rights of an unborn child over those of a pregnant woman'.¹⁴ And Hewson comments that: 'The President took a consequentialist view of pregnant women in *Re S*, opening up alarming vistas of obstetric coercion. ...But allowing obstetricians to cut open women's bodies against their will, as the means of saving their foetuses, is open to powerful moral and legal objections'.¹⁵ Lord Justice Thorpe, however, while arguing for the need for legislation in this area, believed: 'the President's decision was not without foundation in law'¹⁶ and 'the President, certainly at that date, was fully entitled to draw support from the USA jurisprudence which, although clearly divided on the issue, demonstrated instances in which the jurisdiction had been found and the discretion similarly exercised'.¹⁷

The only English authority referred to in *Re S* was Lord Donaldson MR's *dictum* in *Re T*. This case concerned the lawfulness of administering a blood transfusion to a young woman who lay unconscious on intensive care following a caesarean¹⁸. Although not herself one, T had, after talking with her Jehovah's witness mother, refused consent to a blood transfusion during the caesarean. The court at first instance declared that, since T's refusal of blood only covered the caesarean - not the postoperative emergency that had arisen - it would be lawful, as in her best interests, for doctors to transfuse blood. T's appeal was dismissed as her decision to refuse consent was vitiated by the change in circumstances and the undue influence exerted by her mother. The *dictum* relied on in *Re S* was: 'An adult patient who, like Miss T, suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the

¹⁴ Stern, K. 'Court-Ordered Caesarian Sections: In Whose Interests?' [1993] 56 *MLR* 238 at 243.

¹⁵ Hewson, B. 'Ethical Triumph or Surgical Rape?' (1993) 137 *SJ* 1182.

¹⁶ *Op cit.* n.1.

¹⁷ *Ibid.*

¹⁸ *Op cit.* n.9.

treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable foetus'.¹⁹

Sir Stephen Brown P held that *Re AC*²⁰ indicated 'that if this case were being heard in the American courts the answer would be likely to be in favour of granting a declaration'.²¹ This was an unfortunate choice because the District of Columbia Court of Appeals reversed the lower court's decision to order a compulsory caesarean.²² As Thomson notes: 'Re AC does not validate, or support, compelled medical treatment against the wishes of a competent patient in order to save or benefit the life of a fetus... It is seen as very clearly stating that a competent patient cannot be compelled to undergo major invasive surgery, even if failure to do so will result in the death of the fetus'.²³ However, some justification for Sir Stephen Brown P's use of *Re AC* as an authority can be found in that court's discussion of *Re Madyun*²⁴. In *Re Madyun* the court ordered a caesarean where there was strong evidence that both the mother and baby would benefit physically. *Re AC* neither approved nor disapproved of this decision which, as noted by Teff: 'did leave open the possibility that intervention was lawful on facts very similar to *Re S*'.²⁵

Following *Re S*, the ethics committee of the Royal College of Obstetricians and Gynaecologists advised against seeking court orders in similar circumstances.²⁶ They produced a report concluding: 'It is inappropriate, and unlikely to be helpful or necessary, to invoke judicial intervention to overrule an informed and competent woman's refusal of a

¹⁹ Op cit. n.9 at 786, per Lord Donaldson MR.

²⁰ Op cit. n.5.

²¹ Op cit. n.2 at 27.

²² Op cit. n.5 at 1249.

²³ Op cit. n.12 at 128.

²⁴ 114 Daily Washington Law Report 2233 (D.C. super Ct., 1986)

²⁵ Teff, H. *Reasonable Care* (1994) at 152.

²⁶ Dimond, B. 'Forcing the Issue' (1996: 14th November) *Health Services Journal* 9.

proposed medical treatment, even though her refusal might place her life and that of the foetus at risk'.²⁷ However, other cases followed.

There have been seven reported instances where an English court has considered the lawfulness of a non-consensual caesarean. In the first and last cases (*Re S* and *Collins*) the court dealt with women competent to determine their own treatment decisions. In *Rochdale*,²⁸ a woman, competent in the eyes of her obstetrician, was deemed incompetent by the judge because she was emotionally upset by the pain and stress of labour. In two cases the courts held the women to be incompetent because a needle phobia rendered them incapable of weighing information in the balance.²⁹ In the other two cases the women were more clearly incompetent with one suffering from paranoid schizophrenia and the other denying that she was even pregnant.³⁰ In all cases, the first instance decision was to override the woman's refusal and declare a non-consensual caesarean lawful. Two of the cases went to the Court of Appeal: in *Re MB*,³¹ the women suffered from a needle phobia and the order was upheld; in *Collins* the first instance decision was overruled and the Court of Appeal upheld the primacy of the woman's autonomy.³² However, the Court of Appeal hearing was after the event, the baby had already been delivered, and no lives were at stake.

As Thorpe LJ noted: 'It is, perhaps, easier for an appellate court to discern principle than it is for a trial court to apply it in the face of judicial instinct, training, and emotion. Applications in Caesarean cases are confined to judges of the Family Division. Those judges are dedicated to upholding child welfare. It is simply unrealistic to suppose that the preservation of each

²⁷ RCOG. *A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Interventions* (1994) at 5.12.

²⁸ *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274.

²⁹ *Re MB* [1997] 2 FCR 541; *Re L* [1997] 1 FCR 609.

³⁰ *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762; *Norfolk and Norwich Healthcare (NHS) Trust* [1996] 2 FLR 613.

³¹ *Re MB* [1997] 2 FCR 541.

³² *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* [1998] 3 All ER 673.

life will not be a matter of equal concern to the Family Division judge surveying the medical dilemma. Whatever emphasis legal principle may place upon adult autonomy with the consequent right to choose between treatments, at some level the judicial outcome will be influenced by the expert evidence as to which treatment affords the best chance of the happy announcement that both mother and baby are doing well. Unless the recognition of this consideration is legitimated there is an obvious risk of strained reasoning, increased litigation both at first instance and on appeal, and stress in interdisciplinary co-operation'.³³

It is this emotional pressure and judicial instinct that makes the caesarean cases so hard. The woman's decision, to refuse a caesarean, may be difficult to understand for someone with different beliefs and their choice may seem 'morally repugnant'.³⁴ The death of a fetus during childbirth is tragic and when that death is preventable, excepting an incomprehensible decision of the pregnant woman, the pressure is on the judge to reach a decision that will result in two live people. Rhoden believes: 'The dilemma is so difficult that it borders on the intractable'.³⁵ In *Re T*, Lord Donaldson MR described the situation as a 'novel problem of considerable legal and ethical complexity'.³⁶ Its complexity arises from the conflict between autonomy and the sanctity of life both of which society values and protects by the law. However, neither receive absolute protection and the court must decide which principle has primacy. Where the person refusing treatment is not pregnant this is settled with public policy and legal precedent supporting the individual. As Lord Donaldson MR stated: 'It is well established that in the ultimate the right of the individual is paramount'.³⁷ The presence of a fetus, however, has a powerful effect on the situation.

³³ Op cit. n.1 at 663-664.

³⁴ Op cit. n.32 at 692.

³⁵ Op cit. n.4 at 1954.

³⁶ Op cit. n.9 at 786.

³⁷ Ibid. at 796.

Pregnancy is a unique physical state in which a developing fetus progressively approaches personhood enclosed within the woman. Anything affecting the woman is also likely to affect the fetus and any need the fetus has must be met through the woman's body. When it was not possible to assess, monitor or treat the fetus there was no moral or legal conflict and what was good for the mother was good for the fetus. The only patient to consider was the woman. With the advent of new medical technologies, allowing it to be monitored and treated, the fetus has become a second patient.³⁸ As Nelson and Milliken note: 'As a result of the rapid development of obstetric knowledge and technology, the physician's relationship to the fetus has changed dramatically'.³⁹ The woman has always had to balance her own interests with those of her fetus but now the doctor and - through the doctor - the state have also become embroiled in the conflict.

The conflict is all the more impassioned because it does not affect the moral community evenly. Women are cast as the villains with the unborn child as the innocent victim and the medical profession - an essentially masculine establishment - the moral saviour. Non-consensual caesareans are major infringements of women's rights and are considered by feminists to be another example of masculine control. Gallagher states: 'The fetus's emergence as patient, plaintiff and even quasi-religious icon serves as a vehicle for efforts to reinforce the claims of traditional maternal norms and gender roles on white, Anglo women'.⁴⁰ Later she states: 'The most draconian expression of this none-too-subtle gender warfare is the court-ordered cesarean section'.⁴¹ Some authors question whether the fetal rights movement treats women simply as 'fetal containers'⁴² and Hewson considers non-

³⁸ Nelson, LJ. Milliken, MD. 'Compelled Medical Treatment of Pregnant Women' (1988) 259(7) *JAMA* 1060.

³⁹ *Ibid.*

⁴⁰ Gallagher, J. 'Collective Bad Faith: 'Protecting' The Fetus'. In: Callahan, JC.(Ed) *Reproduction, Ethics, and the Law: Feminist Perspectives* (1995) 343 at 345.

⁴¹ *Ibid.* at 346.

⁴² Annas, GJ. 'Pregnant Women as Fetal Container' (1986) *Hastings Center Report* 13.

consensual caesareans to be the equivalent of 'surgical rape'.⁴³ The position is concisely stated by Johnsen: 'By creating an adversarial relationship between the woman and her fetus, the state provides itself with a powerful means for controlling women's behaviour during pregnancy, thereby threatening women's fundamental rights'.⁴⁴

The American experience was further complicated by the disproportionate number of women from ethnic minorities being challenged by the state. In 1987 Kolder et al reported a national survey of the United States: in 21 cases, across 11 states, court orders for compulsory caesareans were successfully sought in 86%. In 81% of the successful cases the women were non-white and 24% did not speak English as their first language.⁴⁵ Because of the differences between the healthcare systems this form of discrimination may be less likely to occur in the U.K. than the U.S. However, as Daniels states: 'Women who differ from their medical or legal practitioners in race, ethnicity, religion or class are less likely to be seen as rational actors in the healthcare and legal systems'.⁴⁶ Thus the danger remains that women who do not fit the doctor's view of a culturally acceptable norm may have their competence questioned more readily than would white middle-class women.

The caesarean debate is a difficult moral and legal problem further complicated by the potential for discrimination against pregnant women in general and non-white women in particular. By adopting a neutral stance and considering the moral and legal dilemma from both the woman's and the fetus' situation, I will avoid either undervaluing the fetus or subjugating the woman's rights to her reproductive function. Using *Collins* as a springboard I will discuss the current legal position, the legal developments that preceded the case and the

⁴³ Op cit. n.15.

⁴⁴ Johnsen, DE. 'The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection' (1986) 95 *Yale Law Journal* 599.

⁴⁵ Kolder, VEB. Gallagher, J. Parsons, MT. 'Court Ordered Obstetrical Interventions' (1987) 316 *NEJM* 1192.

⁴⁶ Daniels, CR. *At Women's Expense* (1993) at 136.

implications that the case holds for pregnant women. I will consider the legal and moral rights of the pregnant woman, in both domestic law and under the European Convention on Human Rights, and how those rights may be affected by third party interests. I will also discuss the legal and moral status of the fetus. Finally, I will consider whether the current law achieves the correct balance of legal protection for the moral rights of the relevant actors and whether any possible improvements may be made. The aims of this thesis are thus: to provide a balanced, unbiased analysis of the maternal-fetal conflict as it relates to the caesarean debate using the judgment in *Collins* as a starting point; and to analyse whether the law could be changed to provide greater protection for the fetus without unacceptably infringing the woman's rights.

Part One: The Caesarean Cases

Chapter One: R v Collins⁴⁷ and the Competent Woman

Collins was the most recent of a short series of cases concerning the lawfulness of doctors overriding a pregnant woman's refusal of consent to a caesarean. Apart from *Rochdale*,⁴⁸ in which the judge's decision that the woman was incompetent was questionable, the only other case involving a competent woman was *Re S*.⁴⁹ As the first Court of Appeal judgment to consider the right of a competent, pregnant woman to refuse treatment as part of the *ratio*, *Collins* represents the current legal situation. *Collins* has added significance because the caesarean was indicated on both maternal and fetal grounds rather than solely for fetal benefit (*infra* p.25).

The Facts

S was a 28 year old veterinary nurse who, at 36 weeks of gestation, sought to register as a new patient with a GP. She was diagnosed with pre-eclampsia severe enough to require hospital admission and an induction of labour. S was advised as to the potentially life-threatening risks to her and her baby. It was accepted that she understood the risks but she rejected the advice because, as she later documented: 'I have always held very strong views with regard to medical and surgical treatments for myself, and particularly wish to allow nature to "take its course", without intervention'.⁵⁰

⁴⁷ Op cit. n.32.

⁴⁸ Op cit. n.28.

⁴⁹ Op cit. n.2.

⁵⁰ Op cit. n.32 at 681.

She was compulsorily detained for assessment under s.2 Mental Health Act (MHA) 1983 justified by; a previous diagnosis of moderate depression, her own admission that she was probably depressed and her GP's statement that her 'mental state may be compromising her ability to make decisions'.⁵¹ However, the real concern was for the fetus and S's physical health and this was highlighted by the approved social worker: 'I do not think that a psychiatric ward was the best place for this patient, but I felt the gravity of the situation was such that she needed some sort of safety containment, assessment and immediate treatment when necessary'.⁵² An *ex parte* declaration that a non-consensual caesarean would be lawful was granted, a caesarean was performed and the baby safely delivered. At no point during her detention was S treated for any mental disorder.

The Court of Appeal's Judgment

S was held competent and the three principles then considered were: autonomy, the legal status of the fetus and the application of the MHA 1983. The Court of Appeal recognised that the right of the individual to decide whether to accept or refuse medical treatment was an established legal principle. A doctor who treated a patient in the face of their refusal would be committing a trespass. It also decided that it was well established that the fetus had no independent existence or legal recognition as a person. Combining these two principles the court concluded: 'In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law... .an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished

⁵¹ Op cit. n.32 at 678.

⁵² Op cit. n.32 at 679.

merely because her decision to exercise it may appear morally repugnant'.⁵³ Thus, the Court of Appeal held that the 'perceived needs of the foetus'⁵⁴ could not justify an infringement of the mother's autonomy (Figure 2).⁵⁵

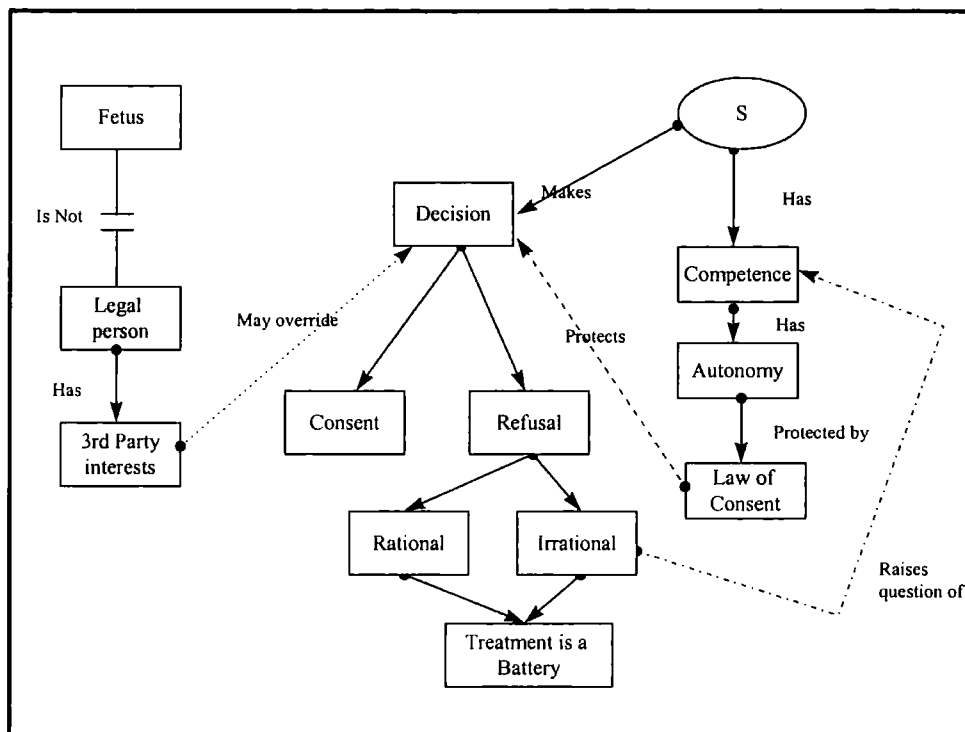


Figure 2: A model of the argument in *Collins*.

Discussion

A competent woman's refusal of a caesarean raises three questions. The first is whether, disregarding the fetus, the woman has the right to refuse consent to medical treatment when her own health and life are at risk. Such an action creates a moral dilemma between the woman's autonomy and society's interest in preserving her well-being and life. It is well established in English law that the individual's right of autonomy trumps the state's interest in the preservation of life.⁵⁶ In *Bland*,⁵⁷ Lord Keith stated: 'Even when his or her own life

⁵³ Op cit. n.32 at 692.

⁵⁴ Ibid.

⁵⁵ The procedural improprieties in this case are not relevant to this thesis.

⁵⁶ Op cit. n.9 at 796.

⁵⁷ *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

depends on receiving medical treatment an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination'.⁵⁸ The Court of Appeal, in *Collins*, was correct in restating this principle and in noting that any invasion of the woman's body without her consent would amount to a battery.⁵⁹

Since the fetus is absolutely dependent upon the pregnant woman, it might be argued that her refusal of consent to medical treatment beneficial to the fetus constitutes a 'harm'. According to JS Mill's 'Harm Theory', the only justification for overriding an individual's autonomous decision is where a third part will be 'harmed'. Thus, the second question is whether the presence of a viable fetus affects the woman's right to refuse consent. It is an important aspect of this case that this question was considered as part of the *ratio*. In *Re S*, although not explained, the court's decision appeared to rely on public interest in the fetus,⁶⁰ rather than the fetus' rights *per se*, as justification for overriding a competent woman's refusal.

The Court of Appeal in *Collins* stated: 'In the present case there was no conflict between the interests of the mother and the foetus; no one was faced with the awful dilemma of deciding on one form of treatment which risked one of their lives in order to save the other'. The second half of the statement refers to the point I raised earlier; that the caesarean was indicated on both fetal and maternal grounds. This is important because, if indicated solely for fetal benefit, a caesarean causes a set-back to the physical well-being of the woman. If performed without her consent then, not only has she suffered an infringement of her autonomy and bodily integrity but her welfare interest⁶¹ in her health has also been harmed.

⁵⁸ *Ibid.* at 860 per Lord Keith.

⁵⁹ *Collins v Wilcock* [1984] 3 All ER 374 at 378 per Goff LJ; See Chapter 3.

⁶⁰ See p.13.

⁶¹ Feinberg, J. *Harm to Others* (1984) at 37. Welfare interests include; continuance of life, physical and mental health, emotional stability, freedom from interference.

Where a non-consensual caesarean is performed on maternal grounds then any infringement of autonomy and bodily integrity is offset by the overall beneficial effect that the operation has on her welfare interest in her health. Thus a non-consensual caesarean performed on both maternal and fetal grounds causes less harm to the woman (Figure 3) than one performed solely for the benefit of the fetus (figure 4). This does not mean that the benefit to her health outweighs the infringement of her autonomy and bodily integrity. Rather, upholding the woman's right to refuse consent despite physical benefits to both her and her fetus is a far stronger statement of protection for the right of autonomy than if it were upheld in the face of physical benefit to the fetus but physical detriment to the woman.

While the second half of their statement was valid and obviously important, the initial point made by the Court of Appeal - that 'there was no conflict between the interests of the mother and the foetus' - is, with respect, clearly wrong. The fetus has no autonomy and no ulterior interests.⁶² Its only 'interests' are its health and being born alive as these are pre-requisites for autonomous life. By denying the fetus the most beneficial mode of delivery the woman causes a set-back to those interests. Providing the woman's choice is based on either her welfare or ulterior interests, as it was in *Collins*, then there must be a conflict between the woman's and fetus' interests. The Court of Appeal's statement would only be correct if it was taken to mean that there was no conflict between the woman's and fetus' *health* interests. But, by equating 'interests' with 'interests in health' the Court of Appeal makes the same mistake as many healthcare professionals: that the effect on the patient's health is the only important variable. This ignores many other welfare, and almost all ulterior, interests and also implies that the woman's decision was not based on any important 'interest'. However, the Court of Appeal in *Collins* still held that the competent pregnant woman had the right to

⁶² Op cit. n.61. Ulterior interests include; a successful career and family life and achieving personal goals.

refuse medical treatment regardless of her own life or that of her fetus, even if the decision 'appear[s] morally repugnant'.⁶³

It is well established in English law that although the fetus has some protected rights it has no *locus standi* to assert those rights until it is born alive.⁶⁴ Thus *Collins*, in protecting the woman's autonomy ahead of the fetus, was correct as far as it went. It failed to consider, however, the situation if the fetus was born alive but damaged - or if it subsequently died - because the mother rejected medical advice. In *Attorney-General's Reference (No. 3 of 1994)* the House of Lords held that injuring a child *in utero* could give rise to liability for manslaughter if the child dies subsequent to a live birth.⁶⁵ Although the case concerned unlawful act manslaughter it would be logical that gross negligent manslaughter is similarly possible. Could an unreasonable or irrational refusal of a caesarean be considered gross negligence? If yes then, a woman who refuses a caesarean - where the child dies subsequent to a live birth - may be guilty of manslaughter. This would be a draconian and undesirable way of 'policing pregnancy'.⁶⁶ By failing to address this question *Collins* has left open the 'lacuna' uncovered in *Attorney-General's Reference (No. 3 of 1994)*.

⁶³ Op cit. n.32 at 692.

⁶⁴ *Paton v BPAS* [1979] 1 QB 276.

⁶⁵ *Attorney-General's Reference (No. 3 of 1994)* [1997] 3 WLR 421.

⁶⁶ Fovargue, S. Miola, J. 'Policing Pregnancy: Implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6 *Med. Law Rev.* 265.

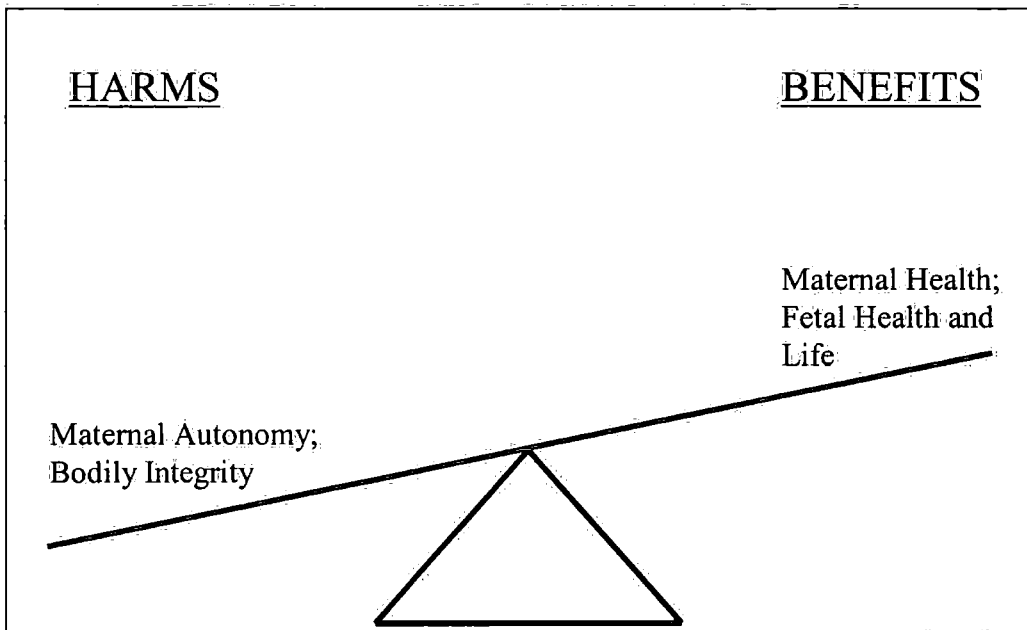


Figure 3: The balance between the harms and benefits when a non-consensual caesarean is performed on both maternal and fetal grounds.

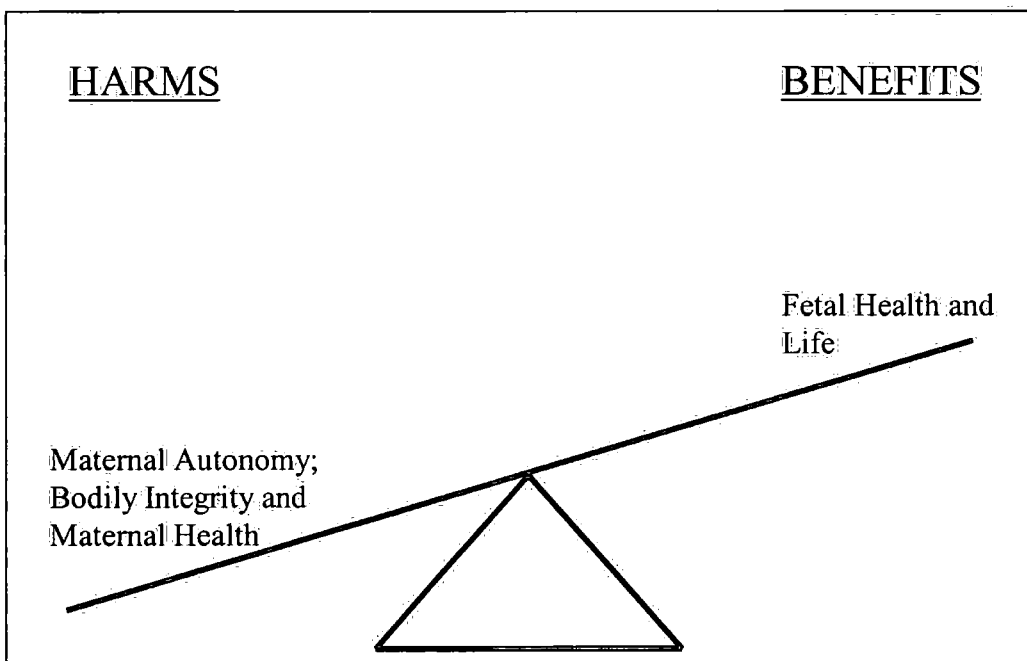


Figure 4: The balance between the harms and benefits when a non-consensual caesarean is performed solely on fetal grounds.

The third question that should have been addressed is whether any other interests might curtail the pregnant woman's right. The most important of these is the public interest. Autonomy and consent are not absolute concepts and public policy may vitiate consent where serious injury is caused.⁶⁷ Refusing consent to a procedure that prevents harm is as much a cause of harm as giving consent to an act that produces harm. Therefore, public policy must be relevant where a refusal of consent may result in such harm.

In *Re S*, Sir Stephen Brown P referred to *Re AC* and Lord Donaldson MR's *dictum* in *Re T* suggesting that public policy played a major role in his decision. In other caesarean cases public policy was side-stepped because the court protected the fetus by finding the woman incompetent. *Re MB* has been specifically criticised for, *inter alia*, failing to consider policy issues.⁶⁸ The Court of Appeal in *Collins* similarly failed to consider any of the potentially relevant public interests. It did consider the fetus' self-interests, but there is a marked distinction between those self-interests and the public interest in preserving the life and health of the fetus. Although *Collins* overrules *Re S* the question of public interest in the fetus remains open. In *Re F*⁶⁹ the Court of Appeal decided that, as a legal non-person, the fetus of a mentally disturbed, drug abusing pregnant woman could not be made a ward of court. Balcombe LJ saw any extension of the law, 'so as to impose control over the mother of an unborn child', as a matter for Parliament.⁷⁰ Since *Collins* involves a similar infringement of the woman's rights if the fetus is to be protected then it may be that the correct place to establish the balance of society's interest is in Parliament. Indeed, Judge LJ, in *Collins*⁷¹ quoted Balcombe LJ (*supra*), which suggests it was his reason for avoiding public interest

⁶⁷ R v Brown [1993] 2 All ER 75.

⁶⁸ Stauch, M. 'Court-Authorised Caesarians and the Principle of Patient Autonomy' (1997) 6 *Nottingham Law Journal* 74.

⁶⁹ Re F (*in utero*) [1988] FCR 529.

⁷⁰ Ibid. at 538 per Balcombe LJ.

⁷¹ Op cit. n.1 at 689-690.

issues. However, it is necessary for these issues to be formally discussed and the status of the fetus in the context of the public interest made more certain (see p.91).

Although the Court of Appeal in *Collins* delivered a useful judgment regarding the MHA 1983 and the procedural elements of applying for a declaratory order, their consideration of the issue of competence was, like previous cases, inadequate. The tenor of the judgment suggests that the Court of Appeal believed S to be obviously competent. It was perhaps because of this that Judge LJ only felt it necessary to re-iterate Lord Donaldson MR's view of a risk-related standard: 'What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health. Others may not'.⁷² However, it is clear that the flexibility of this concept allows the court - or the doctors - to manipulate the assessment of competence in a way that is easiest on their conscience. Perhaps this is what Thorpe LJ had in mind when he warned of the '...obvious risk of strained reasoning, increased litigation... ..and stress in interdisciplinary co-operation'.⁷³

The Court of Appeal in *Collins* was wrong to accept the risk-related standard. It requires a higher standard of competence when the health risk is great compared to when it is low. Since medical treatment is only justified if, on balance, it is beneficial then a refusal of treatment creates a greater health risk than does consenting. It follows that a risk-related standard allows a doctor to raise the level of competence when a patient rejects their advice. Thus, where the risk is high, as in the refusal of caesarean, a risk-related standard makes it considerably easier to circumvent an unconscionable decision.

⁷² Op cit. n.9 at 789 per Lord Donaldson MR.

⁷³ Op cit. n.1 at 664.

When a woman puts her own life and that of her fetus at risk, doctors and the courts, may feel under moral and emotional pressure to move the goal posts and demand an unreachable level of competence of the woman in order to protect her fetus: 'By and large doctors (and other health professionals) are more likely to be guided in their decision-making by conscience (or what seems to them to be the right course) than by any legal constraints'.⁷⁴ Thorpe LJ, hints that the same propensity may be found in the judges of the Family Division.⁷⁵ A risk-related standard effectively means that, where there is a high risk, the only real option open to the patient is to consent and thus paternalism sneaks in through the back door. A pregnant woman who refuses consent may be deemed incompetent which means her only 'choice' is to accept the doctor's advice. Since choice may be defined as the: 'act of choosing between two or more possibilities'⁷⁶ then a risk-related standard denies the woman any 'choice' at all. Wicclair neatly summarises the error behind a risk-related standard: '...it is important to recognise that a stronger reason for making sure that a patient is decisionally capable should not be confused with a stronger standard of decision making capacity'.⁷⁷ The level of competence required for a particular decision should be determined by the complexity of that decision and not by the risk involved.

Another way in which *Collins* has left open an escape route from the primacy of autonomy is by accepting, without further comment, that 'fatigue, shock, pain or drugs' affect competence.⁷⁸ Harpwood states: 'difficulties are likely to arise when consent to treatment is sought from women in labour, many of whom may temporarily lack the mental capacity to give consent, because of pain, fatigue or the effects of analgesia'.⁷⁹ As Brazier notes: 'All are

⁷⁴ Wear, AN. Brahams, D. 'To Treat or not to Treat: the Legal, Ethical and Therapeutic Implications of Treatment Refusal' (1991) 17 *Journal of Medical Ethics* 131 at 132.

⁷⁵ Op cit. N.1. at 664.

⁷⁶ *Oxford Advanced Learner's Dictionary* (1990).

⁷⁷ Wicclair, MR. 'Patient Decision-Making Capacity and Risk' (1991) 5 *Bioethics* 91.

⁷⁸ Op cit. n.32 at 693.

⁷⁹ Harpwood, V. *Legal Issues in Obstetrics* (1996) at 67.

in so many cases an inevitable part of childbirth'⁸⁰ but, while competence may be affected, their relevance must only exist at the extremes. If this was not the case then all labouring women and emergency patients would be deemed temporarily incompetent. The danger is that a subjective analysis of these factors' effects may tip the balance towards finding a woman incompetent if she rejects medical advice. This is what happened in *Rochdale*⁸¹ when Johnson J found the woman incompetent because her thought process had been affected by the 'throes of labour'. The paternalistic potential of using the woman's state of being in labour is exacerbated by the concomitant use of a risk-related standard. Since the guidelines, detailed in *Collins*, effectively allow doctors to determine competence and only approach the court when in doubt, they are given almost a *carte blanche* to treat a labouring woman in the way *they* feel would be in her best interests. Furthermore, the potential for subjectivity is increased by the *Re C*⁸² test of which the third part - weighing information in the balance to arrive at a choice - allows greatest scope.

The Court of Appeal's restatement of the law relating to autonomy and consent to medical treatment, in *Collins*, was a very strong defence of the individual's right of self-determination: '...how can a forced invasion of a competent adult's body against her will even for the most laudable of motives (the preservation of life) be ordered without irremediably damaging the principle of self-determination? When human life is at stake the pressure to provide an affirmative answer authorising unwanted medical intervention is very powerful. Nevertheless, the autonomy of each individual requires continuing protection even, perhaps particularly, when the motive for interfering with it is readily understandable, and indeed to many would appear commendable'.⁸³

⁸⁰ Brazier, M. 'Hard Cases Make Bad Law?' (1997) 23 (6) *Journal of Medical Ethics* 341.

⁸¹ *Op cit.* n.28.

⁸² *Re C (An Adult: Refusal of Treatment)* [1994] 2 FCR 151. See p.39.

⁸³ *Op cit.* n.1 at 688.

In re-establishing the primacy of autonomy, the Court of Appeal in *Collins* has correctly stated the current law.⁸⁴ However, despite being 'legally sound' the judgment failed to confront the very real problem of the issue of competence being used as a sword by doctors and the courts instead of a shield by the pregnant woman. Hewson is right to describe this situation as a catch-22;⁸⁵ women may only refuse consent if they are competent but any refusal signifies a lack of competence and may be overridden. Whether or not women's rights should take precedence over fetal rights, salving the doctor's - or judge's - conscience by using a conveniently flexible standard of competence cannot be right. Society must have an interest in the protection of *both* mother and fetus. If judges are unwilling to confront the policy arguments then they need urgent consideration by Parliament.

⁸⁴ Kahn, M. 'Right to Bodily Integrity' (1998) 3(2) *Journal of Civil Liberties* 127.

⁸⁵ Hewson, B. 'Could the High Court Order You to Have an Operation?' (1998) 115 *Living Marxism* 24.

Chapter Two: Non-consensual Caesareans and the Incompetent Woman

Three issues spring to mind when considering the treatment (excluding treatment under the MHA 1983) of patients whose competence is in question:

1. competence assessment;
2. the determination of the appropriate treatment; and
3. the legal justification for that treatment.

By considering each of the five caesarean cases - heard in this jurisdiction - in which the competence of the woman was questioned by the court I will analyse how these issues are dealt with in practice.

Temporary Incapacitating Factors

Three cases have considered temporary incompetence: one relied on the pain and stress of labour,⁸⁶ while the other two concerned needle phobias.^{87,88} The issue of temporary incompetence caused by analgesic drugs was raised in *Re L*.⁸⁹ The leading case is *Re MB*,⁹⁰ which is important for its consideration of competence, its procedural guidelines and its *obiter* on the legal position of a competent woman.

Re MB

MB consented to the caesarean but, because of a needle phobia, refused consent to the anaesthesia. At first she agreed to inhalational anaesthesia but withdrew that consent when she saw the mask. The baby was breech and a vaginal delivery was assessed as posing a 50% risk of serious injury to the foetus but little physical risk to the mother. The hospital sought a

⁸⁶ Op cit. n.28.

⁸⁷ *Re L (An Adult: Non-consensual Treatment)* [1997] 1 FCR 609.

⁸⁸ Op cit. n.31.

⁸⁹ Op cit. n.87.

⁹⁰ Op cit. n.31.

declaration that it would be lawful to operate. At first instance, the declaration was granted on the basis that the needle phobia rendered MB temporarily incompetent to decide.⁹¹ Later that evening, the Court of Appeal upheld the declaration.⁹²

The Court of Appeal’s Judgment (See Figure 5)

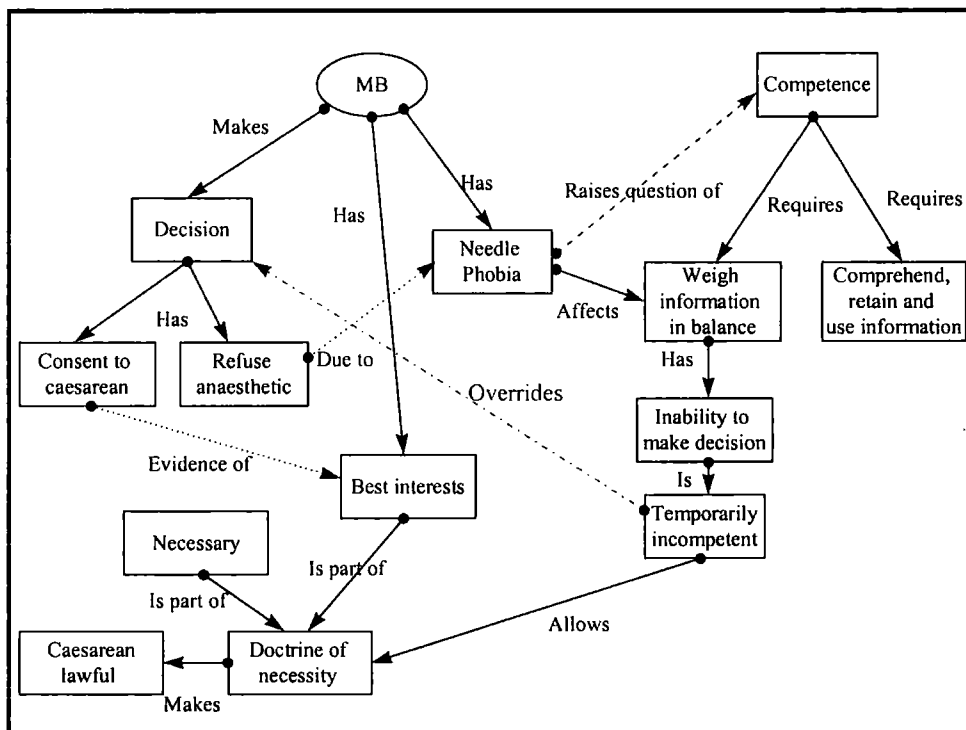


Figure 5: A model of the legal argument in *Re MB*.

The Court held that MB’s will had been ‘paralysed’ by her needle phobia. Although fear may be a rational reason to refuse consent, if - as with MB - that fear is sufficient to ‘paralyse the will’ then the capacity-to-decide is absent. The Court argued that, while not equivalent to incompetence, irrationality may be evidence of it and factors such as shock, pain or drugs may cause temporary incapacity where they ‘were operating to such a degree that the ability

⁹¹ *Re MB (Medical Treatment)*[1997] Fam Law 542.

⁹² *Op cit.* n.31.

to decide was absent'. The Court stated, *obiter*, that there was an 'absolute right' to refuse medical treatment: 'A competent woman who has the capacity to decide may, for religious reasons, other reasons, rational or irrational reasons or for no reason at all, choose not to have medical intervention even though the consequence may be the death or serious handicap of the child she bears or her own death'.⁹³ The Court approved the risk-related standard and also held: 'A person lacked capacity when some impairment or disturbance of mental functioning rendered that person unable to comprehend, retain and use information and weigh it in the balance'. *Re S* and the observation by Lord Donaldson MR in *Re T* were disapproved.⁹⁴

Discussion

The Court of Appeal held that the starting point for any assessment of competence is the presumption of competence.⁹⁵ It was correct in restating this principle as the Law Commission⁹⁶ considered it a 'fundamental concept' and included the principle in their Draft Bill.⁹⁷ However, it may sometimes be difficult for the doctor or judge to follow this requirement when faced with a recalcitrant woman who refuses a caesarean and puts the life of her fetus at risk on the basis of an 'irrational' decision. An example of this difficulty is seen in *Rochdale* (*infra* p.48).⁹⁸ However, the decision itself must be ignored when assessing competence objectively otherwise it is difficult to make a genuine presumption of competence.

⁹³ Op cit. n.31 at 553.

⁹⁴ The court also handed down procedural guidelines not relevant to this thesis.

⁹⁵ Op cit. n.31 at 542.

⁹⁶ Law Commission *Report on Mental Incapacity* (1995) No. 231.

⁹⁷ *Ibid.* at para 3.2.

⁹⁸ Op cit. n.28.

The Court of Appeal in *Re MB* did note that an irrational decision was insufficient to establish incompetence but may be evidence of it. Thus, an irrational decision, while indicating the patient's competence should be questioned, does not equate to incompetence. This is the correct approach to irrationality and incompetence and follows *Sidaway*⁹⁹ and *Re T*, in which Lord Donaldson MR stated: 'This right of choice... exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent'.¹⁰⁰ This principle was included in a green paper on incapacity¹⁰¹ following the Law Commission's proposal: 'a person should not be regarded as unable to make a decision by reason of mental disability merely because he or she makes a decision which would not be made by a person of ordinary prudence'.¹⁰² Roth et al noted the "'reasonable' outcome of choice' test is 'probably used more often than might be admitted by both physicians and courts... .When life is at stake and a court believes that the patient's decision is unreasonable, the court may focus on even the smallest ambiguity in the patient's thinking to cast doubt on the patient's competency so that it may issue an order that will preserve life or health'.¹⁰³

The "'reasonable' outcome of choice test' is based on the syllogism: if treatment is beneficial it would be unreasonable to refuse it; competent patients do not make unreasonable decisions therefore the patient is not competent. This argument is invalid because: firstly, the patient's view of what is in his interests may be different to the doctor's view. The doctor is concerned with the physical health of the patient but the patient may be more interested in other aspects

⁹⁹ *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871.

¹⁰⁰ *Op cit.* n.9 at 786 per Lord Donaldson MR.

¹⁰¹ Lord Chancellor's department. 'Who decides? Making decisions on behalf of the mentally incompetent patients'. (1997) *Consultation Paper*.

¹⁰² *Op cit.* n.96 at para 3.19.

¹⁰³ Roth, LH. Meisel, A. Lidz, CW. 'Tests of Competency to Consent to Treatment' (1977) 134 (3) *American Journal of Psychiatry* 279.

of their life. Thus, what is reasonable to the doctor may not be reasonable to the patient; secondly, competent people do - sometimes - make wrong or unreasonable decisions. If patients possessed ideal rationality then all their decisions would be reasonable. However, perfect rationality is unrealistic and all that should be expected is 'minimal rationality'.¹⁰⁴ This would require only *some* of the patient's decisions to accord with their belief-system and thus incompetence would not follow from an isolated irrational decision. Roth et al conclude: 'The benefits and costs of this test are that social goals and individual health are promoted at considerable expense to personal autonomy. The reasonable outcome test is useful in alerting physicians and courts to the fact that the patient's decision-making process may be, but not necessarily is, awry'.¹⁰⁵ Other authors have also expressed concern about the 'reasonable outcome test'.¹⁰⁶ Likewise, the Mental Health Act Commission stated: 'Outcome, in the sense of agreement or disagreement with the doctor is not a valid guide to capacity or incapacity'.¹⁰⁷ Fennell comments: 'The main point behind this statement by the commission may be to seek to discourage doctors from setting too high a threshold of capacity'.¹⁰⁸ Thus the Court of Appeal in *Re MB* was correct to emphasise the gap between an irrational decision and a finding of incompetence.

Butler-Sloss LJ further protected the competent person by her narrow definition of irrationality: '...a decision which is so outrageous in its defiance of logic or accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'.¹⁰⁹ However, the Court of Appeal stopped short of fully protecting

¹⁰⁴ Cherniak C. *Minimal Rationality*. (1986).

¹⁰⁵ Op cit. n.103.

¹⁰⁶ Gostin L. 'Consent to Treatment: the Incapable Person'. In: Dyer, C. (Ed.). *Doctors, Patients and the Law* (1992) 72.

¹⁰⁷ Mental Health Act Commission. *Third Biennial Report 1987-9*, para. 7.6h.

¹⁰⁸ Fennell P. 'Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder' (1990) 17(1) *Journal of Law and Society*; 29 at 47.

¹⁰⁹ Op cit. n.31 at 553.

the competent person whose decision seems irrational. The deficiency of the judgment is in its failure to discuss that competence should be assessed by analysing the patient's decision-making *ability* and not their actual decision. This is essential to avoid equating an irrational decision with incompetence for making a decision of comparable complexity. Knowledge of the actual decision may taint an assessor's ability to consider the patient's competence objectively. As Roberts notes: 'it may be the case that *what* the patient decides may subtly or overtly influence others' assessment of his capacity'.¹¹⁰ Objectivity may be ensured only by assessing competence before a decision is made or without knowledge of the patient's decision.

The paternalistic reasoning that follows from assessing competence based on the actual decision relies on an illogical syllogism: an irrational decision is evidence of lack of competence to make that decision; being in labour may affect a woman's competence; if a woman in labour makes an irrational decision then she must lack the competence to make that decision. This argument is a *non-sequitur*,¹¹¹ while both premises are arguably correct, the conclusion does not logically follow from them. This non-sequitur is clearly evident in *Rochdale*.¹¹²

Rochdale was considered in *Re MB*: 'One may question whether there was evidence before the court which enabled the judge to come to a conclusion contrary to the opinion of the obstetrician that she was competent. Nonetheless he made the declarations sought'.¹¹³ This mild criticism by Butler-Sloss LJ does not go far enough. By failing to disapprove the

¹¹⁰ Roberts, E. 'Re C and the Boundaries of Autonomy' (1994) 10(3) *Professional Negligence* 98 at 99.

¹¹¹ Popkin, R.H. Stroll, A. *Philosophy* (1993) at 316.

¹¹² *Op cit.* n.28. See p.48.

¹¹³ *Op cit.* n.31 at 551.

decision she has effectively sanctioned a finding of incompetence based, almost entirely, on the actual decision made by the patient. Furthermore, Butler-Sloss LJ commented that the woman changed her mind and consented to the operation. If she was incompetent to refuse consent then surely she was incompetent to give consent. The only difference was that her decision altered from 'irrational' to 'rational'. Unless the finding of incompetence was based on her actual decision, her change-of-mind is irrelevant. By specifically mentioning the woman's change-of-mind, Butler-Sloss LJ has emphasised the importance of the actual decision when assessing competence. This surely runs counter to the principle in *Sidaway* and *Re T* that the reasons for a decision may be: '...rational, irrational, unknown or even non-existent'.¹¹⁴ As de Cruz comments: 'the approach to irrational decisions suggests that there is still considerable scope for refusal of consent to be ignored and for paternalism to reign supreme as ever justified 'in the best interests of the patient''. The legal and ethical debates will undoubtedly continue'.¹¹⁵

The test of capacity recommended in *Re MB* was based on the Law Commission's Report on mental incapacity¹¹⁶ and the test accepted by the court in *Re C*.¹¹⁷ The *Re C* test was:

1. comprehending and retaining treatment information;
2. believing it; and
3. weighing it in the balance to arrive at a choice.

However, the Law Commission - and *Re MB* - dropped the second part of the test. By not requiring belief the Court of Appeal has removed a highly subjective component of the test.

Requiring belief in the information denies the right to question or evaluate that information.¹¹⁸ Autonomy does not mean that information cannot be accepted without

¹¹⁴ Op cit. n.9 at 786 per Lord Donaldson MR.

¹¹⁵ de Cruz, P. 'Caesareans, Consent and the Courts' (1998) 11(1) *Practitioners Child Law Bulletin* 8.

¹¹⁶ Op cit. n.96 at para. 3.2-3.23.

¹¹⁷ Op cit. n.82.

¹¹⁸ Gordon, R. Barlow, C. 'Competence and the Right to Die' (1993) 143 *NLJ* 1719.

investigation, however, one should have good reason for accepting the source of the information as believable.¹¹⁹ Dropping the need for belief implies that the Law Commission and Court of Appeal in *Re MB* accept that doctors are not infallible and that the patient has every right to question the information.

Another difficulty with 'belief' is the tendency to reason abductively from the patient's actual decision: if the patient believes information given by the doctor then, ignoring problems of rationality, they will make the 'right' decision. The patient makes the 'wrong' decision and therefore cannot have believed the information. It is only a small leap-of-faith to argue that because the information was given to them by the doctor and it would have been rational to believe it then not believing it indicates the patient must be irrational and *ipso facto* incompetent. Thus, dropping the second part of the *Re C* test promotes a greater respect for the patient's autonomy.

A significant issue the Court of Appeal has failed to resolve is that the test in *Re C* is applied to the actual decision rather than to the patient's decision-making ability. Applying the test to an actual decision facilitates equating an irrational decision with incompetence. This is especially true of the third part of the test which is extremely vulnerable to subjective analysis and abductive reasoning. As Robbins JA notes in *Mallette v Shulman*, which concerned the right of a Jehovah's witness to refuse - by advance directive - a blood transfusion: 'It is not for the doctor to second guess the reasonableness of the decision or to pass judgement on the religious principles which motivated it'.¹²⁰ Although abductive

¹¹⁹ Benson J. 'Who is the Autonomous Man?' (1983) 58 *Philosophy* 1983.

¹²⁰ *Mallette v Shulman* (1990) 67 DLR (4th) 321 at 336.

reasoning is rational and logically acceptable as evidence it is weaker than deductive or even inductive reasoning.¹²¹ Again it is a leap-of-faith to argue that if a patient does not weigh-up the actual information then they are incapable of weighing-up information generally and hence are incompetent. It is only an *indication* that the patient's competence should be assessed.

The Court of Appeal in *Re MB* appears confused by the concepts of an irrational decision and weighing information in the balance to reach a decision. If weighing information in the balance is applied to the actual decision then this seems diametrically opposed to the fact that the patient's decision is allowed to be based on irrational reasons or even no reasons at all. These concepts may only be reconciled if weighing the information is assessed in the abstract rather than applied to the decision in question. As Stauch notes: 'The suspicion is that, notwithstanding pronouncements to the contrary which endorse the patient's right to make irrational choices, this third element [of the *Re C* test] functions to filter out precisely these kind of choices: an undue attachment on a patient's part to a factor deemed by others of little import is readily translated into a conclusion that the patient cannot weigh up information and is therefore incompetent'.¹²²

The Court of Appeal in *Re MB*, as in *Collins*, accepted that 'temporary factors such as shock, pain or drugs' might affect competence. I have already discussed this issue (*supra* p.30) so it will suffice to point out that these factors allow leeway to find an otherwise competent woman incapable of deciding on their medical treatment. The Court of Appeal attempted to mitigate the risks associated with a subjective analysis by requiring: 'that such factors were operating to such a degree that the ability to decide was absent'. However, unless the judge

¹²¹ Walton D. *Argument structure: a Pragmatic Theory* (1996).

¹²² *Op cit.* n.68 at77.

visits the labouring woman at her bedside the court will have to rely on the doctor's opinion and the doctors are the very people in conflict with the woman. Harpwood notes: 'The wishes of these women may well be ascertainable by examining the birth plans which they made before going into labour, though these might not take account of the fact that some people change their minds after labour commences, particularly in the case of first babies'.¹²³ This potential for a change of mind may negate any advance directive.¹²⁴ Furthermore, 'In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms'.¹²⁵

The Law Commission has suggested a statutory presumption in favour of the preservation of life: '...in the absence of any indication to the contrary it shall be presumed that an advance refusal of treatment does not apply in circumstances where those having the care of the person who made it consider that the refusal (a) endangers that person's life or (b) if that person is a woman who is pregnant, the life of the fetus'.¹²⁶ Thus, a woman who makes a birth plan refusing consent to a caesarean for an abnormal fetal position may find that refusal invalidated if the indication for caesarean changes to become one of fetal distress. Unless she composes an all encompassing advance directive the labouring woman will always be subject to the doctor's paternalism. Even the support for autonomy gained in *Collins* is of little help because the woman in that case was not in labour and each decision depends on 'the particular facts before the court'.¹²⁷ Thus, the current position for labouring women is: an irrational decision may be considered sufficient evidence that the stressful effects of labour, accompanying exhaustion and analgesics have rendered her temporarily incompetent. Any advance directive may be ignored if the circumstances have changed from those predicted.

¹²³ Op cit. n.79 at 77.

¹²⁴ Op cit. n.9.

¹²⁵ Ibid. at 796 per Lord Donaldson MR.

¹²⁶ Op cit. n.96 at para. 5.26.

¹²⁷ Op cit. n.31.

Stauch has further criticised the Court of Appeal's reasoning. Firstly, he claimed that *Re MB*, along with other cases, had 'lost sight of the underlying logic of patient autonomy as it relates to refusal of treatment'.¹²⁸ Upholding an irrational decision, he argued, is not necessarily respecting the patient's autonomy as it depends exactly how the decision fits in with the 'general scheme of the patient's life'. He believes that the test in *Re C* is too vague and allows a subjective analysis of competence. Instead, the courts should amend the test of competence to take into account the 'general scheme of the patient's life'. This approach to competence corresponds with Kennedy's view: '... if the beliefs and values of the patient, though incomprehensible to others, are of long standing and have formed the basis for all the patient's decisions about his life, there is a strong argument to suggest that the doctor should respect and give effect to a patient's decision based on them. That is to say that the doctor should regard such a patient as capable of consenting (or refusing). To argue otherwise would effectively rob the patient of his right to his own personality which may be far more serious and destructive than anything that could follow from the patient's decision as regards a particular proposed treatment'.¹²⁹ This viewpoint may be the appropriate approach when dealing with an individual. However, where third parties are affected, irrational beliefs, value-sets and decisions are less easily accepted.

Secondly, while accepting that: 'the court does not have jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child',¹³⁰ Stauch, criticises the court for 'assuming that a court will *never* have jurisdiction to declare treatment lawful in such a case, i.e. on other grounds'.¹³¹ He points out that this is contrary to other recent authorities and 'as a judicial tool, declaratory relief has been developed precisely to

¹²⁸ *Op cit.* n.68 at 79.

¹²⁹ Kennedy, I. 'Consent to Treatment: the Capable Person'. In: Dyer, C. (Ed). *Doctors, Patients and the Law* (1992) at 56.

¹³⁰ *Op cit.* n.31 at 561.

¹³¹ *Op cit.* n.68 at 81.

provide assistance to those, such as doctors, who are faced with urgent ethical dilemmas in situations of legal uncertainty'. He suggests that *Re S* may have been just such a case: 'a case where a pregnant woman will die without obstetric intervention, also possesses features which set it apart from other cases in which life-saving treatment is refused. Most obviously, not only the woman but also her foetus, which (whatever its other attributes) is a potent symbol of life, stands to die.'¹³² He concludes: 'given its failure even to begin the task [of analysing the issues], the Court of Appeal's decision in *Re MB* (effectively) to overrule *Re S* must, at the very least, be open to question'.¹³³

The actual decision in *Re MB* concerned the irrational refusal of a caesarean because MB suffered from a needle phobia. Whether a fear of needles is sufficient to render a woman incompetent to refuse a caesarean must be a matter of degree and this was recognised by the Court of Appeal when it held that a patient is rendered incompetent when the fear is sufficient to 'paralyse the will'.¹³⁴ A fear becomes a phobia when it significantly interferes with the person's life and quite properly the Court of Appeal recognised that a fear of this degree would prevent the woman from making the decision compatible with her autonomous-self. The evidence was that MB, in theory, consented to the caesarean. However, because of her needle phobia she was unable to consent to intravenous anaesthesia. Thus, it is clear that MB's needle phobia was preventing her from pursuing her preferred option of a caesarean. The Court of Appeal clearly made the correct decision which, while it infringed the woman's liberty in restricting her irrational self, in fact promoted her autonomy.

¹³² Op cit. n.68 at 84.

¹³³ Ibid. at 84.

¹³⁴ Op cit. n.31 at 542.

In conclusion, the Court of Appeal correctly decided that MB's will was paralysed by her needle phobia. However its treatment of irrationality and competence was confused and inconsistent. It is hard to reconcile the Court of Appeal's acceptance that the woman's decision may be based on irrational reasons with the application of the modified *Re C* test to the actual decision. This is compounded by its failure to disapprove *Rochdale*. Acceptance of the third part of the *Re C* test also allows a subjective analysis of the patient's competence based largely on the doctor's interpretation of their decision. Furthermore, the Court of Appeal's *dictum* that the 'court did not have the jurisdiction to take the interests of the foetus into account'¹³⁵ is suspect given that it failed to consider all of the relevant issues including, most notably, the public interest in the fetus. Thus, as in *Collins*, the Court of Appeal has failed to restrict the leeway, allowed by the flexibility of the tests used to assess competence, to override a pregnant woman's refusal of consent.

Re L¹³⁶

L had been in labour for 8 hours without cervical dilation and her obstetrician believed the baby would die without intervention. L agreed in principle to the caesarean but, because of her needle phobia, refused intravenous anaesthesia. She did agree to inhalational anaesthesia but the anaesthetist was unwilling to perform a gaseous induction because of the risk of gastric inhalation and its potentially fatal outcome. At the time of the hearing, L was felt to be confused as a result of using nitrous oxide/oxygen inhalational analgesia.

¹³⁵ Op cit. n.31 at 542.

¹³⁶ Op cit. n.87.

The Judgment

Kirkwood J granted the declaration sought and stated: 'her extreme needle phobia amounted to an involuntary compulsion that disabled L from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled L against medical advice with such force that her own life would be in serious peril. Accordingly, I held that L... lacked the relevant mental competence to make the treatment decision'.

Discussion

The legal argument (Figure 6) is similar to that in *Re MB* except that Kirkwood J did not consider the potential effect of the fetus on a competent woman's decision and the *Re C* test was accepted in its entirety. Although Kirkwood J described the effect of the needle phobia as 'an involuntary compulsion' rather than a fear that 'paralyse[d] the will', these phrases are essentially different ways of describing the same phenomenon. There are two points worthy of mention:

firstly - although not essential to the judgment - L was held to be confused due to inhalational analgesia. As Douglas comments: 'The present case... appears to confirm the view that pain-relieving treatment given in labour - here gas and air - may itself cause a patient to become incapable and thus be used as part of the evidence to justify overriding her wishes'.¹³⁷ I have already discussed the issue of the effect of temporary factors, such as analgesics, on competence (p.30 & 41). However, it is worth noting that 'gas and air' (nitrous oxide/oxygen) has a rapid onset and an almost equally rapid offset. Although at its peak effect 'gas and air' probably does affect competence it would only take 2-3 minutes for the effects to largely wear off. In many cases, especially where the contractions are more than

¹³⁷ Douglas, G. 'Re L (Patient: Non Consensual Treatment)' [1997] 27 *Fam. Law* 325.

two minutes apart, it should be possible to consent the woman in the absence of any significant effect from the 'gas and air'. This is not so with the longer acting narcotics such as pethidine;

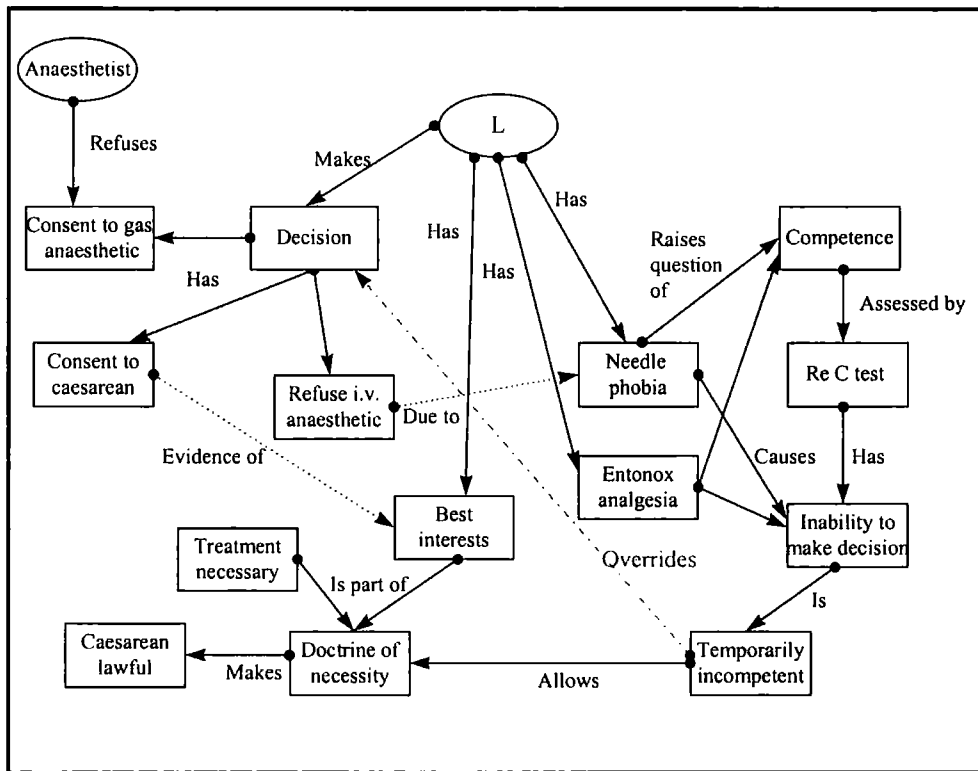


Figure 6: A model of the legal argument in *Re L*.

secondly, L was willing to have the caesarean providing anaesthesia was induced using gas rather than an injection. Because it presented a greater risk to the woman the anaesthetist was not willing to use the inhalational route. The relevance of the risk, however, is surely that it is the woman's risk and not the anaesthetist's. For the anaesthetist to deny her that option is rank paternalism. The law, however, will not compel a doctor to perform a particular treatment.¹³⁸ In *Re L*, the conflict between the patient's right to self-determination and the doctor's right not to offer a particular treatment was a moot point. Because the court held that her needle phobia made her temporarily incompetent, the doctors were justified in treating L

¹³⁸ *Re J (Minor: Child in Care, Medical Treatment)* [1993] Fam 15.

in her 'best interests'. However, would the situation be any different if the woman's fear of needles was not disabling? (See p.86)

Rochdale Healthcare (NHS) Trust v C¹³⁹

The consultant obstetrician believed that without a caesarean both C and her unborn child would die. Mrs C refused consent to a caesarean because of the backache and scar pain she had suffered following a previous caesarean. She said that she would rather die than have a caesarean again. In the time allowed a psychiatric opinion was unavailable but the obstetrician believed C was competent to consent.

The Judgment

In granting the declaration that a non-consensual caesarean would be lawful Johnson J decided, contrary to the obstetrician's opinion, that C was not competent: 'I concluded that a patient who could, in those circumstances [the throes of labour], speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh-up the consideration that arose so as to make any valid decision'.

Discussion

This decision (Figure 7), although only at first instance, has implications for the autonomy of patients in emergency situations generally and pregnant women in particular. It highlights two important points:

¹³⁹ Op cit. n.28.

1. temporary incompetence (p.30, 41, 46). It is difficult to accept that a judge could make a valid decision regarding the competence of a woman whom he has not seen and who is not represented. This is especially true where, as in this instance, the judge overrules the opinion of a consultant obstetrician who has seen the patient. As Hewson notes: 'The issue of competency cannot be analysed satisfactorily given the peremptory way in which it was dealt with, in the absence of any evidence and in the absence of the women themselves'.¹⁴⁰

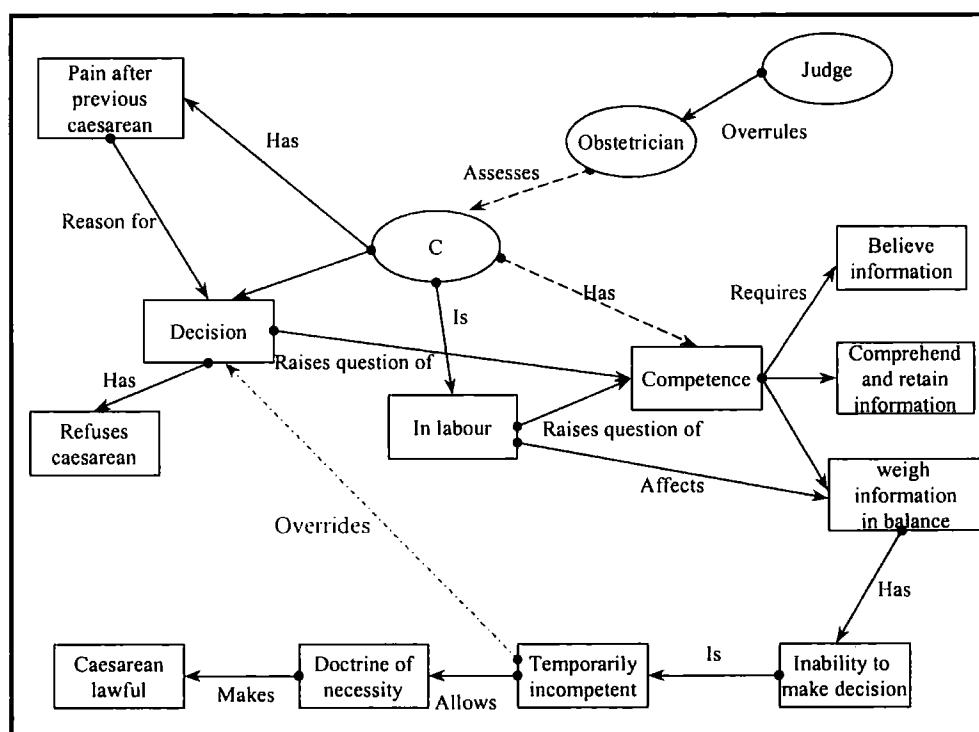


Figure 7: A model of the legal argument used in *Rochdale*.

2. the problem of assessing competence based on the actual decision rather than on decision making ability (*supra* p.38). Johnson J based his judgment on the fact that C made an 'irrational' decision whilst in the 'throes of labour'. Since an irrational decision is only evidence of incompetence it cannot be *sufficient* for such a finding. While labour may be sufficient for a finding of incompetence this is not a certainty. Competence must be assessed

¹⁴⁰ Hewson, B. 'Right to Refuse Medical Intervention; Right to a Fair Hearing'. (1997) 2 *Journal of Civil Liberties* 44 at 48.

in person. The only explanation for Johnson J's judgment is that it is a perfect example of the 'strained reasoning' highlighted, by Thorpe LJ,¹⁴¹ as an obvious risk in such an emotionally charged situation.

The Use of Force

There have been two cases concerning the use of force to compel a non-consensual caesarean. The use of force is not being considered with regard to enforcing the court's judgment because a declaratory order merely states the civil court's opinion as to whether the activity in question would be lawful.¹⁴² It does not state that the woman must undergo a caesarean or risk being in contempt of court but a declaratory order does allow the doctor to proceed with the sanction of the civil court. Because the declaratory order does not compel a woman to succumb to the doctor's opinion the question remained as to whether the doctors could lawfully use force to compel the woman to do something she was not legally obliged to do. This question was considered under the MHA 1983 in *Tameside*,¹⁴³ and under common law in *Norfolk and Norwich*.¹⁴⁴

Tameside and Glossop Acute Services Trust v CH

A 41 year old woman with paranoid schizophrenia was admitted under s.3 MHA 1983. It was later discovered that she was pregnant. She had a tendency to resist treatment and was deemed incapable of understanding its purpose. Although wanting the baby she harboured the delusional belief that the medical advice and treatment were malicious and harmful to her fetus. Because of fetal intra-uterine growth retardation the obstetrician wanted to induce

¹⁴¹ Op cit. n.1 at 664.

¹⁴² Re F (Mental Patient: Sterilisation) [1990] 2 AC 1 at 20.

¹⁴³ Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762.

¹⁴⁴ Norfolk and Norwich Healthcare (NHS) Trust v W [1996] 2 FLR 613.

labour. As CH was not competent to consent a court order was sought to authorise a caesarean and, if necessary, the use of force to restrain CH.

The Judgment (Figure 8)

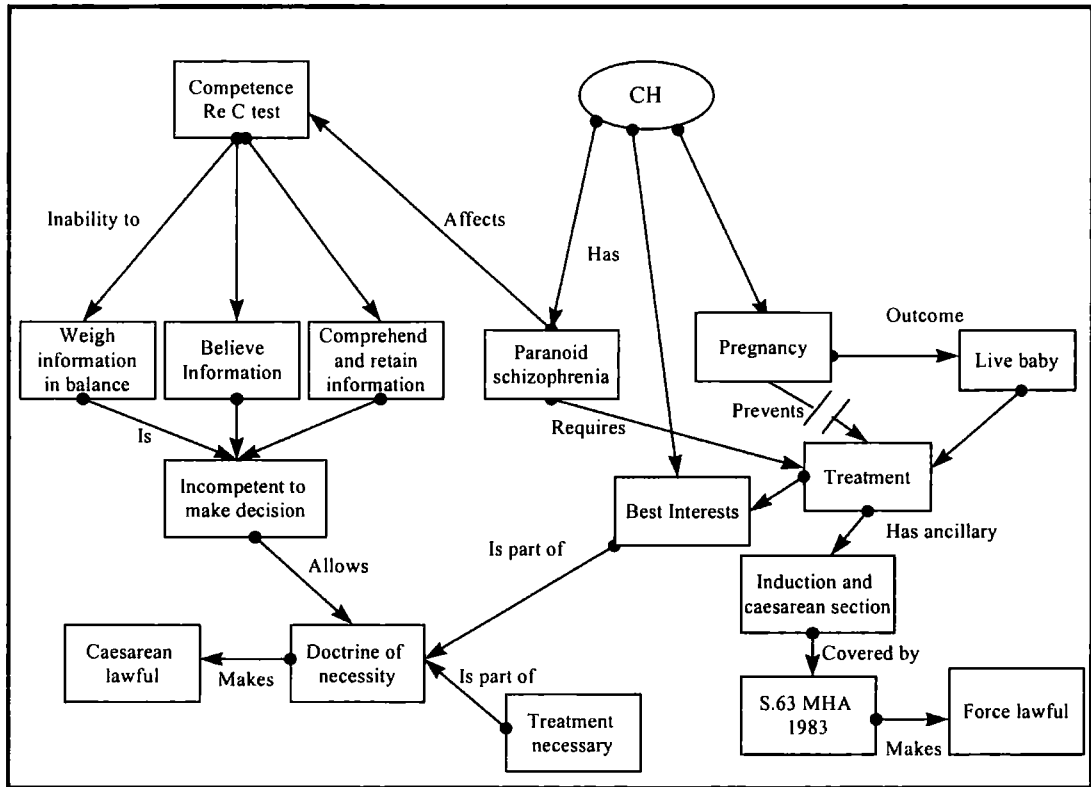


Figure 8: A model of the legal argument used in *Thameside*.

Wall J granted the declaratory order that, because CH was incompetent to give or refuse consent, a non-consensual caesarean would be lawful as in her best interests. He also decided that forcible restraint would be lawful under s.63 MHA 1983 because the caesarean could be considered as ancillary treatment to CH’s mental disorder. He declined to consider the common law position.

Discussion

This case is interesting because of the Wall J's justification of force under s.63 MHA 1983. To justify force under s.63 the treatment must be for a mental illness/disorder as defined by the Act. Wall J reasoned that a caesarean could be considered an ancillary treatment for the patient's schizophrenia, because:

1. it would prevent a deterioration of the patient's mental state;
2. a dead baby might make her schizophrenia less responsive to treatment;¹⁴⁵
3. her anti-psychotic medication was interrupted by pregnancy and could not be resumed until delivery.

As Montgomery states: 'this may suggest that compulsory maternity care can be administered to all pregnant women who are 'sectioned' under the 1983 Act. However, it should be observed that the court heard specific evidence from the woman's psychiatrist that this would be a danger in her case'.¹⁴⁶

S.63 MHA 1983 states: 'The consent of the patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within ss 57 and 58 above, if the treatment is given by or under the direction of the responsible medical officer'. An ordinary interpretation of this provision is that any non-consensual treatment must have the purpose of alleviating or preventing the deterioration of the patient's mental disorder. Any other treatment must be justified under the doctrine of necessity. However, Wall J wanted to avoid the common law and he therefore relied on the precedents of *B v Croydon HA*¹⁴⁷ and *Re KB*.¹⁴⁸

¹⁴⁵ Based on evidence from the psychiatrist.

¹⁴⁶ Op cit. n.13 at 406.

¹⁴⁷ *B v Croydon HA* [1994] 2 WLR 294.

¹⁴⁸ *Re KB (Adult) (Mental Patient: Medical Treatment)* (1994) 19 BMLR 144.

B v Croydon HA concerned the force feeding of a psychopathic patient on hunger strike and *Re KB* considered the non-consensual tube feeding of an anorexic. Their arguments used the concept of ancillary treatment and Hoffman LJ stated: '...in my view this test [the prevention or alleviation of the mental disorder] applies only to the treatment as a whole. Section 145(1) gives a wide definition to the term 'medical treatment'. It includes 'nursing, and also includes care, habilitation and rehabilitation under medical supervision'. So a range of acts ancillary to the core treatment fall within the definition. I accept that by virtue of s 3(2)(b) a patient with a psychopathic disorder cannot be detained unless the proposed treatment, taken as a whole, is 'likely to alleviate or prevent a deterioration of his condition'... ..It does not however follow that every act which forms part of that treatment within the wide definition in s 145(1) must in itself be likely to alleviate or prevent a deterioration of that disorder. Nursing and care concurrent with the core treatment or as a necessary prerequisite to such a treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder are in my view all capable of being ancillary to a treatment calculated to alleviate or prevent a deterioration of the psychopathic disorder'.¹⁴⁹

Wall J's argument may be summarised; because anti-psychotic medication had to be suspended until after the delivery and because a dead baby might make CH's schizophrenia resistant to further treatment, a rapid delivery of a healthy baby was a 'prerequisite' for the effective treatment of her psychosis. Therefore if a caesarean was necessary to ensure a healthy baby it could be viewed as ancillary treatment to her mental disorder. This argument adopts logic essentially inverse to the doctrine of double effect: if treatment aimed at a non-mental disorder also happens to alleviate or prevent the deterioration of a mental disorder then, for the purposes of s.63 MHA 1983, that treatment will be considered as being administered with the ancillary intention of treating the mental disorder. The doctrine of

¹⁴⁹ Op cit. n.147 at 297 per Hoffman LJ.

double effect allows an unintentional bad outcome to be considered a 'side-effect ... justified according to the totality of the circumstances'.¹⁵⁰ Wall J's argument, however, is that an intentional side-effect (improvement in CH's psychosis) justifies a 'bad' action (the use of force to compel a caesarean).

Surely a caesarean is intended to improve her (or her fetus') physical condition and should be justified under the doctrine of necessity. It is easier to accept the inclusion of feeding an anorexic as being treatment for her mental condition because the anorexic's refusal to eat is symptomatic of the condition and treating disorders symptomatically is a large part of accepted medical practice. Thus, treatment for a broken arm would rightly include pain relief although this has no direct effect on healing the break. Likewise, in *B v Croydon HA*, self-harm was a symptom of B's mental disorder and refusing to eat could be seen as a form of self-harm. Therefore, force-feeding could be considered symptomatic treatment. However, it is stretching the point, almost to breaking, to contend that a caesarean is treatment for a mental disorder.¹⁵¹

Although the main reason for wanting to induce labour was because the fetus was growth retarded the court accepted the argument that anti-psychotic treatment could not be restarted until after delivery. However, restarting the anti-psychotic medication would have been a more direct means of treating CH's schizophrenia even if that treatment had adversely affected the fetus. In reality, the doctors and the judge were trying to balance CH's treatment to maximise the welfare of the fetus without a significant deterioration of her mental state. This understandable desire for a 'good' outcome led to more 'strained reasoning'. The only saving grace is that Wall J's judgment relied on specific evidence from the consultant

¹⁵⁰ Price, DPT. 'Assisted Suicide and Refusing Medical Treatment: Linguistics, Morals and Legal Contortions' (1996) 4 *Med. Law Rev.* 270 at 277.

¹⁵¹ Jewell, L 'Treatment Without Consent' [1998] 28 *Fam. Law* 774 at 775.

psychiatrist as to the likely effect of a dead baby and thus it could be argued that it is limited to the facts of the case.

Norfolk and Norwich Healthcare (NHS) Trust v W¹⁵²

A 32 year old woman was admitted fully dilated and in a state of arrested labour. She had a past history of psychiatric treatment 'marked by non-co-operation by her with those seeking to help her'. The psychiatrist opined that she was not suffering from a mental disorder under the MHA 1983 and she was capable of instructing a solicitor. However she had persisted throughout the day in denying her pregnancy. On the basis of the *Re C* test,¹⁵³ the psychiatrist determined that she was unable to weigh treatment information in the balance and hence lacked the capacity to consent. There were two potential risks if the delivery of her baby was not assisted: the fetus might be deprived of oxygen and possibly die *in utero*; and secondly, the scar from her previous caesareans might rupture. A declaratory order for a caesarean was sought.

The Judgment (see figure 9)

Johnson J stated: '...although she was not suffering from a mental disorder within the meaning of the statute, she lacked the competence to make a decision about the treatment that was proposed because she was incapable of weighing up the considerations that were involved'.¹⁵⁴ He decided that intervention would be in the patient's best interests as it 'would end the stress and pain of her labour, it would avoid the likelihood of damage to her physical health which might have potentially life-threatening consequences and, despite her present view about the foetus, would avoid her feeling any feeling of guilt in the future were she, by

¹⁵² Op cit. n.144.

¹⁵³ Op cit. n.82.

¹⁵⁴ Op cit. n.144 at 615-616.

her refusal of consent, to cause the death of the foetus'.¹⁵⁵ He also found that the court had a common law power to authorise the use of reasonable force. This was provided there was a 'necessity to act... [and] the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person'.¹⁵⁶

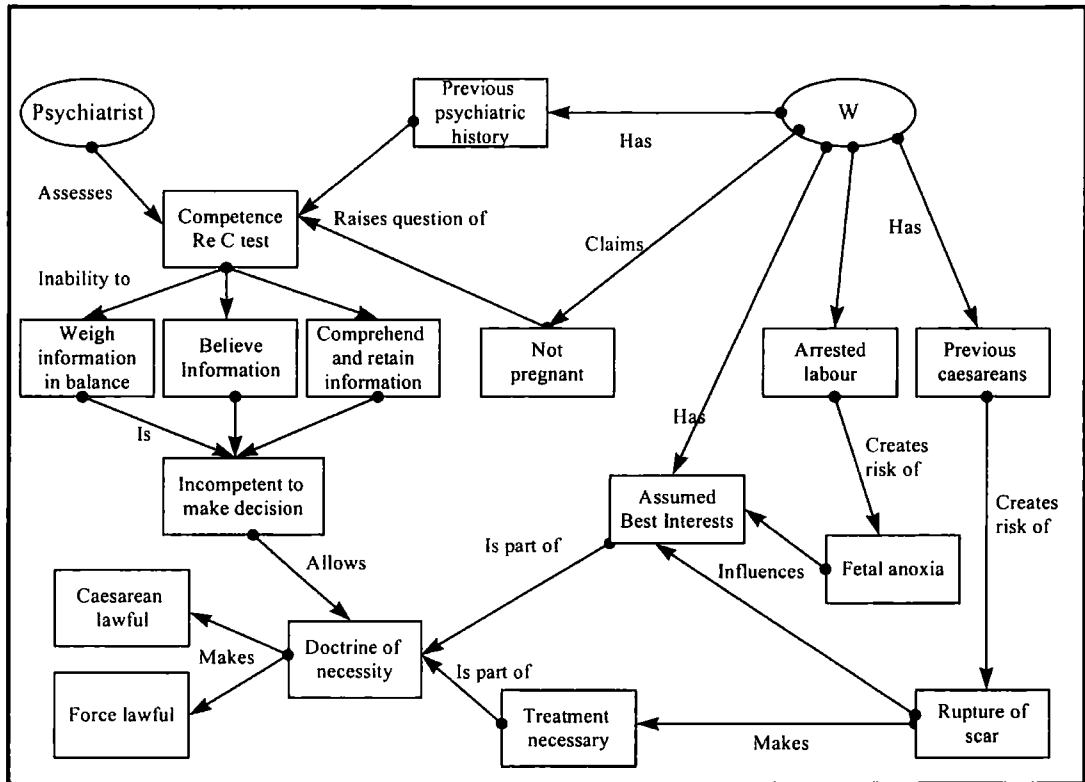


Figure 9: A Model of the legal argument used in *Norfolk and Norwich*.

Discussion

Johnson J's judgment concerning the use of force under the common law is undoubtedly correct. The doctrine of necessity, by its very nature, justifies the use of force provided that it is objectively reasonable. The essence of necessity is that it makes lawful the application of a force which would otherwise be unlawful. Johnson J's judgment is deficient in that it fails to even begin to define what might be considered 'reasonable' under the circumstance of a

¹⁵⁵ Op cit. n.144 at 616.

¹⁵⁶ Op cit. n.142 at 75 per Lord Goff.

refusal of a caesarean. Would the court consider it 'reasonable' to shackle the woman to the bed or use manual physical restraint? Furthermore, the court has failed to consider what standard will be used to judge the 'reasonableness' of an action. Would this be another instance when the *Bolam* test¹⁵⁷ would rear its ugly head? Johnson J has effectively left the decision, about how much force is reasonable, in the doctor's hands.

This is another instance in which the fact that the woman is in labour has been considered relevant. Although it was unlikely to have been a major factor in the decision Johnson J did consider it worthy of specific mention: 'She was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour made even more difficult for her because of her own particular mental history'.¹⁵⁸ This statement does not carry as much weight as his decision in *Rochdale*,¹⁵⁹ in which the incapacitating effect of labour was a major justification for his judgment. However, when taken in conjunction with that decision and the other caesarean cases - such as *Collins* and *Re MB* - in which it has been accepted (*obiter*) as a temporary incapacitating factor then it becomes a useful 'get-out-clause' when a labouring woman makes an 'unacceptable' decision.

At the end of his conclusion, Johnson J stated: 'Throughout the judgment I have referred to the 'foetus' because I wish to emphasise that the focus of my judicial attention was upon the interests of the patient herself and not upon the interests of the foetus which she bore.

However, the reality was that the foetus was a fully formed child, capable of normal life if only it could be delivered from the mother'.¹⁶⁰ The fact that he felt it necessary to explain himself suggests that the fetus - or rather the child it was capable of becoming - was the

¹⁵⁷ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

¹⁵⁸ *Op cit.* n.144 at 616.

¹⁵⁹ See p.48.

¹⁶⁰ *Op cit.* n.144 at 616.

focus of his concern. Although the decision in this case was legally justified under the doctrine of necessity, Johnson J's comment suggests that his interpretation of the woman's 'best interests' was tainted by his desire to allow the fetus to realise its potential for 'normal life'. Johnson J phrased this aspect of the woman's 'best interests' by arguing that a healthy baby: 'despite her present view about the foetus, would avoid her feeling any guilt in the future were she, by her refusal of consent, to cause the death of the foetus'.¹⁶¹ The inclusion of the emotional and psychological effects of failing to 'rescue' a 'victim' who shares a close bond (or relationship) with the subject does have a legal precedent. *Re Y* concerned a mentally incapacitated woman whose sister needed a bone marrow transplant.¹⁶² Connell J stated: '...it is to the benefit of the defendant that she should act as donor to her sister, because in this way her positive relationship with her mother is most likely to be prolonged... [it] is likely to improve the defendant's relationship with her... and also to improve her relationship with the plaintiff who will be eternally grateful to her'.¹⁶³ Similarly, almost 30 years previously, the Kentucky Court of Appeal authorised a kidney transplant from an incompetent patient to his brother to prevent the 'extremely traumatic effect' that his brother's death would have on him.¹⁶⁴

Commenting on *Re Y*, Grubb states: 'the court might well as a rule-of-thumb look for the 'agreement' (though obviously not the consent) of the donor as a condition to allowing the donation... it is unthinkable that the 'best interests' test could be satisfied if the donor objected to the donation'.¹⁶⁵ Like the potential organ donor the pregnant woman is expected to submit - for the benefit of another (the fetus) - to an invasive medical procedure which will be detrimental to their physical health. Thus, if it is 'unthinkable' for an incompetent person

¹⁶¹ Op cit. n.144 at 616.

¹⁶² *Re Y (Adult Patient) (Transplant: Bone Marrow)* (1996) 35 BMLR 111.

¹⁶³ *Ibid.* at 114.

¹⁶⁴ *Strunk v Strunk* 445 SW 2d 145 (1969).

¹⁶⁵ Grubb, A. 'Commentary on *Re Y*' (1996) 4 *Med. Law Rev.* 204 at 207.

to be expected to donate bone marrow, blood or an organ in the face of their expressed opposition then the same is true for an incompetent woman expected to submit to a caesarean solely for the fetus' benefit. Where it is indicated on maternal grounds there is a good case for suggesting that it is in her best interests. However, where the indication is fetal then there must be a danger that the doctor, or judge, will base his judgement on his own values. This risk of transferring the assessors values and belief on to the patient when determining their best interests is also a risk where the benefits to the woman are physical. However, predicting the physical effect is more certain than predicting the likely psychological and emotional consequences. Thus, the 'best interests' test will probably be less reliable when the emotional and psychological consequences are considered.

In *Norfolk and Norwich*, Johnson J is saved from some of this criticism because the caesarean was indicated for the benefit of the fetus and the woman. Thus, preventing the woman's scar from rupturing was a very obvious physical benefit that would satisfy the 'best interests' test without the need to recourse to the effect that the death of the fetus might have at some time in the future. However, Johnson J's words create the impression that a major concern was for the fetus. As Plomer notes: 'medical decisions which are really intended to benefit the unborn foetus could be rationalized with the court's approval as decisions intended to benefit the allegedly mentally incompetent or mentally disordered woman instead. If this were to be the case, then the Caesarean cases would have succeeded in effecting a *de facto* inversion of the relative legal status accorded to women and unborn foetuses, because the interests and rights of women would be *de facto* subsumed to those of the unborn foetus. In view of the procedural shortcomings of these cases, such an outcome would seem difficult to avoid'.¹⁶⁶

¹⁶⁶ Op cit. n.11 at 254-255.

Conclusion to Part 1: The Current Legal Position

Although *Collins* proclaimed the primacy of autonomy, pregnant women are still at risk of being overridden if they refuse consent to a caesarean. The importance of *Collins* is that it confirms the *dictum* in *Re MB* that the interests of the fetus are irrelevant when considering a pregnant woman's right to refuse a caesarean. Equally important is its strong defence of the pregnant woman's right to autonomy. However, the woman in *Collins* was articulate and, perhaps more importantly, not in labour. In both *Collins* and *Re MB*, the Court of Appeal accepted that labour itself may cause temporary incapacity. This effect of labour was one of the main justifications for overriding the woman's decision in *Rochdale*. Likewise, other temporarily incapacitating factors that may be utilised to circumvent a patient's decision include the effects of analgesic drugs.

Temporarily incapacitating factors are not the only judicial tool for circumventing a woman's refusal of consent. In *Collins* and *Re MB*, the Court of Appeal proclaimed that a competent woman was entitled to refuse consent even if her reasons were irrational, or, even non-existent. However, an irrational refusal would be accepted as evidence that the woman might be incompetent. The Court of Appeal, in *Re MB* based their test of competence on the recommendations of the Law Commission that was, in turn, based on the test proposed in *Re C*. In both, the test for incompetence was based on the actual decision rather than an the abstract *capacity* to make a decision of commensurate complexity. Since this was accepted in *Re MB*, and not disapproved in *Collins*, it would seem that the courts currently accept that the test should be based on the actual decision. This makes it more likely that an irrational decision will be equated with incompetence rather than simply considered as an indication for assessing competence. If the law is to pay more than just lip-service to the allowance of

irrational decisions then it must surely require that the test for competence be based on abstract *capacity* rather than on the actual decision. An even stronger acknowledgement of the competent person's right to make irrational decisions would require that the assessor be unaware of that person's actual decision.

Finally, the acceptance in both *Collins* and *Re MB*, of Lord Donaldson MR's risk related standard allows yet another way around the woman's right of self-determination. It requires a higher level of competence for a refusal of consent than when consent is given. Furthermore, the greater the risk involved the higher the level of competence required. Since it would be hard to find a medical situation of greater risk than where the lives of both the woman and her fetus are threatened a risk-related standard requires pregnant women to be more competent than other adults making commensurately complex decisions.

When the caesarean cases are considered as a whole, it is clear that the court will do everything within its power to achieve a 'good outcome' for both mother and baby. The courts at first instance have, to some extent, become fetal advocates. While *Collins* has re-established the role of the court as legal arbiter, it is notable that the fetus had already been delivered and was no longer at risk. Thus, despite the Court of Appeal's powerful defence of the pregnant woman's right of autonomy, the doctors - and the courts - are still left with sufficient leeway to achieve the outcome they desire.

Part Two: The Materno-fetal Conflict

Traditionally, the only means for protecting fetal health was by optimising the pregnant woman's health. But, as Daniels notes: 'Technological, social, political, and economic developments in the second half of the twentieth century have challenged the "organic unity" of the pregnant woman and the fetus'.¹⁶⁷ It is now possible to assess, monitor and treat the fetus through the use of techniques including: ultrasound, fetal heart monitoring, blood sampling and surgery. Oberman states: 'Visualising the fetus had a profound effect on the practice of obstetrics: it provided absolute proof that a new life was growing inside the patient. Somehow, the impact of rendering the pregnant woman transparent made it possible to imagine the pregnant woman and the fetus as separate entities'.¹⁶⁸ The fetus has become a second patient and 'some writers conflate fetuses and children, unable to see any morally relevant differences between them: they seem oblivious to the fact that fetuses live in women's bodies'.¹⁶⁹ However: 'In no other situation is the physician faced with one patient literally inside the body of another patient. Conceptually, the medical care of each can be approached independently, but practically, neither can be treated without affecting the other'.¹⁷⁰

This conceptual independence of the fetus has engendered the materno-fetal conflict which is expressed in two situations: where the pregnant woman's conduct is potentially harmful to the fetus; and where the woman refuses consent to medical treatment beneficial to the fetus. Materno-fetal conflict implies that the conflict is between the pregnant woman and her fetus but it is really between the pregnant woman and doctors (or other 'state representatives' such

¹⁶⁷ Op cit. n.46 at 1.

¹⁶⁸ Oberman, M. 'Women, Fetuses, Physicians, and the State: Pregnancy and Medical Ethics in the 21st Century'. In: Monagle, JF. Thomasma, DC. (Ed.) *Health Care Ethics: Critical Issues for the 21st Century* (1998) 67 at 69.

¹⁶⁹ Purdey, LM. 'Are Pregnant Women Fetal Containers?' (1990) 4 *Bioethics* 273 at 275.

¹⁷⁰ Op cit. n. 38.

as the court)¹⁷¹ who have become fetal advocates. Thus, it is the doctor who identifies the conflict when a woman refuses consent to a caesarean. Nelson notes: 'In such situations, a physician may be frustrated or offended by the woman's non-compliance. If this might result in avoidable harm to the fetus and perhaps to the mother, frustration may turn into the pain of a serious moral and professional dilemma: to respect the woman's wishes and permit preventable harm or to ignore her wishes to protect the fetus'.¹⁷² However, when a woman refuses a caesarean because she believes that operative delivery is forbidden by God then she is acting in what she believes to be the best interests of her child-to-be. To her, the spiritual health of her child-to-be is more important than its physical health and there is no conflict between her decision and the fetus' interests. The conflict arises when the doctor is unable to see beyond his clinical judgement which: 'displays an arrogance and a lack of understanding of the woman's life'.¹⁷³

In caring for pregnant women, doctors are motivated to achieve the 'best' outcome for both mother and baby. This involves a balancing act governed by the principles of beneficence and non-maleficence. From the doctors viewpoint the outcome variables are clinical: a live baby and a woman with a scar are better than an intact woman and a dead baby. The woman, however, will not measure outcome purely in clinical terms but will include the clinical result as part of a much wider social, religious, emotional and economic picture. The principles of beneficence and non-maleficence must be tempered by a respect for the autonomy of the patient.¹⁷⁴ Thus the materno-fetal conflict is comprised of two sub-conflicts: respect for the woman's autonomy against beneficence towards the fetus; and beneficence towards the fetus

¹⁷¹ The courts at first instance have, arguably, become fetal advocates by using 'strained reasoning' to protect the fetus. *Collins* has re-established the role of the court as arbiter.

¹⁷² Nelson, LJ. 'Legal Dimensions of Maternal-fetal Conflict' (1992) 35(4) *Clinical Obstetrics and Gynecology* 738.

¹⁷³ Mair, J. 'Maternal/Foetal Conflict: Defined or Defused?' In: McLean, SAM.(Ed.) *Contemporary Issues in Law, Medicine and Ethics* (1996) 79 at 94.

¹⁷⁴ See Mahowald, MB. 'Maternal-fetal Conflict: Positions and Principles' (1992) 35(4) *Clinical Obstetrics and Gynecology* 729.

against non-maleficence towards the woman. The main actors are the woman and the doctor with the fetus sitting uneasily between them. If the conflict cannot be resolved then the judiciary will become involved to decide whose rights prevail. In court the rights and interests to be considered are those of: the woman (Figure 10); the fetus (figure 11) and the state or public (figure 12). Included within the state interest are the rights and interests of the doctor (figure 13).

Persons, other than the woman, the doctor and the state, have interests in the well-being of mother, fetus or both. This wider conflict involves the woman's dependant family and the father of the fetus (figure 14). The narrow conflict can be divided into three sub-conflicts which focus on the internal conflicts that determine the events that occur whenever a caesarean is advised on fetal grounds. They are best represented by figures 15 to 17. I will consider these conflicts and the wider conflict further in Chapter 4.

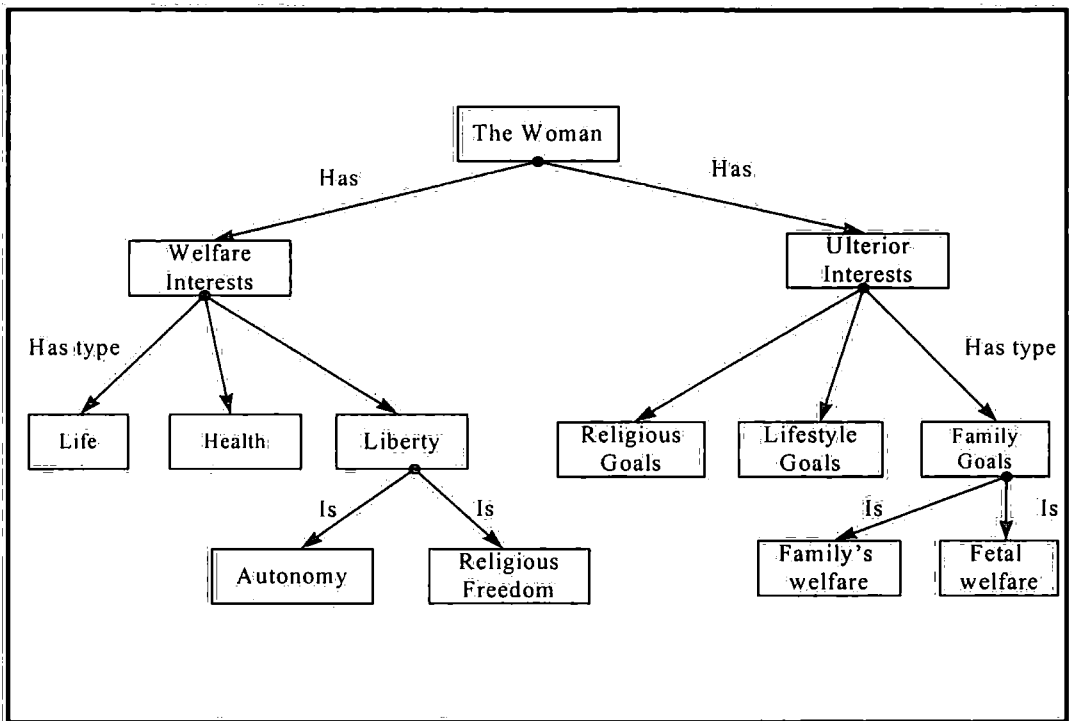


Figure 10: The woman's interests that may affect her medical treatment decision.

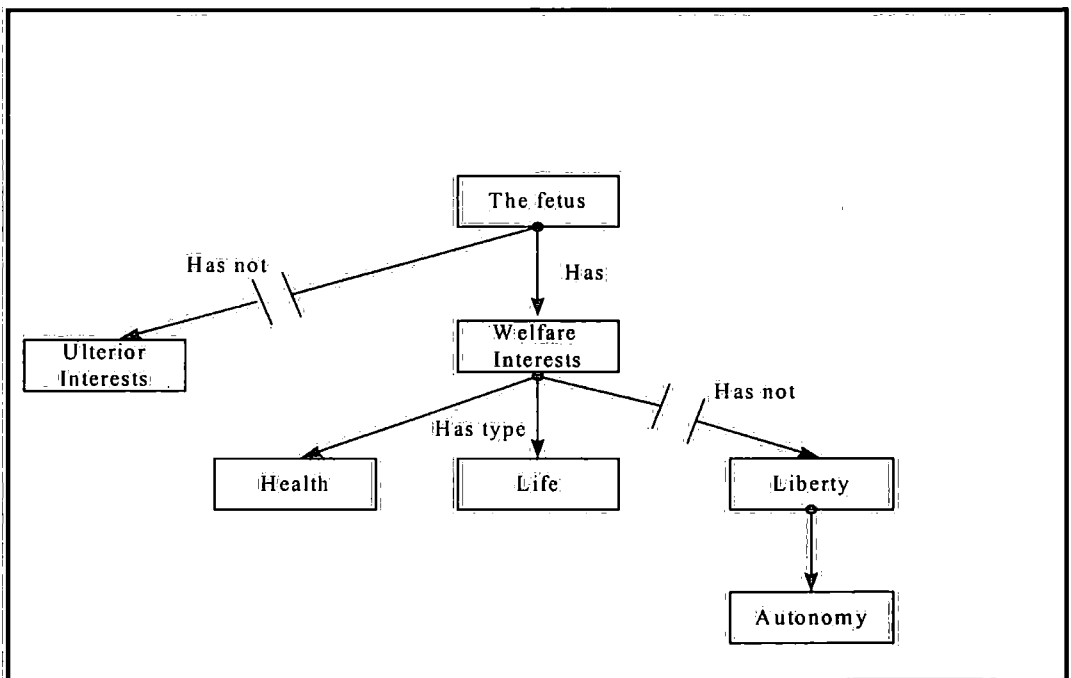


Figure 11: The fetus' interests relevant in determining whether to override a competent woman's decision.

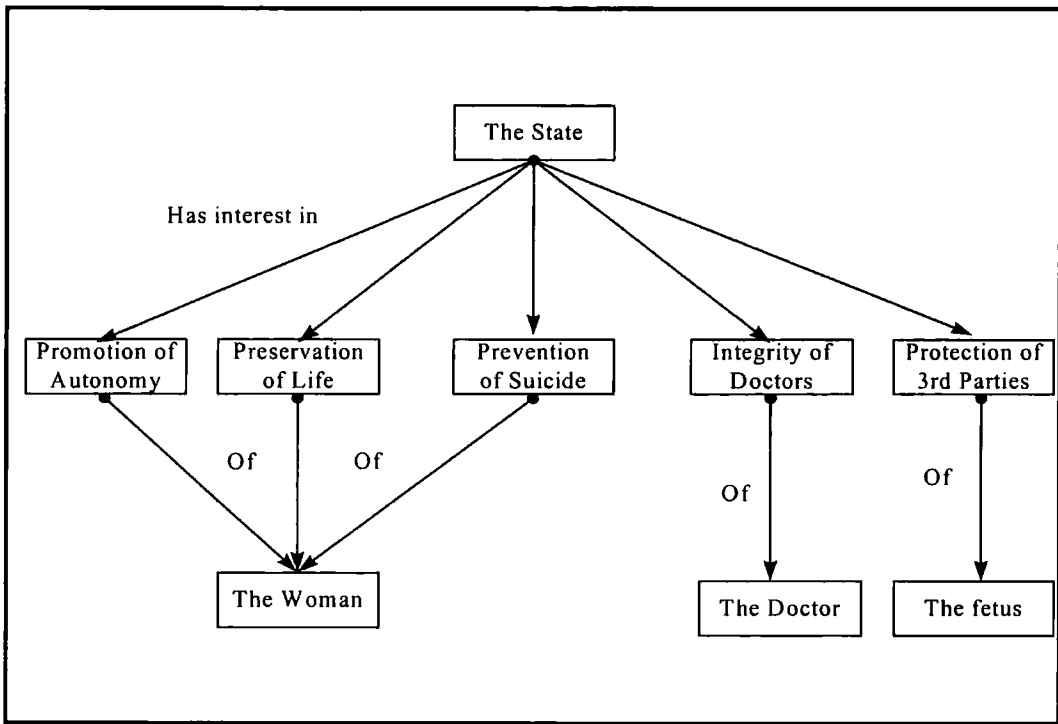


Figure 12: The State's interests in the caesarean debate.

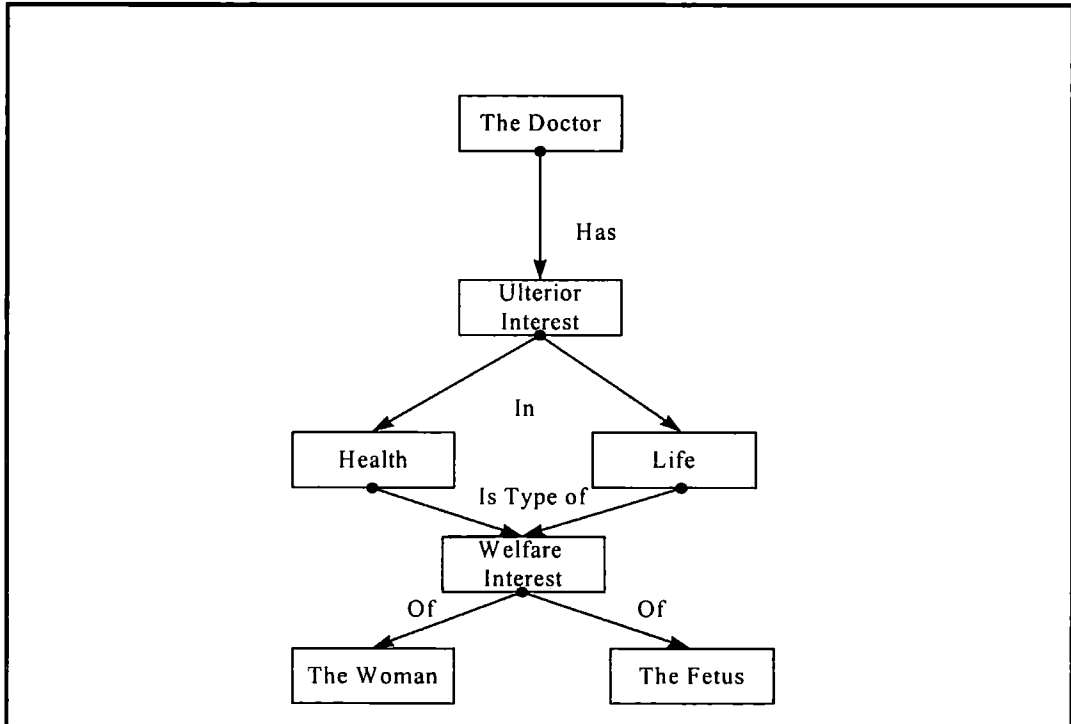


Figure 13: The doctor's interests in the caesarean debate.

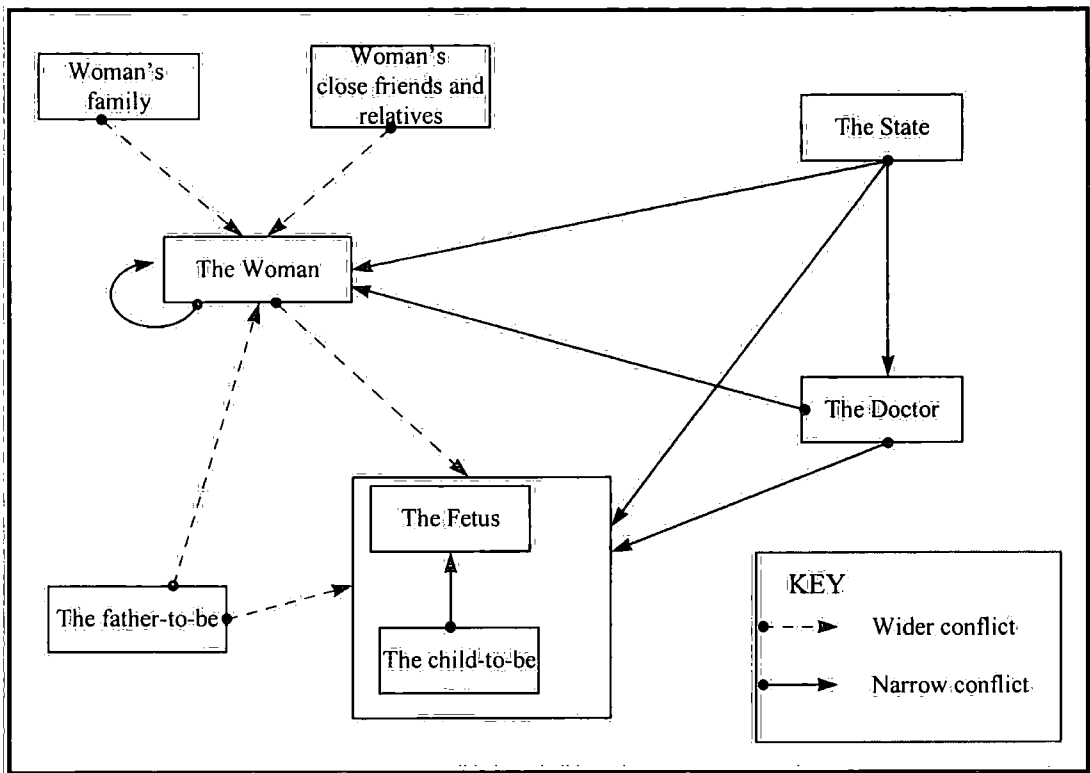


Figure 14: The actors involved in the materno-fetal conflict. The woman's interest in the fetus - although it may be considered part of the narrow conflict - is here shown as part of the wider conflict. This is because her interest in having a healthy baby is often ignored when the choice between respecting her autonomy and protecting the fetus is considered.

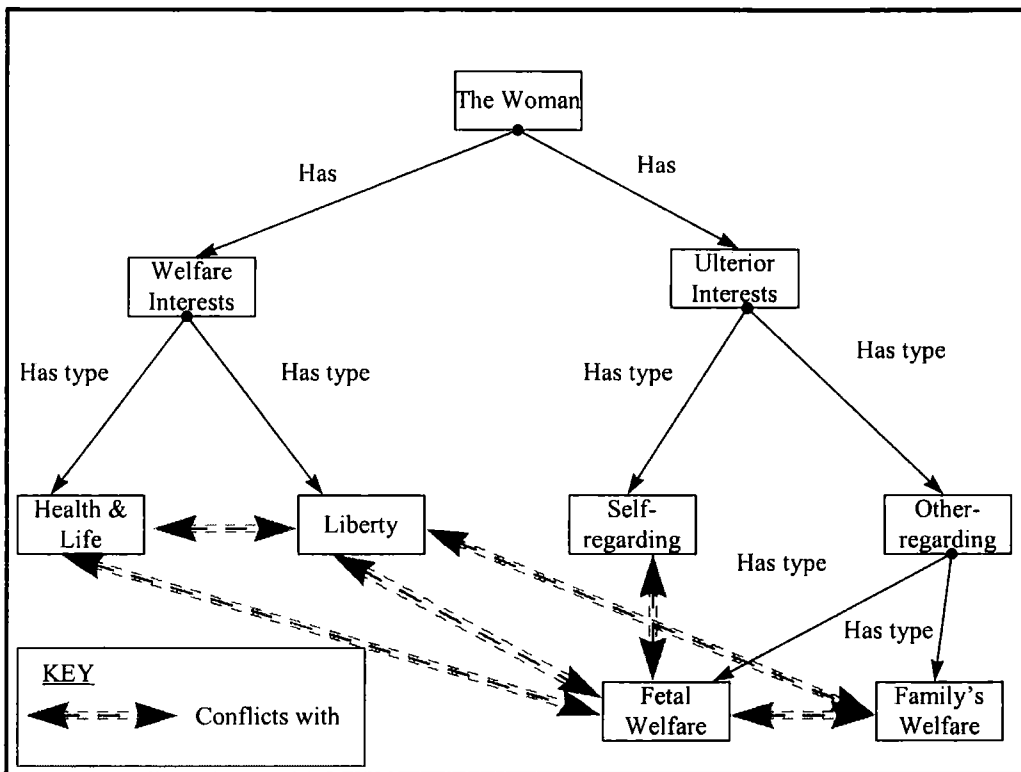


Figure 15: The pregnant woman's conflict of interests.

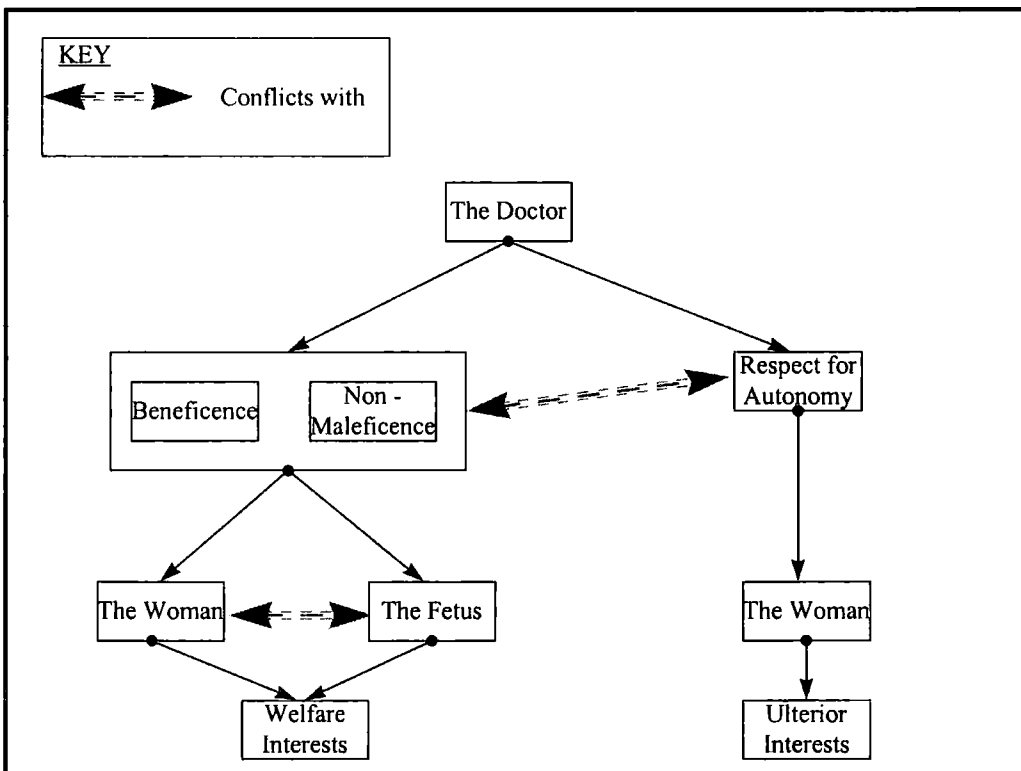


Figure 16: The doctor's conflict of interests.

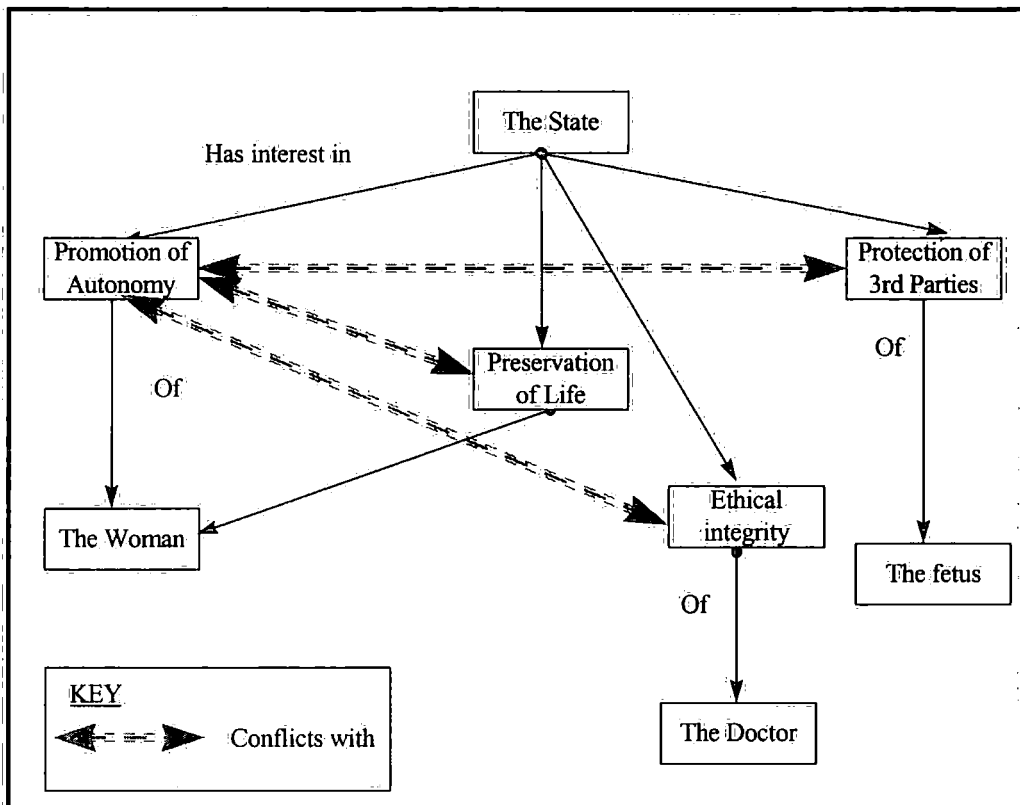


Figure 17: The State's conflict of interests.

Chapter Three: The Pregnant Woman's Right to Autonomy

The competent, pregnant woman enjoys the same rights as any other competent adult and, regarding medical treatment, the important rights are those of autonomy and bodily integrity. Legally these rights are protected by trespass against the person, battery, and the rules of consent. 'The fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, might amount to a battery'.¹⁷⁵ This principle is not absolute and a number of exceptions have been recognised. Consent, for example, provides the justification for medical treatment. Thus: 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault...'.¹⁷⁶

Just as a competent woman has the right to give consent so she has the right to refuse it. In *Bland*, Lord Keith stated: '...it is unlawful so as to constitute both a tort and a crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die'.¹⁷⁷ Lord Goff explained: 'To this extent, the principle of the sanctity of human life must yield to the principle of self-determination, and, for present purposes perhaps more important, the doctor's duty to act in the interests of his patient must likewise be qualified'.¹⁷⁸ This right to refuse consent exists regardless of the rationality of the decision.¹⁷⁹

¹⁷⁵ Op cit. n.59.

¹⁷⁶ *Schloendorff v New York Hospital* (1914) 105 NE 92.

¹⁷⁷ Op cit. n.57 at 860.

¹⁷⁸ *Ibid.* at 866.

¹⁷⁹ Op cit. n.9 at 786.

Whether the legal protection of self-determination goes further than the moral right to autonomy depends on how autonomy is defined. Clouser and Gert note: 'One side may favour overruling a patient's refusal on the ground that the refusal is irrational, claiming that therefore the choice is not autonomous, whereas the other side may favour going along with the patient's explicitly stated refusal on the ground that, though the refusal is irrational, the patient is competent and therefore the refusal is an autonomous choice'.¹⁸⁰ Their first argument demands that an autonomous action be based on rational thought; their second argument allows any action to be autonomous providing the actor is capable of rational thought.

Gillon defines autonomy as: '...the capacity to think, decide, and act on the basis of such thought and decision freely and independently... In the sphere of action it is important to distinguish between... simply doing what one wants to do and, on the other hand, acting autonomously, which may also be doing what one wants to do but on the basis of thought or reasoning'.¹⁸¹ Gerald Dworkin believes: 'Autonomy is a second order capacity to reflect critically upon one's first order preferences and desires, and the ability either to identify with these or to change them in light of higher order preferences and values'.¹⁸² Alternatively, autonomy is: '...freely and actively making one's own evaluative (requires true beliefs and rationality) choices about how one's life should go'.¹⁸³ These definitions all require both the *capacity* for reasoning/self-reflective thought and the *practice* of basing one's actions on such reasoning/self-reflection.

¹⁸⁰ Clouser, KD. Gert, B. 'Morality vs. Principlism'. In: Gillon, R. Lloyd, A. (Ed.) *Principles of Health Care Ethics* (1994) 250 at 254.

¹⁸¹ Gillon, R. *Philosophical Medical Ethics* (1985) at 60.

¹⁸² Dworkin, G. *The Theory and Practice of Autonomy* (1988)..

¹⁸³ Savulescu, J. Momeyer, W. 'Should Informed Consent be Based on Rational Beliefs?' (1997) 23 *Journal of Medical Ethics* 282.

Both Gillon and Dworkin recognise the difference between deciding what is right and acting in accordance with that decision. There is also an important difference between an act by an autonomous actor and an autonomous act: to be autonomous an act must further the autonomy of the actor and be based on autonomous judgement but an act by an autonomous actor only requires that the actor *be capable* of autonomous judgement. The principle of autonomy requires respect for autonomy. However, does this mean that the law must respect any act of an autonomous person or only those acts which are themselves autonomous?

Beauchamp and Childress argue that an autonomous action has 3 components: a) an intentional act; which is b) based on an understanding of the circumstances; and c) is without controlling influences.¹⁸⁴ Both understanding and controlling influences are variable and establish a broad spectrum across which an action may be more or less autonomous. The line drawn between what is considered an autonomous act and what is not, is - to some extent - arbitrary. However: 'No theory of autonomy is acceptable if it presents an ideal beyond the reach of normal choosers'.¹⁸⁵ Equally, autonomy is meaningless if there is no requirement for rational thought or freedom from controlling influences. Thus, no rationality is too weak and ideal rationality is unobtainable. Beauchamp and Childress¹⁸⁶ would '...require a substantial degree of understanding and freedom from constraint' but, Cherniak suggests only a minimal level of rationality is required.¹⁸⁷

Culver and Gert argue that an act qualifies as irrational if the harm potentially caused by the act is greater than the harm potentially prevented (or good potentially generated) by the

¹⁸⁴ Beauchamp, TL. Childress, JF. 'Respect for Autonomy'. In: *Principles of Biomedical Ethics* (1994) 120.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Cherniak, C. *Minimal Rationality* (1986).

act.¹⁸⁸ Also: 'Judging the adequacy of a reason always involves a balancing of evils versus evils (or evils versus goods)'.¹⁸⁹ However, this begs the question as to who act as judge: should it be judged subjectively or objectively? Culver and Gert would give the job to 'rational persons'. The danger here is that goods and evils depend to some extent on the individual's circumstances, life values and belief-set. Persons with different belief-sets may rationally rank goods and evils in different hierarchies: to some, loss of life is the greatest harm while to others pain and disability would rank higher. Respect for autonomy, in the face of different belief-sets, demands moral pluralism and tolerance.¹⁹⁰ Brown suggests: 'a rational agent is one whose fundamental beliefs are based on an appropriate body of evidence; where sufficient rules for decision making are lacking a rational agent will exercise judgement and that judgement should be evaluated against the judgements of a community of those who share the relevant expertise for evaluation against their own judgements'.¹⁹¹ The one restriction on a belief-set is that it is acceptable to society as a whole and, providing that is the case, an individual's action should be judged in the context of their belief set.

I have argued that the rationality of an act should be judged objectively, by 'rational persons', based on the subjective belief-set of the actor. This would be best done by persons sharing the same belief-set. When a woman refuses consent to a caesarean the assessment will be made, at least initially, by the doctor who will probably have different beliefs and values to the woman. He is also unlikely to be aware of all the personal circumstances involved in the woman's decision. The danger of an action being judged by someone with a different belief-set is that they will apply their own beliefs to the decision. This risks confusing incomprehensibility with irrationality with the subsequently unjustified conclusion that an

¹⁸⁸ Culver, CM. Gert, B. *Philosophy in Medicine* (1982) 26. Harms include: death; pain; disability; and the loss of freedom; opportunity or pleasure.

¹⁸⁹ *Ibid.* at 31.

¹⁹⁰ Raz, J. 'Autonomy, Toleration and the Harm Principle'. In: Gavison, R. (Ed.) *Issues in Contemporary Legal Philosophy* (1989) 313.

¹⁹¹ Brown HI. *Rationality*. (1988).

irrational decision is an indication of lack of decision-making capacity. As Clouser and Gert note: 'Neglecting the fact that there are different rational rankings is one of the primary causes of unjustified paternalism'.¹⁹²

One possible solution is that the woman's decision and subsequent refusal of consent be judged by 'rational' representatives of a community with similar beliefs to the woman. This 'jury' could then decide whether the decision was autonomous and furthered the woman's interests. However, overruling even a non-autonomous decision would still be a restriction of the woman's moral liberty. Moral liberty is the freedom to do what one wants without the interference from others. It has less moral force than autonomy because it does not require reflective thought and consideration of long term goals.¹⁹³ However, liberty is still a moral good and: 'Any restraint on liberty to do what one likes is seen as something requiring justification'.¹⁹⁴ This follows because: 'Any interference... with a voluntary action... is an invasion of a person's interest in liberty, and is thus harmful'.¹⁹⁵

J.S. Mill's harm principle requires that legal coercion is only justified when used to prevent harm to others.¹⁹⁶ Raz extends this to include self-harm.¹⁹⁷ To be justified, a restriction of liberty must cause less harm than it prevents. Harm may result if an actor performs a non-autonomous act as it may affect the actor's long term autonomous goals. A respect for autonomy demands, not only that we do not restrict a person's autonomy but, that we positively enhance it. Thus there may be occasions when a restriction of liberty is justified in that, although it obstructs the actor's short term first order desires, it prevents a detrimental

¹⁹² Op cit. n.181 at 253.

¹⁹³ Op cit. n.183.

¹⁹⁴ Harris, JW. *Legal Philosophies* (1980) 115.

¹⁹⁵ Feinberg, J. 'Harm and Self-interest'. In: Hacker, PMS. Raz, J. (Ed.) *Law, Morality and Society* (1979) 285 at 299.

¹⁹⁶ Mill, JS. *On Liberty* (1982) 68.

¹⁹⁷ Op cit. n.191.

effect on the actor's long term goals and hence promotes the actor's autonomy. Gerald Dworkin uses Odysseus as illustration: 'Not wanting to be lured onto the rocks of the sirens, he commands his men to tie him to the mast and to refuse all later orders he will give to be set free... Although his behaviour at the time he hears the sirens may not be voluntary... there is another dimension to his conduct that must be understood. He has... a desire not to have or act upon various desires. He views the desire to move his ship closer to the sirens as something that is no part of him, but alien to him. In limiting his liberty, in accordance with his wishes, we promote, not hinder, his efforts to define the contours of his life'.¹⁹⁸ There is, however, a difference between abiding by an actor's advance directive - such as the decision made by Odysseus to be tied to the mast - and restricting the liberty of an actor based on a paternalistic interpretation of that actor's best interests. Stauch argues: 'However, suppose that, having expressed no prior wish, he were not tied to the mast and, on hearing the sirens, began to steer the ship towards the rocks. The sailors who laid hands on him and bound him at this point would be acting paternalistically in Odysseus's best interests; nevertheless, on the facts, they would also be promoting his autonomy. This is because it can be assumed that long-term survival is part of Odysseus's life plan and is what he, in his collected state, would prefer'.¹⁹⁹

The important thing to note, in Stauch's amendment, is that Odysseus is not acting autonomously since he temporarily lacks competence. The sailors were not only justified but would have failed in their duty if they had not secured Odysseus to the mast. Respect for autonomy demands that when a person temporarily lacks the capacity to be autonomous we should act to promote that person's recovery of capacity and to protect their 'welfare interests' essential for achieving their autonomous 'ulterior interests'.²⁰⁰ Where the woman

¹⁹⁸ Op cit. n.183 at 14.

¹⁹⁹ Op cit. n.68 at 79.

²⁰⁰ Op cit. n.196 at 285.

lacks decision-making capacity, providing it is necessary and in her best interests, the law allows doctors to treat her under the doctrine of necessity.²⁰¹ Dworkin's and Stauch's arguments simply provide moral justification for, respectively, the acceptance of advance directives and the treatment of incompetent patients. The question remains; can it be morally justified to override an irrational decision made by a competent autonomous actor?

There are occasions when self-harm is consistent with autonomous goals such as when the woman believes that the caesarean is against God's will and to act against God will result in eternal damnation. Thus, if a woman's choice is made autonomously, based on her acceptable belief set, then society has no right to interfere with her refusal of treatment even if that choice might result in her death. If her compelling 'ulterior interest' is to live according to God's will and hence go to heaven when she dies then dying accordingly furthers her 'ulterior interests'. Thus preventing her death, in a manner which she believes to be against God's will, is a devastating and irreversible infringement of her autonomy that makes her worse off than if she had died. Simply because we cannot understand her beliefs does not mean that her choice is irrational and should not be respected. If, however, given the woman's belief set, her decision would not further her 'ulterior interests' then it is irrational and there may be a moral duty to prevent her from acting on it.

If the woman's decision is not detrimental to her 'ulterior interests' then there is no justification to interfere with her decision simply because it does not promote them.

According to Culver and Gert's definition (*supra*) the woman's decision would not, in any case, be irrational since it has not caused self-harm. However, their definition is narrow and a more commonly held view is that expressed by the Oxford English Dictionary: 'Contrary to or not in accordance with reason, unreasonable, utterly illogical, absurd'. Reason is: 'That

²⁰¹ Re F (Mental patient: sterilisation) [1990] 2 AC 1.

intellectual power or faculty... which is ordinarily employed in adapting thought or action to some end; the guiding principle in the human mind in the process of thinking'; or 'A ground or cause of, or for, something'. Using this definition it is possible for the woman's decision to be irrational without causing self-harm. There would be no justification to override an irrational decision that is harmless. However, what if her decision risks self-harm?

We would certainly be justified in temporarily restricting the woman's liberty in order to explain the danger to her. But consider if, on hearing all the facts, she still insists on following her decision because she believes the risk worth taking in order to live by her values. Even though we may not understand her value hierarchy, the risk incurred by following her values would be consistent with her 'ulterior interests' and we have no justification for interfering with her decision. If this were not the case we would be obliged to prevent any dangerous activity. The difficulty here is at what level of risk to draw the line and interfere with a person's liberty: there may be good argument to ban boxing but should we also ban climbing, parachuting, driving or even walking under ladders? Should society value health and life over the right of autonomous persons to make their own decisions?

This may appear a simple choice between paternalism and autonomy but: both good health and life are pre-requisites for full autonomy; and not all decisions/actions made by autonomous persons will themselves be autonomous. When an irrational decision made by an autonomous person risks their health to such a degree that their future autonomy is jeopardised then acting paternally to override the decision is consistent with the principle of respect for autonomy. As Raz states: 'It is not surprising, however, that the principle of autonomy... yields duties which go far beyond the negative duties of non-interference, which are the only ones recognised by some defenders of autonomy'.²⁰² Preventing an irrational

²⁰² Op cit. n.191 at 324.

action is an interference with liberty and not autonomy, however, it must still be justified.

Difficulties in justification include:

- 1) distinguishing an irrational decision from an incomprehensible one. To make this distinction requires an understanding of both the actor's belief-set and life circumstances. Doctors are not the best group to make this assessment because their propensity towards a somatic perspective risks ignoring other relevant influences such as social and spiritual factors. As Robbins JA stated in *Malette*: 'It is not for the doctor to... to pass judgement on the religious principles which motivated it';²⁰³
- 2) assessment of risks. Medical decisions are often a question of balancing one probability against another. The weighting of probabilities is based on population studies but then applied to an individual. How appropriately the doctor applies those statistics to the individual depends on how closely the individual matches the general characteristic of the population studied. The combination of statistics and assumptions made by the doctor means that the final opinion is just that - an opinion. While some opinions can be given with relative certainty, or with little risk of harm, others are less certain and more risky. This uncertainty is highlighted by *Jefferson*²⁰⁴ in which the woman was diagnosed as having a complete placenta praevia (an abnormally sited placenta obstructing the opening of the birth canal). Doctors estimated the woman's risk of death to be 50%, and that of her fetus 99%, if delivered vaginally. An order for a compulsory caesarean was granted but a subsequent ultrasound demonstrated that the placenta had shifted and the baby was delivered vaginally without complication.²⁰⁵ The less certain an opinion then the less weight should be attached to it and the more weight given to the other factors important to the patient. Consideration must also be given to the disempowering effect, on the patient and their relatives, of an infringement of liberty. A harrowing example of this was the

²⁰³ *Malette v Shulman* (1990) 67 DLR 321.

²⁰⁴ *Op cit.* n.3.

²⁰⁵ Gallagher, J. 'Collective Bad Faith: 'Protecting' the Fetus'. In: Callahan, JC. (Ed.) *Reproduction, Ethics, and the Law: Feminist Perspectives* (1995) 343.

Nigerian man who committed suicide after his wife was forcibly restrained with leather straps to enable a court ordered caesarean.²⁰⁶ Alternatively, restricting the woman's liberty may empower the woman's dependants as was the case in *Re S* in which the interests of S's two children were advanced by overriding S's refusal of consent.²⁰⁷ The final balancing of the factors is a matter of judgement and the patient is the person best able to make the judgement;

- 3) consistency. An argument that it is justifiable to infringe a person's liberty to protect their welfare interests must be applied throughout society and not just the realm of healthcare. Thus priests would be justified in refusing to marry 'unsuitable' couples since marriage can certainly affect a person's future autonomy. Furthermore, all potentially harmful activities, which satisfied only first order desires rather than promoting 'ulterior interests', would have to be banned. While society has taken this view with some harmful activities, such as using controlled drugs, it does not do this consistently. Thus we are allowed to smoke, eat an unhealthy diet, drink too much alcohol and have unprotected sex with as many partners as we choose.

English law avoids these difficulties by avoiding the issue and allows that the competent adult's right to self-determination, with regard to medical treatment, is protected by law. This right has been affirmed on many occasions using phrases such as: 'completely at liberty';²⁰⁸ 'his choice must be obeyed';²⁰⁹ 'absolute right to choose';²¹⁰ 'entitled to refuse';²¹¹ and 'a basic human right protected by the common law'.²¹² In this way the law does not need to

²⁰⁶ Kolder, VEB. 'Woman's Health Law: a Feminist Perspective' (1985) Unpublished manuscript discussed in: Gallagher, J. Op cit. n.205.

²⁰⁷ Op cit. n.2.

²⁰⁸ Op cit. n.57 at 860 per Lord Keith .

²⁰⁹ Op cit. n.57 at 889 per Lord Mustill .

²¹⁰ Op cit. n.9 at 786 per Lord Donaldson MR.

²¹¹ *Malette v Shulman* (1988) 47 DLR 18 at 44 per Donnelly J.

²¹² Op cit. n.99 at 882 per Lord Scarman.

determine whether an actual decision is irrational and its only concern is that the person possesses decision-making capacity.

This reluctance to interfere with irrational decisions may be because the law recognises the difficulty in filtering out the incomprehensible from the irrational. It also protects against the risk of a doctor taking the moral high ground and overriding a decision simply because he morally disagrees with it. A morally pluralist society demands a degree of tolerance and, therefore, the law will respect any decision made by a person competent to decide regardless of whether the decision is based on irrational or even non-existent reasons.²¹³ In this respect, the law protects the right to self-determination to a greater extent than is required by the principle of respect for autonomy. While this protects the autonomous decisions of an autonomous person it also protects their non-autonomous decisions which may paradoxically harm that person's future autonomy. Thus, in trying to avoid determining which decisions are autonomous and which are not, the law may conflict with the principle of respect for autonomy. If the law's primary motivation was respecting the principle of autonomy then it would be justified in overriding any decision, including autonomous ones, that may reasonably be expected to restrict the actor's future autonomy. As Raz states: 'A moral theory which values autonomy highly can justify restricting the autonomy of one person for the sake of the greater autonomy of others or even of himself in the future'.²¹⁴ In not respecting autonomy per se the law focuses on the person rather than the principle and by respecting any decision of an autonomous person allows that individual to take responsibility for their life.

²¹³ *Op cit.* n.9 at 786 as per Lord Donaldson MR.

²¹⁴ *Op cit.* n.191 at 331.

Chapter Four: The Liberty-limiting Role of Countervailing Interests

The right to self-determination is not absolute. Professor Beaudoin noted two limitations: 'First the corresponding rights of others. Accordingly, an individual may not use his body in a manner which may have the effect of putting in jeopardy the life or health of others. Second, public order (policy). The law sometimes imposes limits on the right to freely do what one wishes with one's body. Accordingly, it does not allow a person to dispose *inter vivos* of a part of his body which is not capable of regeneration or, a vital organ'.²¹⁵

Third Party Interests

The third party most obviously affected is the fetus. This was recognised by Lord Donaldson MR whose *dictum* in *Re T*²¹⁶ was relied on in *Re S*. The decision in *Re S* although contrary to the earlier Court of Appeal judgment in *Re F (in utero)* - and the established legal position that the fetus is not a legal person - has received support from Thorpe LJ: 'Obviously, the jurisdictional foundation for that [the decision in *Re S*] may, as a matter of rationality, be difficult to tease out. The autonomy of the patient is a clear rule... But of course to recognise the autonomy of the patient seemed to put an end not only to her life but to the life of the child she was about to bear. Can we not all understand the pressure on the judge to make the order that has the prospect of saving human life?'²¹⁷

The decision in *Re S* has now been disapproved by the Court of Appeal in *Re MB (obiter)* and *R v Collins*. These decisions confirm that the fetus has no legal existence until it is born alive. Legally, the fetus cannot be considered a relevant third party whose rights conflict with the autonomous woman when she refuses consent to a caesarean and the doctrine of necessity

²¹⁵ Beaudoin, J-L. 'Le Droit de Refuser d'être Traité (The Right to Refuse to be Treated)': Translation quoted in: *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR 385.

²¹⁶ *Op cit.* n.9.

²¹⁷ Thorpe LJ. 'The Courts and Medical Treatment' [1996] 26 *Fam Law* 728.

cannot justify overriding her decision for the fetus' sake (see p.112). Nor can the contingent rights of the child-to-be justify a caesarean against the woman's will. Legally, there is no materno-fetal conflict.

Another third party affected by the woman's refusal is the doctor. It may be argued that, because the doctor's main interest is to ensure his patient's health, a refusal of treatment that jeopardises the fetus and/or the woman harms the doctor. However, the doctor has no duty to treat the competent patient against their wishes and, under the Declaration of Lisbon (*infra*), has a duty not to treat. Thus, the doctor's duty to act in the patient's best interest must be qualified by the patient's right to self-determination.²¹⁸ The risk to the fetus, however, complicates this scenario. Legally, since the fetus is not a person, the doctor has no justification for overriding the woman's decision, regardless of how morally compromised he feels in respect of the fetus. I will consider the doctor's position in more detail later.

The fetus' father may be able to act as a fetal advocate but, it is unlikely that he would have legal standing to compel a woman to consent to treatment for the fetus' benefit. This follows from *Paton*,²¹⁹ in which a request for an injunction to prevent the woman from aborting their fetus was denied. This decision was upheld by the European Commission of Human Rights, in *Paton v UK*,²²⁰ because protection of the woman's rights justified limiting the father's putative rights under Article 8.²²¹ Following this, there is no legal justification for allowing the father an injunction to prevent the woman from refusing consent to treatment.

²¹⁸ Op cit. n.57 at 866 per Lord Goff.

²¹⁹ Op cit. n.64.

²²⁰ *Paton v UK* (1980) 3 EHRR 408.

²²¹ Article 8 of the European Convention on Human Rights allows 'the right to respect for his private and family life, his home and his correspondence'.

Public Policy

In *Robb*,²²² Thorpe J,²²³ noted 4 state interests that may affect the individual's right to decide (See figure 12):

- 1) the preservation of life;
- 2) the prevention of suicide;
- 3) maintaining the integrity of the medical profession;
- 4) the protection of innocent third parties.²²⁴

He stated: 'The principle of the sanctity of human life in this jurisdiction is seen to yield to the principle of self-determination'.²²⁵ This view follows the House of Lords opinion in *Bland*.²²⁶ Further support comes from *Re MB* and in *Collins*, Judge LJ stated: 'Even when his or her own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it'.²²⁷

The state interest in preventing suicide is not relevant in the context of refusing medical treatment.²²⁸ Where the caesarean is indicated for fetal reasons refusing consent cannot be taken to indicate suicidal intent. Even where the operation is required on maternal grounds a suicidal intent cannot be implied. This is because, in most instances the patient desires to live, not at all expense, but only in accordance with her belief-set. Death is an unwanted side effect and, under the doctrine of double effect, is not morally wrong. Furthermore, refusing a caesarean is by no means a certain way of ensuring death. However, even if death were certain, the courts would be unlikely to consider it suicide. As Price notes: 'The courts typically adopt a narrow construction of intention in this context, equating it with desire'.²²⁹

²²² Secretary of State for the Home Department v Robb [1995] 2 WLR 722.

²²³ based on Thor v Superior Court (1993) 855 P.2d 375.

²²⁴ Op cit. n.222 at 727.

²²⁵ Ibid.

²²⁶ Op cit. n.57 at 866 per Lord Goff.

²²⁷ Op cit. n.32 at 685.

²²⁸ Op cit. n.57.

²²⁹ Op cit. n.150 at 276.

Thus, in *Nancy B*, a ventilator-dependent patient insisting on being disconnected from the ventilator was not suicide but simply 'nature taking its course'.²³⁰ Even where the person has plainly indicated a desire to die the courts will deny that a refusal of treatment is suicide.²³¹ Thus, in *Bouvia*, Beach J argued: '...it is clear she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide...'.²³² The courts appear to be making an arguably unjustified, but crucial, distinction between acts and omissions in this context.²³³

The integrity of the medical profession is maintained if the doctors are allowed to practice according to established ethical principles. The World Medical Association (WMA), in the Declaration of Geneva, state: 'The health of my patient will be my first consideration'.²³⁴ The Declaration of Lisbon, adopted by the WMA in 1981, states: 'a physician should always act according to his/her conscience and always in the best interest of the patient'.²³⁵ These statements suggest the doctor is obliged to act paternalistically to ensure his patient's health. However, the Declaration of Lisbon later states: 'The patient has the right to accept or to refuse treatment after receiving adequate information'. Likewise, the British Medical Association states: 'Doctors offer advice but it is the patient who decides whether or not to accept the advice'.²³⁶ Thus, a refusal of treatment does not threaten the doctor's integrity since he is only ethically obliged to act in the patient's best interests if consented to by the patient.

²³⁰ *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR 385.

²³¹ Price, DPT. 'Assisted Suicide and Refusing Medical Treatment: Linguistics, Morals and Legal Contortions' (1996) 4 *Med. Law Rev.* 270

²³² *Bouvia v Superior Court* 179 Cal App 3d 1127 (1986).

²³³ See: Price, DPT. Op cit. n.231.

²³⁴ The Declaration of Geneva (as amended) (1983) Reproduced in: The British Medical Association. *The Handbook of Medical Ethics* (1984) 70.

²³⁵ The Declaration of Lisbon (1981) Reproduced in: The British Medical Association. *The Handbook of Medical Ethics* (1984) 72.

²³⁶ The British Medical Association. *The Handbook of Medical Ethics* (1984) 19 para 2.15.

The fetus, although not a legal-person, can still be a patient and this creates an ethical dilemma: because the fetus lacks autonomy the doctor is ethically obliged to act in its best interests which may be contrary to the competent woman's decision. This dilemma comprises a balance between the respect for the woman's autonomy and beneficence towards the fetus and the woman. A non-consensual caesarean harms the woman's right to self-determination, bodily integrity and potentially her right to life. Not performing the caesarean risks harming the fetus' right to life. Legally, the doctor is not justified in placing beneficence above the right to self-determination. Morally, however, there are arguments that support either the woman or the fetus.²³⁷ Thus, a doctor who believes that he is morally justified in overriding the woman's decision will be able to claim support from within society. However, he will not have the support of society as a whole.

Upholding that doctor's ethical integrity would result in an unsatisfactory conclusion for two reasons: since not all doctors agree on the correct ethical approach, women would be subjected to different treatment on a geographical basis; and more importantly, infringing the doctor's ethical integrity is a lesser harm than infringing the woman's right to self-determination and her bodily integrity. Guidelines issued by the Royal College of Obstetricians and Gynaecologists state: 'Obstetricians must respect the woman's legal liberty to ignore or reject professional advice, even to her own detriment and that of her foetus'.²³⁸ Thus, the ethical integrity of the doctors is not sufficient to establish a public interest in overriding a competent woman's refusal of treatment.

One potential difficulty is that while the patient has the right to refuse treatment she has no right to demand an alternative against the doctor's advice. As Kennedy and Grubb state: 'The

²³⁷ Op cit. n.175.

²³⁸ Royal College of Obstetricians and Gynaecologists, *A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Interventions* (1994).

right to refuse treatment has limitations... It is a negative right... Consequently, a doctor cannot be required to provide treatment which in his clinical judgement he does not believe to be in a patient's best interests'.²³⁹ This view is supported by *Re J*²⁴⁰ in which, Lord Donaldson MR, as part of the *ratio*, repeated his *dictum* from *Re R*.²⁴¹ 'No doctor can be required to treat a child whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgment...'.²⁴² *Re C* concerned a disagreement between the doctors and the parents of a 16 month old girl suffering from spinal muscular atrophy. Both parties agreed the girl should be taken off ventilation but the parents wanted ventilation restarted if necessary. Sir Stephen Brown P refused to instruct the doctors to comply with the parent's wishes, as: 'That would of course be tantamount to requiring the doctors to undertake a course of treatment which they are unwilling to do. The court could not consider making an order which would require them so to do'.²⁴³

Since the patient has the right to refuse treatment and the doctors cannot be compelled to use a treatment against their better judgement, the scene is set for a potential impasse. In *Re L*,²⁴⁴ because of a needle phobia, L refused consent to intravenous anaesthesia. She was willing to have anaesthesia induced by gas inhalation but the anaesthetist refused this method because of the risk of gastric regurgitation and aspiration pneumonitis. The court circumvented the deadlock by finding that, because of her needle phobia, L was not competent to refuse consent. However, the anaesthetist's refusal to perform a gaseous induction of anaesthesia was simply his personal opinion. In *Re MB* the woman also suffered from a needle phobia but

²³⁹ Kennedy, I. Grubb, A. 'Treatment Without Consent: Adult' (1993) 1 *Med. Law Rev.* 83 at 85.

²⁴⁰ *Op cit.* n.138 at 27.

²⁴¹ *Re R (a Minor: Wardship Consent to Treatment)* [1992] Fam 11.

²⁴² *Ibid.* at 26 per Lord Donaldson MR.

²⁴³ *Re C (A Minor) (Medical Treatment)* [1998] Lloyd's Law Reports Medical, 1 at 5.

²⁴⁴ *Op cit.* n.87.

here the anaesthetist was willing to perform a gaseous induction.²⁴⁵ How would the court have dealt with the issue if L had simply been frightened of needles rather than suffering from a true phobia?

Given that, since *Collins*, a competent woman's refusal must be respected, will doctors be compelled to perform a treatment against their better judgement? In *Re C* the situation was slightly different: the choice was between ventilating or not ventilating. In the caesarean cases, the choice will generally be between a caesarean or vaginal delivery. It may be thought that for a doctor to refuse to assist a vaginal delivery simply because he disagrees with the woman's rejection of his professional advice would be unthinkable. However, Chervenak and McCullough consider that refusal is justified. In arguing that certain conditions, e.g. a complete placenta praevia, are grounds for coercive intervention, they state:

1. 'No physician is justified in accepting such a refusal because doing so would be based on unreliable clinical judgement; and
2. the physician is justified in resisting a patient's exercise of a positive right [to choose a treatment] when fulfilling their positive right contradicts the most highly reliable clinical judgement, dooms the beneficence-based interests of the fetus, and virtually dooms the beneficence-based interests of the pregnant woman'.²⁴⁶

They also believe that allowing a woman the right to refuse obstetric intervention endorses 'a policy that altogether ignores the integrity of medicine as worthy of serious consideration or even protection'.²⁴⁷ This follows from their argument that the fetus is a second patient with ethical significance arising from its link with the 'child it can become'. However, medical

²⁴⁵ In the event, MB panicked when she saw the mask and withdrew her consent. She was subsequently deemed incompetent and the caesarean was performed using an intravenous induction.

²⁴⁶ Chervenak, FA. McCullough, LB. 'Justified Limits on Refusing Intervention' (1991) 21 *Hastings Centre Report* 12.

²⁴⁷ Chervenak, FA. McCullough, LB. 'Legal Intervention During Pregnancy' (1991) 265(15) *JAMA* 1953.

integrity is infringed by allowing the woman to refuse intervention *only* if it is the doctor who assesses the reasonableness of the risk. If the woman makes the assessment then the beneficence-based obligations of the doctor are rightly restricted to those interventions that the woman is willing to risk. Surely, since it is the woman who takes the risk she should be allowed to decide if the risk is reasonable. The doctor's role is to counsel the woman about the risks and benefits of an intervention. It is not his role to make the decision for her; to do so would be a paternalism that fails to respect the woman's autonomy.

Furthermore, when a woman refuses a caesarean she is not making a positive demand for an alternative intervention. Vaginal delivery is the default mode of birth and it would be strained reasoning to argue that rejecting a caesarean in favour of vaginal delivery is an exertion of a positive right. Effectively, their argument rests on whether the doctor's moral obligations to the fetus outweigh his obligations to the pregnant woman. While it might be argued that the woman has a moral obligation to the fetus she is not under any obligation to take major risks for its benefit. Since a caesarean is a significant invasion of bodily integrity, with risks of both morbidity and mortality, she cannot be obliged to agree to a caesarean for her fetus' sake. Consenting to a caesarean may be morally commendable but refusing consent is not morally reprehensible.

Just as the integrity of medicine is not infringed by a potential organ donor refusing consent which will result in the potential recipient's certain death neither is it infringed by the refusal of a caesarean. To argue differently would demand that doctors act as moral arbiters and would place them in conflict with their patients and the law. This would create too large a burden for the doctor and runs a much greater risk of infringing their moral integrity than does demanding that they respect their patient's decisions. Demanding respect for patient's decisions adds a definite boundary to the doctor-patient relationship that frees the doctor

from moral responsibility for that decision and allows him to concentrate on the role for which he was trained: providing medical care.

If the doctor believes that the caesarean is the right treatment would he be legally justified in refusing to assist the woman deliver vaginally? The answer is no. Firstly, the woman, by refusing the caesarean effectively reduces the treatment options to assisting, or not assisting, her vaginal delivery. The caesarean is no longer part of the equation and the doctor must therefore decide whether assisting her or not is in her best interests. If the doctor still owes her a duty of care then there is really little choice but to assist her delivery. Secondly, the woman will still be under the care of the hospital and the doctor's contractual obligations to the hospital would probably require that he assists the delivery. Thirdly, although he might be able to argue that the woman's refusal of his advice negates his personal duty of care he would still remain under an obligation to refer her to a colleague who would be willing to assist. Finally, if a doctor chooses not to assist the woman without making alternative arrangements then, should the woman or the fetus suffer harm because of the lack of assistance, the doctor may be liable for negligence. Thus, although the doctor cannot be compelled to follow a particular course of action he must act in his patient's best interests within the confines of the options left open by her treatment decision. If the doctor chooses to do nothing then he may be liable for negligence if his inaction results in harm. Hopefully, no doctor would be churlish enough to refuse to help a woman simply because she rejected his professional advice.

The final state interest is the protection of innocent third parties. These include; the fetus, the woman's dependants, and others emotionally dependent on the woman. The persons emotionally dependent on the woman may be harmed if she dies or is seriously injured. However, this type of harm is emotional rather than physical and does not infringe their

rights, moral or legal. Where the harm is unintentional and not associated with the breach of a recognised right or duty then the state does not owe its citizens a right not to be emotionally hurt. In criminal law: 'the phrase 'actual bodily harm' is capable of including psychiatric injury. But it does not include mere emotions such as fear or distress or panic nor does it include, as such, states of mind that are not themselves evidence of some identifiable clinical condition'.²⁴⁸ Likewise, tort law will not allow an action for emotional harm unless that harm is either associated with 'some other type of actionable injury' or where the harm is severe enough to cause a 'medically recognised psychiatric illness'.²⁴⁹ Furthermore, unintentionally causing a psychiatric injury would not incur liability unless it was caused negligently.²⁵⁰ Since a refusal of medical treatment may be based on irrational reasons it seems unlikely that a pregnant woman could be negligent when she refuses a caesarean. It would be morally good for the woman to consider the feelings of others when she makes her decision but the State has no right to interfere with that decision. The massive interference that would be required by the State, if it was to try and prevent emotional harm, would be impossible to achieve on a practical level.

Essentially, the woman's dependants are her children. The State does restrict her autonomy for her children's benefit to ensure that they are provided with essentials such as food, shelter and medical care. However, child neglect laws do not require that she refrains from dangerous activity such as mountaineering or even smoking, nor do they require her to put herself at risk for her children. While she may be required to 'rescue' her child if there was no risk she would not be expected to enter a burning house to do so. Nor would she be legally required to donate an organ or even just a pint of blood. In *McFall*,²⁵¹ the court held that a cousin could not be compelled to donate bone marrow even though his refusal 'appears to be

²⁴⁸ Chan-Fook [1994] 2 All ER 552 at 559.

²⁴⁹ Cane, P. *The Anatomy of Tort Law* (1997) at 68.

²⁵⁰ Rogers, WVH. *Winfield & Jolowicz on Tort* (1994) at 119.

²⁵¹ *McFall v Shrimp* 10 Pa D&C 2d 90 (1978).

revolting in the moral sense'. From the State's perspective, the harm to the woman, in overriding her refusal, would be much greater than the harm suffered by the children. Thus the State cannot compel a woman to undergo an operation against her wishes simply because they suffer an emotional harm and may become a financial burden to the state.

The ultimate third party, that may require protection under the umbrella of public interest, is the fetus. Although the fetus has no independent legal personality the State may still have a legitimate interest in its protection. This follows because any *in utero* harm may affect its ability to become an autonomously useful member of society. This could later place a burden on society and thus its prevention must be within the public interest. However, if a parent cannot be compelled to undergo even minor procedures for their child's sake then they cannot be compelled to do so for the sake of their fetus. In the U.S., one judge refused to override a woman's refusal and order a caesarean because he recognised there was no jurisdiction to force her to donate an organ to one of her children, even if it would die without it.²⁵² As Nelson and Milliken observe: '...our society refuses to force the donation of organs or tissues from cadavers to benefit or save the lives of the thousands in need of them. We see no good reason why pregnant women should be treated with less respect than corpses'.²⁵³

Current public policy as evinced by Statute Law emphasises the primacy of the mother over her unborn child. Thus, the Abortion Act 1967 puts the woman's health ahead of the fetus, even at full term. Likewise, the Congenital Disabilities (Civil Liability) Act 1976 makes all liability to the fetus derivative to a tort committed against the parent (usually the mother) and it denies any maternal liability for ante-natal harm except for that caused by dangerous

²⁵² Unpublished opinion, No. 84-7-50006-D (Super Ct Benton Cty Wash, April 20, 1984) discussed in: Nelson, LJ. Milliken, N. Op cit. n.38.

²⁵³ Op cit. n. 38.

driving. This suggests that the legislature places maternal liberty above the prevention of fetal harm and shifts the balance of decision making power away from the doctors and midwives and towards the woman. As Eekelaar and Dingwall state: 'The Congenital Disabilities (Civil Liability) Act 1976 only recognises a separate duty to the child after the moment of birth, defined as the point when the child has a life "separate from its mother". Before that, the attendant's first duty appears to be the care of the mother in which, clearly, deference to her wishes will be a significant feature. If in deferring to her and giving her correct professional attention, the child is injured, the law appears to hold that this is just too bad. On the other hand, if the attendant overrides the mothers wishes in attending to the child, he would seem at risk of litigation'.²⁵⁴

More recent government reports^{255,256} also add weight to the woman's position. The Expert Maternity Group stated: 'The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having fully discussed matters fully with the professionals involved'.²⁵⁷ An earlier Department of Health Memorandum states: 'Women should as far as practicable, be able to choose and have access to the type of care which they feel is best suited to their needs'.²⁵⁸ Similarly, the Health Committee focused on the woman's needs and recommended that: '...a hospital delivery unit should: ensure the feasibility of the woman being 'in control' of her labour'.²⁵⁹

All these considerations suggest that public policy does not require a woman to submit to a non-consensual operation for the fetus' benefit. As Hewson notes: 'There is no clear 'public

²⁵⁴ Eekelaar, JM. Dingwall, RWJ. 'Some Legal Issues in Obstetric Practice' [1984] *Journal of Social Welfare Law* 258 at 267.

²⁵⁵ House of Commons Health Committee. *Maternity Services* (1992).

²⁵⁶ Department of Health Expert Maternity Group. *Changing Childbirth* (1993).

²⁵⁷ *Ibid.* at 9.

²⁵⁸ Quoted in: House of Commons Health Committee. *Maternity Services* (1992) xv.

²⁵⁹ *Ibid.* at xcvi.

policy' argument to justify hospitals imposing unwanted services on unwilling consumers, especially by force'.²⁶⁰ Currently, the public interest in ensuring that the rights of the adult woman are protected is perceived to be stronger than the public interest in protecting the fetus. This position should only be changed by Parliament and not the courts.²⁶¹ As Thorpe LJ states: 'The issue lies across the fields of jurisprudence, morality, medical ethics and constitutional rights. The debate is more in the political than the legal arena. It is for society to resolve the debate through its democratic and legislative processes'.²⁶²

²⁶⁰ Hewson, B. 'Women's Rights and Legal Wrongs' (1996) 146 *NLJ* 1385.

²⁶¹ *Re F (In utero)* [1988] Fam 122 at 144 per Balcombe LJ.

²⁶² *Op cit.* n.1 at 664.

Chapter Five: The Woman's Rights Under the European Convention on Human Rights (ECHR)

The woman's position receives further support under the ECHR.²⁶³ A non-consensual operation may violate Articles 3, 5 and 8. If the woman's refusal of consent is for religious reasons it may also breach Article 9. Article 3 states: 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'. To violate these provisions the treatment must exceed a threshold level which '...depends on all the circumstances of the case, such as the duration of treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc'.²⁶⁴ Thus, for an emotionally and physically vulnerable pregnant woman, especially one in labour, the threshold level would be lower than for a healthy adult prisoner. The obligation of the State to comply with Article 3 is not relieved by the patient being obstructive or uncooperative.²⁶⁵ Furthermore, the fact that medical treatment is not intended to cause suffering is irrelevant: 'inhuman treatment need not be intended to cause suffering... the crucial distinction lies in the degree of suffering caused'.²⁶⁶

In *Herczegfalvy*,²⁶⁷ the Commission stated: 'Compulsory medical treatment does not violate Article 3 if it is necessary from the medical point of view and carried out in conformity with standards accepted by medical science'.²⁶⁸ The Court stated that: 'a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must

²⁶³ See Hewson, B. 'Right to Refuse Treatment; Right to a Fair Hearing' (1997) 2 *Journal of Civil Liberties* 44.

²⁶⁴ *Ireland v UK* A 25 (1978) para 162.

²⁶⁵ *Herczegfalvy v Austria* A 244 (1992) at 45.

²⁶⁶ Harris, DJ. O'Boyle, M. Warbrick, C. *Law of the European Convention on Human Rights* (1995) 61.

²⁶⁷ *Herczegfalvy v Austria* A 244 (1992).

²⁶⁸ *Ibid.* at 45.

nevertheless satisfy itself that the medical necessity has been convincingly shown to exist'.²⁶⁹ However, *Herczegfalvy* concerned a mentally incompetent patient under compulsory detention who was force fed while on hunger strike. Harris et al argue that the effect of Article 3 on compulsory medical treatment of detainees is not clear: 'At the least, it is likely that Article 3 permits the compulsory treatment by the state in accordance with the 'standards accepted by medical science' of all persons in its custody where this is necessary to save them from death or serious injury... Such treatment would not be inhuman or degrading just because of the lack of consent or the manner of its administration'.²⁷⁰ Under Article 2 a State has a positive obligation, '...to take appropriate steps to safeguard life'.²⁷¹ The Commission has held that, at least in respect to a person in the state's custody, this positive obligation supersedes issues under Article 3.²⁷²

When the court authorised a caesarean in *Collins*, the woman was detained in the State's custody under s.3 MHA 1983. Irrespective of whether the detention itself was lawful this would still justify non-consensual treatment to safeguard her life and would take that treatment outside of Article 3. It may also be argued that, although not compulsorily detained, patients in NHS hospitals are in the State's care and that the State's obligations to persons in its care are the same as to those in its custody. If this argument is accepted then non-consensual treatment would not breach Article 3. However, the position taken by the Commission in *X v FRG*,²⁷³ that the obligation under Article 2 'should in certain circumstances call for positive action on the part of the contracting parties, in particular an active measure to save lives when the authorities have taken the person in question into their

²⁶⁹ Op cit.n.267 at 26.

²⁷⁰ Op cit. n.266 at 72.

²⁷¹ Opinion of the Commission in *McCann and others v UK* (1996) 21 EHRR 97 at 138, para 187.

²⁷² *X v FRG* (1985) 7 EHRR 152.

²⁷³ *Ibid.* at 153.

custody', has been criticised.²⁷⁴ An alternative view is that the duty is to make treatment available but there is no duty to enforce treatment against the will of a competent woman.

Article 5 states: 'Everyone has the right to liberty and security of person'. In *X v Austria*, the Commission held: '...that enforcing a blood test on a person is a deprivation of liberty'.²⁷⁵ If this is the case then a non-consensual caesarean must also qualify as a violation of Article 5.

Article 8 states:

- '1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others'.

In *Herczegfalvy*, the Court held: 'the right to respect for a person's private life includes his right to decide himself whether he wishes undergo a certain medical treatment'.²⁷⁶ In *Laskey*,²⁷⁷ the Commission considered whether overriding a person's consent to sado-masochistic acts that inflicted actual bodily harm was 'necessary in a democratic society', under Article 8, 'for the protection of health or morals'. The Commission stated: 'any interference under Article 8 had to correspond to a pressing social need and be proportionate to the aim pursued, taking into account the State's margin of appreciation [in relation to

²⁷⁴ Op cit. n.266 at 40.

²⁷⁵ *X v Austria* No. 8278/78 18 DR 154 at 156 (1979).

²⁷⁶ Op cit. n.267 at 49.

²⁷⁷ *Colin Laskey, Roland Jaggard, and Anthony Brown v UK* [1996] EHRLR 194.

morality]’.²⁷⁸ The Commission held, that even though Article 8 covered sexual relationships, the derogation ‘for the protection of health and morals’ was justified.

It might be argued that where a fetus is likely to be born alive then there is a ‘pressing social need’ to ensure that it is born healthy. If it is the only safe way to deliver the baby then a non-consensual caesarean might be considered proportionate. Likewise, given the ‘margin of appreciation’ in relation to moral issues, if a state felt morally obliged to protect the life of the fetus a non-consensual caesarean would not necessarily be a violation of Article 8. However, in *Bouchelkia*, the Commission emphasised the need to ensure that: ‘...a fair balance has been struck between the legitimate aim pursued and the seriousness of the interference with the applicant’s right’.²⁷⁹ This view was endorsed by the Court. Thus, even if protecting the health of the fetus is a legitimate aim it would still have to be offset against the woman’s rights. In *Cossey*, the Court stated: ‘the fair balance that has to be struck [is] between the general interest of the community and the interests of the individual’.²⁸⁰ Thus the Court would have to be convinced that protection of the fetus outweighed the woman’s right to self-determination and bodily integrity. Following earlier decisions,²⁸¹ and given that a non-consensual caesarean is a major infringement of the woman’s bodily integrity and liberty, it seems unlikely that the public interest in the fetus would trump the woman’s rights.

Similar arguments pertain to ‘the protection of the rights and freedoms of others’: it is doubtful if the fetus would be considered as an ‘other’ under the Convention and even if it was the rights of the woman would trump any limited rights given to the fetus. It may be that the father-to-be of the fetus could be a victim under this section and this would certainly be so if the father-to-be could make a claim under the Convention as a victim of the woman’s

²⁷⁸ Op cit. n.277 at 195.

²⁷⁹ *Bouchelkia v France* (1997) 25 EHRR 686 at 702, para 47.

²⁸⁰ *Cossey v UK* A 184 para 37 (1990).

²⁸¹ Op cit. n.221.

decision regarding her pregnancy. In *Bowman*, the Commission stated: 'in order to be a victim of an interference with a right an applicant must be 'directly affected' by the measure complained of'.²⁸² Indirect victims may also be allowed providing they are closely affected and not simply acting as advocates. 'Broadly speaking the concept of indirect victims encompasses those who are also prejudiced by the violation as well as those who may have a valid personal interest in having the violation established'.²⁸³ In *Paton*, a prospective father was held to be so closely affected, by the decision of the woman to terminate her pregnancy, that he was considered a victim. However, the rights of the woman under Article 8 trumped both the rights of the fetus under Article 2 and any rights the father might have had under Articles 8 and 12.²⁸⁴ This would also be the case for refusal of medical treatment and thus a non-consensual caesarean could not be justified as 'protection of the rights and freedoms of others'.

Notwithstanding the difficulties in arguing that State interests override the woman's rights, any interference of those rights must be 'in accordance with the law'.²⁸⁵ Overriding a competent woman's consent would not be in accordance with the current law in England as stated in *Collins and Re MB*. Any proposed change in the law would have to take into account the need for certainty.²⁸⁶ Prior to *Re S*, the law regarding a refusal of a caesarean was uncertain. Lord Donaldson MR's *dictum* about the presence of a viable fetus being a possible exception to the right to self-determination was possibly one of the justifications for overriding S's refusal of consent. However, since the fetus is not a person under English law, Lord Donaldson MR's *dictum* did not make it foreseeable that it would be lawful to perform a non-consensual caesarean on a competent woman. Given the serious nature of the

²⁸² *Bowman and the SPUC v UK* (1996) 21 EHRR CD 79.

²⁸³ *Op cit.* n.266 at 637.

²⁸⁴ Article 12 states: 'Men and women of marriageable age have the right to marry and to found a family according to the national laws governing the exercise of this right'.

²⁸⁵ S.2 Article 8.

²⁸⁶ *Malone v UK* A 82 para 87 (1984).

infringement of the woman's rights and the lack of foreseeability of the decision,²⁸⁷ *Re S* was probably not in accordance with the law for the purposes of a derogation under Article 8.

Article 9(1) states: 'Everyone has the right to freedom of thought, conscience and religion: this right includes freedom... to manifest his religion or belief, in worship, teaching, practice and observance'. Article 9 protects both religious and non-religious beliefs. Non-religious beliefs are fairly generously interpreted and, in *Arrowsmith*, pacifism satisfied the requirements because it was a 'philosophy'.²⁸⁸ The beliefs held by S, in *Collins*, that nature should not be interfered with and therefore her pregnancy should be left to take its course, would probably fall under Article 9. In *Re S*, S and her husband were 'described as 'born again Christians' and are clearly quite sincere in their beliefs'.²⁸⁹ Their refusal of a caesarean for religious reasons would be protected by Article 9 providing they could show that such a refusal was consistent with or required by their beliefs.²⁹⁰ Under Article 9(2) the State may interfere with the manifestation of religion or belief in 'the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others'. Ignoring the need for foreseeability, the Court may accept that a violation is justified under the grounds of protecting the woman's (and/or the viable fetus') health. In *X v UK* it was held that the requirement that a Sikh prisoner clean his cell's floor, although contrary to accepted Sikh practice, was justified for the protection of health.²⁹¹ Similarly the potential risk to the health/life of the mother or her child-to-be may justify a violation of Article 9.

²⁸⁷ *Silver v UK* A 61 paras 91, 93-95 (1983). The law must be certain and foreseeable and the knowledge of those factors must have been available to or accessible by the victim.

²⁸⁸ *Arrowsmith v UK* No. 7050/75, 19 DR 5 (1978) Com Rep paras 69-71; CM Res DH (79) 4.

²⁸⁹ *Op cit.* n.2 per Sir Stephen Brown P.

²⁹⁰ *Op cit.* n.266 at 358.

²⁹¹ *X v UK* No. 8231/78, 28 DR 5 at 38 (1982).

In summary, a non-consensual caesarean will violate the rights of a competent woman under Articles 3, 5 and 8. If her refusal is on religious or conscientious grounds then Article 9 will also be breached. Furthermore, if the woman dies following the caesarean then her rights under Article 2 will have been infringed. If the caesarean is indicated on maternal grounds then Article 3 may not have been breached because of the State's positive obligations under Article 2. This may also be the case if the Court allows the viable fetus a limited right to life. While the violation of Article 9 may be justified under the protection of health or the rights of others it is unlikely that the same can be argued for the breach of the woman's rights under Article 8. Certainly that would be the case where the caesarean was indicated solely on fetal grounds because the gross invasion of the woman's rights, under Article 8, would outweigh any State interest in the potential life of the fetus. Therefore, a non-consensual caesarean would be a violation of a competent woman's rights under the ECHR.

Chapter Six: The Legal Status of the Fetus

In *Collins*,²⁹² the Court of Appeal considered the full-term fetus: 'Whatever else it may be, a 36-week foetus is not nothing; if viable, it is not lifeless and it is certainly human'. It argued: '...the interests of the foetus cannot be disregarded on the basis that in refusing treatment which would benefit the foetus, a mother is simply refusing treatment for herself'. However, Judge LJ found that, both in criminal²⁹³ and civil law,²⁹⁴ legally protected interests of the fetus are not realised until it is born alive. The Court of Appeal concluded: 'Although human, and protected by the law in a number of different ways ...an unborn child is not a separate person from its mother'. This was also the conclusion in *Re MB*.²⁹⁵ The Court of Appeal was undoubtedly correct, on the basis of current law, to deny that the fetus has legally protected interests that may override the competent woman's right to self-determination. The law is strongly weighted in favour of the competent woman's autonomy but the first-instance decisions suggest there is a significant amount of judicial sympathy with the fetus. It is therefore important to consider the legal and moral status of the fetus in order to determine whether the legal balance is weighted appropriately.

Legal Protection of the Fetus as Fetus

It is certain that, under English law, the fetus is not a legal person. In Attorney General's Reference (No.3 of 1994), Lord Mustill stated: 'It is sufficient to say that it is established beyond doubt for the criminal law, as for the civil law... that the child *en ventre sa mere* does not have a distinct human personality whose extinguishment gives rise to any penalties or liabilities at common law'.²⁹⁶ Thus, a stillborn child cannot give rise to liability for homicide

²⁹² Op cit. n.32.

²⁹³ Op cit. n.65.

²⁹⁴ Op cit. n.69.

²⁹⁵ Op cit. n.31 at 561.

²⁹⁶ Op. cit. n.65 at 434.



and in *Tait*,²⁹⁷ a threat to kill a pregnant woman's fetus is not a threat to kill a 'legal person'. As Sir George Baker said, in *Paton*: 'The foetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother'.²⁹⁸ Likewise, in *Re F* an attempt to make a fetus a ward of court failed.²⁹⁹ As Balcombe LJ explained: '...an unborn child has, ex hypothesi, no existence independent of its mother'.³⁰⁰ However, the fetus is not bereft of legal protection.

Three criminal law statutes provide limited protection for the fetus: the Infant Life (Preservation) Act 1929; the Offences Against The Person Act (OAPA) 1861 and the Abortion Act 1967. The 1861 Act makes it an offence to 'unlawfully administer ...any poison or other noxious thing, or [shall] unlawfully use any instrument or other means whatsoever' with 'intent to procure' a 'miscarriage'.³⁰¹ Under the 1929 Act, any intentional destruction of 'the life of a child capable of being born alive' is an offence unless it is done in 'good faith for the purpose only of preserving the life of the mother'.³⁰² Because it requires a 'wilful act', intentional omissions escape the ambit of the 1929 Act which means that refusing medical treatment could never be an offence under this Act even if it was virtually certain³⁰³ the child would die before achieving an independent existence. Likewise, recklessly or negligently causing fetal death is not an offence under the 1929 Act - or the OAPA 1861 - and so recklessly or negligently refusing medical treatment, not caring whether the fetus dies, would not create a liability. Similarly, the Abortion Act 1967 gives little protection to the fetus. Up to 24 weeks gestation, it may be aborted on 'social' grounds.³⁰⁴ After 24 weeks,

²⁹⁷ *R v Tait* [1990] 1 QB 290.

²⁹⁸ *Op cit.* n.64 at 279.

²⁹⁹ *Op cit.* n.69.

³⁰⁰ *Ibid.* at 538.

³⁰¹ OAPA 1861, s.58.

³⁰² Infant Life (Preservation) Act 1929, s.1.

³⁰³ *R v Nedrick* [1986] 1 WLR 1025.

³⁰⁴ s.1(2) allows the woman's 'actual or reasonably foreseeable environment' to be taken into account. In: *Health Care Law* (1997) at 365, Montgomery, J. notes: 'While this ground clearly refers to health matters, it has been described as a 'social' ground... This means that the inconvenience of having a

although termination of the fetus requires stronger justification, its 'right-to-life' is still subservient to the woman's right to preserve her life or avoid 'grave permanent injury' to her health.³⁰⁵ Thus, the criminal law, does not require a pregnant woman to place the interests of the fetus *qua* fetus before her own well-being

The fetus fares even worse in the civil law which provides no protection against *in utero* death. Both under common law³⁰⁶ and under the Congenital Disabilities (Civil Liability) Act 1976 the child must first be born alive before it acquires any standing.³⁰⁷ Similarly, a parent cannot claim for bereavement loss, under the Fatal Accidents Act 1976, when a child is stillborn.³⁰⁸ The argument is succinctly stated by Whitfield: 'There can be no actionable breach of duty to those born dead: before they are born they are not 'persons' and after they are born they have no legal rights'.³⁰⁹

The ECHR provides for the right-to-life which is '...the most basic human right of all'.³¹⁰ Article 2 states: 'Everyone's right-to-life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law'. This article 'establishes a positive obligation for states to make adequate provision in their law for the protection of human life', but whether 'everyone' includes the fetus has not yet been fully resolved.³¹¹

child may provide a basis for an abortion'. He also notes that in 1993, of the 157,846 abortions in England and Wales, 96% were on 'social grounds'.

³⁰⁵ Abortion Act 1967, s.1(1)(b), (c).

³⁰⁶ *B v Islington Health Authority* [1991] 1 QB 638.

³⁰⁷ Congenital Disabilities (Civil Liability) Act 1976

s. 1, 2. In some circumstances, such as under the laws of inheritance, the civil law has engineered the fiction that a child can be deemed 'born legally' before its physical birth. Thus, in *The George and Richard* (1871) LR3A and *E.466*, a child born after the death of its father was a dependent for the purposes of an action under the Fatal Accidents Act 1846.

³⁰⁸ *Bagley v North Herts Health Authority* (1986) 136 NLJ 1014.

³⁰⁹ Whitfield, A. 'Common Law Duties to Unborn Children' [1993] 1 *Med. Law Rev.* 28.

³¹⁰ *Op cit.* n.266 at 37.

³¹¹ *Op cit.* n.266 at 41.

In *Paton v UK*³¹² the Commission noted that although not defined: 'both the general usage of the term 'everyone' in the Convention and the context in which this term is employed in Article 2 tend to support the view that it does not include the unborn'.³¹³ Later the Commission argued that the fetus does not have an absolute right-to-life because: 'The 'life' of the foetus is intimately connected with, and it cannot be regarded in isolation of, the life of the pregnant woman. If Article 2 were held to cover the foetus and its protection under this Article were, in the absence of any express limitation, seen as an absolute, an abortion would have to be considered as prohibited even where the continuance of the pregnancy would involve a serious risk to the life of the pregnant woman. This would mean that the 'unborn life' of the foetus would be regarded as being of a higher value than the life of the pregnant woman'.³¹⁴ However, because the case involved the abortion of a fetus during the first half of gestation, the Commission declined to consider whether the fetus had a limited right-to-life or no right at all under the Convention.

After *Paton* it is still possible that the fetus may have a limited right-to-life under Article 2.³¹⁵ Implied limitations to this right would reasonably include protection of the woman's health and life but it is not clear whether their application would be uniform throughout gestation. However, the fragile right-to-life of the pre-viable fetus received another blow in *H v Norway*³¹⁶ which involved the abortion of a 14 week fetus on the statutory ground that continuation of the pregnancy 'may place the woman in a difficult situation of life'. The Commission held that this was not contrary to Article 2 thus allowing the woman's lifestyle to further limit the pre-viable fetus' right-to-life. This decision means that the pre-viable fetus has no real right-to-life at all.

³¹² *Paton v UK* No. 8416/79 19 DR 244 (1980).

³¹³ *Ibid.* at 250.

³¹⁴ *Op cit.* n.313 at 252.

³¹⁵ *Op cit.* n.266 at 42.

³¹⁶ *H v Norway* No. 17004/90 (1992) unreported.

The refusal of a caesarean concerns a viable fetus rather than the pre-viable fetus considered in the abortion cases. After *H v Norway* it is unlikely that the pre-viable fetus has a right-to-life protected by the Convention, but it is still possible that the viable fetus has a limited right-to-life. In *Bruggerman*³¹⁷ the Commission stated that 'pregnancy cannot be said to pertain uniquely to the sphere of private life. Whenever a woman is pregnant, her private life becomes closely connected with the developing foetus'. Also, in *H v Norway*, despite allowing social abortions, the Commission would not exclude the possibility of circumstances (not defined) in which Article 2 may offer protection to the fetus. As Douglas notes: 'It [the Commission] seems to be unsure about the position of the foetus, and has yet to make up its mind'.³¹⁸

*Re MB*³¹⁹ is the only caesarean case in which the court considered (*obiter*) the rights of the fetus under the Convention. The Court of Appeal concluded that none of the Commission's opinions were helpful in deciding the issue. Thus, until the Commission considers the status of the full-term fetus - or at least the viable fetus - the courts must rely on current English law which allows the fetus only very limited protection. The implication is that the interests of the fetus *qua* fetus cannot be heeded when considering the right of a pregnant woman to refuse consent.

The United Nations Convention On The Rights Of The Child, adopted in 1989, may be interpreted to afford the fetus greater protection. The preamble, by stating 'the child... before as well as after birth', implies that the fetus has as much 'inherent right-to-life' as the child after birth.³²⁰ Since a human being is not defined, the definition of a child may

³¹⁷ *Bruggerman and Scheuten v Federal Republic of Germany* [1977] 3 EHRR 244. (10 DR 100).

³¹⁸ Douglas, G. *Law, Fertility and Reproduction* (1991) at 37.

³¹⁹ *Op cit.* n.31.

³²⁰ Article 6 demands that: 1) States Parties recognize that every child has the inherent right-to-life; and 2) States Parties shall ensure to the maximum extent possible the survival and development of the child.

arguably include the fetus. However, 'The definition was indeed left deliberately vague to permit individual states to give it their own meaning'.³²¹ Also, 'appropriate legal protection' could be interpreted differently for the child post- as opposed to pre-birth. Furthermore, the Convention is only politically persuasive not legally binding.

Legal Protection of the Fetus as a Child-to-be

Despite the lack of protection afforded the fetus killed *in utero* the law recognises that the child born alive is affected by pre-birth events. In *Re D*, a wardship case, Lord Goff stated: 'They [magistrates] have, of course to consider the question whether the relevant (factual) continuum exists, at the date when they are asked to make their order, with reference to a living child. But in looking for evidence whether such continuum exists, there is no reason why they should not look at events which occurred while the child was still unborn'.³²²

Glazebrooke notes: '...it has long been clear that, if the baby had died of ante-natal injuries deliberately or recklessly inflicted, the person causing them would be guilty of manslaughter'.³²³ The authority for this was *Senior*: a male midwife, who negligently crushed a baby's skull causing it to die immediately after birth, was found guilty of manslaughter.³²⁴ In *Kwok Chak Ming* the defendant was convicted of manslaughter for stabbing a pregnant woman causing her baby's death 3 days post-partum.³²⁵ The decision was based on the doctrine of transferred malice which: 'applies we think with equal force even where [the third party] was only an embryo or foetus at the time when the malice was manifested and the injury inflicted but is subsequently born alive and dies of the injury'.³²⁶

³²¹ Op cit. n.318 at 39.

³²² *Re D (A minor)* [1987] 1 FLR 422 at 438 per Lord Goff.

³²³ Glazebrook, PR. 'What Care Must be Taken of an Unborn Baby?' (1993) 52(1) *Cambridge Law Review* 20.

³²⁴ *R v Senior* (1832) 1 Mood 346.

³²⁵ *Kwok Chak Ming v The Queen* [1963] HKLR 349.

³²⁶ *Ibid.* at 354.

The doctrine of transferred malice was again applied by the Court of Appeal in *Attorney-General's Reference (No.3 of 1994)*.³²⁷ The decision was criticised because: the argument that the fetus should be treated as part of the mother would negate transferred malice which applies between persons and not between parts of the same person, and: 'If it is not possible to have the *mens rea* for murder in relation to a foetus, on the basis that the foetus is not a person in being, surely it cannot be possible to transfer the *mens rea* to a person not in being'.³²⁸ When the case came before the House of Lords it held that transferred malice was not applicable and: 'That a foetus was neither a distinct person separate from its mother nor merely an adjunct of the mother, but was a unique organism to which existing principles could not necessarily be applied'.³²⁹ However, as the defendant had stabbed a woman in the abdomen knowing she was pregnant, there was sufficient *mens rea* for manslaughter.

Pre-natal injury to a fetus may also support a charge of murder. In *Attorney-General's Reference (No.3 of 1994)*. Lord Hope stated: 'For the foetus, life lies in the future, not the past. It is not sensible to say that it can never be harmed, or that nothing can be done to it which can ever be dangerous. Once it is born it... may also carry with it the effects of things done to it before birth which, after birth, may prove harmful. It would not seem unreasonable therefore, on public policy grounds, to regard the child in this case, when she became a living person, as within the scope of the *mens rea* which B had when he stabbed her mother before she was born'.³³⁰ Lord Mustill considered, *obiter*, that an act of murder could be initiated ante-natally providing: 'it is possible to interpret the situation as one where the mental element is directed, not to the foetus but to the human being when and if it comes into existence'.³³¹

³²⁷ *Attorney-General's Reference (no.3 of 1994)* [1996] 2 WLR 412.

³²⁸ Seneviratne, M. 'Pre-natal Injury and Transferred Malice: the Invented Other' (1996) 59 *MLR* 884.

³²⁹ *Op cit.* n.65.

³³⁰ *Op cit.* n.65.at 443.

³³¹ *Ibid.* at 434.

The decision of the House of Lords in the *Attorney-General's Reference (No.3 of 1994)* has implications for the materno-fetal conflict.³³² By adopting the principle of 'transferred malice to establish the necessary *mens rea* and their assertion that *qua foetus* the child-to-be is an integral part of the mother, the Court of Appeal appeared to rule out any possibility of maternal criminal liability'.³³³ However, by overruling the Court of Appeal, the House of Lords have established that maternal liability for homicide is possible for a pre-natal act. Unlawful act manslaughter is not relevant to the caesarean section debate because refusing medical treatment is lawful. However, might gross negligent manslaughter, or even murder,³³⁴ arise when a pregnant woman rejects or ignores medical advice?

Refusing medical treatment is an omission rather than an act.³³⁵ Both gross negligent manslaughter³³⁶ and murder³³⁷ may be committed by omission but only where a there was a duty-to-act. A duty-to-act arises where there is a special relationship between the defendant and victim. Such a relationship exists between parent and child³³⁸ but does it exist between the woman and her fetus? The provisions of the Abortion Act 1967 make it difficult to establish a duty-of-care to the fetus before it reaches 24 weeks of gestation. It would be nonsensical to argue that a woman has both a duty-of-care and a liberty³³⁹ to abort on minimal grounds.³⁴⁰ However, if the woman elects to carry the fetus to term does the rejection of a termination establish a duty-of-care?

³³² Fovargue, S. Miola, J. 'Policing Pregnancy: Implications of the Attorney-General's Reference (No.3 of 1994)' (1998) 6 *Med. Law Rev.* 265.

³³³ Brazier, M. 'Parental Responsibilities, Foetal Welfare and Children's Health'. In: Bridge, C.(Ed.) *Family Law Towards The Millennium: Essays For P.M. Bromley* (1997) 263 at 284.

³³⁴ This might arise in the unlikely event that, in rejecting medical treatment, an intent (satisfied by the virtual certainty of the consequences: *R v Nedrick* [1986] 1 WLR 1025) to kill or cause grievous bodily harm is directed, by the pregnant woman, at the child-to-be rather than the fetus.

³³⁵ *Op cit.* n.57.

³³⁶ *R v Instan* [1893] 1 QB 450.

³³⁷ *R v Gibbons & Procter* (1918) 13 Cr. App. R. 134.

³³⁸ *Ibid.*

³³⁹ As healthcare workers are not obliged to assist in an abortion the woman merely has a liberty and not a right.

³⁴⁰ See n.304.

Morally, it may be argued that once a woman elects to continue with a pregnancy and to carry a fetus to term then she owes a duty-of-care to the child. As Draper suggests: '...having decided that the child is going to be born, the woman bearing him has an obligation not to injure him irrespective of whether or not she intends to mother him personally'.³⁴¹ Legally, for births prior to the Congenital Disabilities (Civil Liability) Act 1976, the common law allowed that a child has a cause of action in negligence for injuries sustained while *in utero*. The duty is contingent ante-natally but crystallises when the child is born alive.³⁴²

This common law duty would be sufficient to establish maternal liability for those offences that may be committed by omission. Thus, a woman who refuses medical treatment resulting in the post-natal death of her child may be guilty of, *inter alia*, murder or gross negligent manslaughter. As Whitfield notes: '...wholly unreasonable refusal to go into hospital despite clear medical advice that home delivery would present a danger to the unborn child would seem to be a dereliction of duty which is difficult to distinguish from an unreasonable refusal to take a living child to hospital'.³⁴³

Criminal liability for negligence is of a different nature to civil liability. Civil liability is black-and-white and once negligence is established the degree of negligence is irrelevant. 'In a criminal court, on the contrary, the amount and degree of negligence are the determining question', per Lord Hewart LCJ.³⁴⁴ He considered that the accused's negligence must show: 'such disregard for the life and safety of others, as to amount to a crime against the State and conduct deserving punishment'. In *Andrews v DPP*, Lord Atkin believed, '...a very high degree of negligence is required to be proved before the felony is established'.³⁴⁵ In

³⁴¹ Draper, H. 'Women, Forced Caesareans and Antenatal Responsibilities' (1996) 22 *Journal of Medical Ethics* 327 at 329.

³⁴² *Op cit.* n.306 at 648 per Potts J; upheld by the Court of Appeal [1992] 3 All ER 833.

³⁴³ *Op cit.* n.309.

³⁴⁴ *R v Bateman* (1925) 94 LJKB 791 at 793.

³⁴⁵ *Andrews v DPP* [1937] AC 5776, [1937] 2 All ER 552.

Adomoko,³⁴⁶ the House of Lords overruled its previous decision in *Seymour*³⁴⁷ and confirmed that the standard of care for gross negligence manslaughter is objective and determined by the jury.

Even if the pregnant woman's refusal of treatment breaches her duty-of-care towards the child-to-be and that child dies as a result it is highly improbable that she would reach the level of negligence required for manslaughter. Eekelaar and Dingwall note: 'Grossly negligent procedures resulting in the child's death after birth may amount to manslaughter, although it seems that this covers only acts, not omissions'.³⁴⁸ Thus in *Knights*³⁴⁹ and *Izod*³⁵⁰ women who failed to summon assistance or arranged to be unattended during labour were not guilty of manslaughter. However, these cases occurred before the common law first recognised a duty to the child-to-be and also before advances in medicine allowed the fetus to be treated as a patient.

The strongest argument against criminal liability of pregnant women for treatment arises from the requirement that the law should be coherent and consistent. Consistency demands that if an individual's right to refuse treatment is absolute under civil law then it should not incur a liability under criminal law. Although *Collins*³⁵¹ and *Re MB*³⁵² did not specifically consider the possibility of the child dying post-natally, they both strongly affirmed the pregnant woman's right to refuse treatment, '...whether her own life or that of her unborn child depends on it'.³⁵³ This statement might mean the unborn child regardless of whether it

³⁴⁶ R v Adomoko [1994] 3 All ER 79.

³⁴⁷ R v Seymour [1983] 2 All ER 1058, [1983] 2 AC 493.

³⁴⁸ Op cit. n.254 at 263.

³⁴⁹ R v Knights (1860) 2 F & F 46.

³⁵⁰ R v Izod (1904) 20 Cox CC 690.

³⁵¹ Op cit. n.32.

³⁵² Op cit. n.31 at 533 a competent woman may refuse consent 'even though the consequence may be the death or serious handicap of the child...'. It is unclear whether this refers to the death of the child in-utero (stillborn) or ex-utero, having been delivered alive.

³⁵³ Op cit. n.32 at 692 per Judge LJ.

dies *in utero* or after birth. If this is accepted then the civil right to refuse treatment regardless of the consequences would negate any liability for gross negligence manslaughter.

Alternatively, the statement might only apply where the child is stillborn and the pregnant woman may, theoretically, still be liable where the child dies following a live birth. However, it would be incoherent for there to be no criminal liability at all if the fetus dies *in utero* but liability for manslaughter if it dies after birth. Although criminal law already differentiates between the intentional death of a fetus and that of a child, under such circumstances, the unlawful killing of a fetus, although not a homicide, is still a criminal offence under The Infant Life (Preservation) Act 1929.

Even if a theoretical liability for gross negligence manslaughter exists it would be extremely unlikely that the crown prosecution service would prosecute. And, if such a case actually reached court, it is improbable that a jury would find a refusal of treatment grossly negligent, especially if the woman had a reasonable justification for her behaviour. Reasonable justification may include religious reasons and poor maternal health that increased the risk of treatment significantly beyond that of non-treatment. An irrational decision may receive less sympathy, however, because maternal mortality associated with caesareans is greater than the rate associated with vaginal delivery, the mother's decision may still be considered reasonable.³⁵⁴

Likewise, since refusing medical treatment is likely to be considered a lawful justification a pregnant woman who refuses a caesarean section will not be liable under s.18³⁵⁵ or s.20³⁵⁶ OAPA 1861.

³⁵⁴ Between 1991-1993, of 140 maternal deaths, 98 were directly or indirectly connected to caesarean sections. From: *Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993*.

³⁵⁵ s.18 OAPA 1861 states: 'Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person ... with intent ... to do some ... grievous bodily harm to any person ... shall be guilty of an offence'.

Maternal liability for criminal offences might allow reasonable force to be used to prevent the woman from injuring her child. Brazier states: 'it could be argued that if gross maternal neglect could constitute manslaughter when a child is born alive but dies of its injuries, s.3 of the Criminal Law Act 1967 justifies anyone intervening to prevent a crime. Section 3 grants to every citizen the right to use 'such force as is reasonable [in the circumstances] in the prevention of a crime'. Could doctors invoke that right to use reasonable force to prevent a crime to detain the drug-abusing mother-to-be or to administer a blood transfusion forcibly to the Jehovah's witness'.³⁵⁷ This argument also applies to a woman refusing a caesarean. However, *Collins*, because it allows the woman a civil right to refuse treatment regardless of the consequences, negates the possibility of a woman committing a criminal offence by refusing treatment.

The common law allows reasonable force to be used in the defence of self or another. As intent for murder can be against the child-to-be there seems no reason why the child-to-be cannot be considered as 'another' and defended against harm. However, common law self-defence may only be invoked against unlawful force or unlawful injury.³⁵⁸ Thus, after *Collins*, injury to the fetus - resulting from a refusal of treatment - would not be unlawful and a doctor could not justify a caesarean as common law self-defence.

The only other possibility that may allow the doctor to override a refusal of consent is the doctrine of necessity. Necessity provides justification for medical treatment of patients where a valid consent is unavailable.^{359,360} Despite a chequered history,³⁶¹ its continued existence

³⁵⁶ Section 20 OAPA 1861 states: 'Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of an offence...'.
³⁵⁷ *Op cit.* n.333 at 290.

³⁵⁸ *Op cit.* n.333 at 290.

³⁵⁸ Smith, J. Hogan, B. *Criminal Law* (1996) 314.

³⁵⁹ Williams, G. 'Necessity' [1978] *Crim LR* 128 at 132.

³⁶⁰ *Op cit.* n.201.

³⁶¹ Gardner, S. 'Necessity's Newest Inventions' (1991) 11 *Oxford Journal of Legal Studies* 125.

has been supported by a number of cases.³⁶² Thus necessity has justified the possession of a firearm,³⁶³ growing cannabis for medical purposes,³⁶⁴ reckless driving³⁶⁵ and driving while disqualified.³⁶⁶ In the situation of a woman refusing a caesarean, the necessity to operate, since it cannot override the known objection of a competent woman, could only be justified in the best interest of the fetus or the child-to-be. Although not discussed in either *Collins* or *Re MB*, the availability of this defence should be considered.

Lord Goff described 3 types of necessity:

1. public necessity - destroying houses to make a fire block to prevent fire spreading;
2. private necessity - an action taken to save the actor's own person or property from damage;
3. where an '...action taken as a matter of necessity to assist another person without his consent'.³⁶⁷

Three conditions must be met:

1. an external pressure to act (the actor's own suicidal tendencies are intrinsic and thus do not justify action)³⁶⁸;
2. the act caused less harm than it averted;³⁶⁹
3. there was no other way of preventing the harm.³⁷⁰

The risk to the life of the fetus would, as the doctor has both a moral and legal duty to the fetus, certainly satisfy the external pressure to act. Whether or not an alternative means of

³⁶² In *R v Rodger and Rose* [1998] 1 CR App R 143, the Court of Appeal accepted that a defence of necessity or duress of circumstances was available in appropriate cases.

³⁶³ *R v Pommell* Times Law Reports, 22 May, 1995; (1996) 60 JCL 173.

³⁶⁴ Watson, M. 'Cannabis and the Defence of Necessity' [1998] 148 *NLJ* 1260.

³⁶⁵ *R v Conway* [1989] QB 290.

³⁶⁶ *R v Martin* [1989] 1 All ER 652.

³⁶⁷ *Op cit.* n.201 at 74.

³⁶⁸ *Op cit.* n.362.

³⁶⁹ Slapper, G. 'Public Policy under Duress' [1995] 145 *NLJ* 1063. Watson (n.364) considered that the two harms need only be comparable.

³⁷⁰ *Op cit.* n.364 at 1262.

preventing the harm was available would most likely be determined using the *Bolam*³⁷¹ principle. However, there will be occasions when a caesarean is the only means of preventing harm to the child-to-be.

Overriding a competent woman's refusal of consent to a caesarean harms the woman but averts harm to the fetus and, arguably, the child-to-be. Since the fetus is not a legal person it cannot be the beneficiary of an act of necessity under Lord Goff's 2nd or 3rd head. However, it may be considered as a beneficiary of public necessity. That the state has an interest in the viable fetus was clearly stated in the U.S. case *Roe v Wade*.³⁷² However, the state also has an interest in the life and wellbeing of the woman and it permeates throughout Anglo-American reproductive law that the health of the woman takes precedence over the life of the fetus.³⁷³ Since a caesarean carries a higher mortality rate than vaginal delivery overriding the woman's refusal of consent would risk her life. This runs counter to currently accepted public policy and thus necessity could not be justified.

It may be argued that, where a caesarean is indicated on both maternal and fetal grounds, there is no conflict between the woman's life and that of the fetus. In these cases the harm prevented is greater (the deaths of woman and fetus) and the harm caused is less (violation of the woman's bodily integrity and autonomy). However, both *Collins* and *Re MB* considered the woman's right to self-determination to be the overriding factor regardless of the outcome. Although they did not consider the public's interest in the life and wellbeing of the fetus, the Court of Appeal's judgment represents the current law unless and until it is overruled by the House of Lords or by legislation. Given Balcombe LJ's opinion, in *Re F*,³⁷⁴ and the major

³⁷¹ Op cit. n.157.

³⁷² *Roe v Wade* 410 U.S. 113 (1973).

³⁷³ The Abortion Act 1967 allows a termination of pregnancy at any stage of the gestation to prevent grave injury to the physical or mental health of the woman (s.1(1)(b)) or to obviate a risk to her life (s.1(1)(c)). This was also the only caveat to the states interest in the fetus in *Roe v Wade*.

³⁷⁴ Op cit. n.69 at 538. See p.28.

human rights implications involved the House of Lords would be unlikely to make a judgment in favour of the fetus. Thus it would be up to Parliament to determine the public interest in the wellbeing of the fetus and to legislate accordingly.

If *mens rea* can be projected onto the child after it is born alive³⁷⁵ surely the justification for necessity could also be projected onto the child-to-be? One may interpret the decision in *Re S*³⁷⁶ as justified by the doctrine of necessity,³⁷⁷ but despite disapproving *Re S*, neither *Re MB* or *Collins* considered the doctrine of necessity.³⁷⁸ In *Attorney General's Reference (No. 3 of 1994)* Lord Hope clearly stated that public policy formed the grounds for including the child-to-be within the scope of the *mens rea* of an act during pregnancy. The Court of Appeal, in both *Re MB* and *Collins*, avoided public policy issues but in *Re F* it held that Parliament was the correct place to determine whether public policy could justify protecting the fetus/child-to-be at the expense of the woman's rights.

Given the Judges' reluctance to make policy decisions on the maternal-fetal conflict, and following *Collins*, it is unlikely that a court would declare it lawful to perform a caesarean against the will of a competent woman for the sake of the fetus. However, if a doctor proceeded anyway a criminal court would have to determine whether necessity justified the act. Judges have a history of protecting the doctor who acts in good faith and it is possible that they may decide that necessity did justify the act. Gardner suggests that a '...rule could be taken as impliedly saying 'do X, unless it is better to do Y'''.³⁷⁹ Regarding the maternal-fetal conflict this would be 'respect the woman's consent unless it is better not to'. This begs the question: when is it better to override the woman's decision?

³⁷⁵ Op cit. n.65 at 434, 443.

³⁷⁶ Op cit n.2.

³⁷⁷ Op cit. n.358 at 307.

³⁷⁸ *Re MB* did consider necessity from the perspective of treating an incompetent pregnant women but failed to consider whether it had any relevance to the fetus or child-to-be.

³⁷⁹ Op cit. n.361 at 133.

Padfield notes: 'The greatest problem with the defence of necessity is its relationship with fundamental rights'.³⁸⁰ A rights-based theory of necessity means that the rights protected must be hierarchically superior to the rights invaded. Under the ECHR the woman's rights are superior to those of the fetus.³⁸¹ The rights of the child-to-be, however, are conceptually different to the rights of the fetus even though the fetus and child-to-be are the same physical entity. The concept of the child-to-be recognises that events during gestation can affect the child once it is born alive. English law recognises this and provides the child-to-be with contingent rights. However, if the fetus has no right-to-life then the child has no right to be born alive and the doctor cannot claim that necessity justifies infringing the woman's rights. The child-to-be, if born alive, might have the right to be born undamaged but this would require balancing the child-to-be's right of bodily integrity against the woman's bodily integrity and her autonomy. Thus, as the doctor's act would infringe two of her *actual* rights as opposed to only one of the child-to-be's *contingent* rights, it would not satisfy necessity's requirement that the harm prevented is greater than the harm caused.

I have shown that necessity would not justify a doctor overriding a competent woman's refusal of a caesarean for the fetus' sake. As Williams noted: 'the abortion cases raise the problem of the relation between necessity and fundamental rights, like the right-to-life and the right to self-determination. We should not regard with equanimity the proposition that a surgeon can kill a patient to get two kidneys to save the lives of two others, or that he could operate to save the life of a sane protesting adult'.³⁸² Likewise, necessity cannot justify infringing the woman's rights of bodily integrity and autonomy to protect the child's limited right to be born alive. Only legislative change could alter the balance of these rights in favour of the fetus.

³⁸⁰ Padfield, NM. 'Duress, Necessity and the Law Commission' [1992] *Criminal Law Review* 778 at 785.

³⁸¹ See Chapter 5.

³⁸² Op cit. n.359 at 135.

The current position is that the criminal law is unlikely to punish a woman for refusing a caesarean. *Collins*, by allowing the woman the civil right to refuse treatment regardless of the consequences means that it would be inconsistent and incoherent of the criminal law to punish the woman for exercising this right. Also, the doctor who uses force to override the woman's refusal is unlikely to succeed in claiming necessity, self-defence or statutory prevention of a crime against a charge of battery.

Tort law also provides some protection for the fetus providing it is born alive. The common law approach was similar to the way criminal law currently deals with ante-natal harm. The ante-natal events that caused the harms are seen as 'links in the chain of causation' resulting in the damage suffered at birth when the child inherits the damaged body.³⁸³ However, the common law only applies to children born before the Congenital Disabilities (Civil liability) Act 1976.

For children born after the 1976 Act the common law is no longer applicable.³⁸⁴ The Act still requires the child to be born alive before any cause of action arises but shifts the focus of the tort-feasor's liability from child to parent. The Act creates a derivative liability such that: 'a person ... is answerable to the child if he was liable in tort to the parent'.³⁸⁵ The dubious value of derivative liability, that maternal liability is almost completely excluded,³⁸⁶ was based on the Law Commission's recommendation that: 'legislation should specifically exclude any right of action by a child against its own mother for pre-natal injury'.³⁸⁷ Except for negligent

³⁸³ *de Martell v Merton and Sutton H.A.* [1992] 3 All ER 820 at 832 per Philips J. See also: *Watt v Rama* [1972] VR 353; and, *Montreal Tramways v Leveille* (1933) 4 DLR 337.

³⁸⁴ S.4(5) Congenital Disabilities (Civil Liability) Act 1976.

³⁸⁵ S.1(3) Congenital Disabilities (Civil Liability) Act 1976. 45 *Halsbury's Statutes* (4th Ed.) (1994) 871.

³⁸⁶ *Op cit.* n.333.

³⁸⁷ *The Law Commission Report on Injuries to Unborn Children.* (1974) Law Com. No.60, p25 para 63.

driving,³⁸⁸ the Act excludes almost all the pre-existing ante-natal responsibility of the mother to her child. Under common law a mother may have been liable for negligently rejecting medical advice or treatment but following the introduction of the 1976 Act she cannot be liable for any such injuries. Thus the child born disabled as a result of maternal refusal of treatment, even if the refusal is wholly irrational, has no recourse under either civil or criminal law.

Just as the law provides the child with no justice³⁸⁹ for injurious ante-natal maternal behaviour so there is no legal mechanism for preventing the damage in the first place.

Although the ante-natal period may be considered when warding a child,³⁹⁰ and an unborn child may be placed on the child protection register,³⁹¹ the Court of Appeal, in *Re F*,³⁹² held that, because it has 'no existence independent of its mother' the court had no jurisdiction to ward the unborn child.³⁹³

I have shown that the civil law provides very limited protection for the fetus as an unborn child. Third party liability to the child for ante-natal injuries is derivative and requires that a tort has been committed against one of the parents. Maternal liability is limited to negligent driving and the courts have no mechanism for prospectively limiting ante-natal injury. A competent woman may, on a whim, refuse medical treatment resulting in the birth of a disabled child and the child has no cause of action for compensation. Since it is only by determining the fetus' value that it is possible to decide if and how it should be protected, I

³⁸⁸S.2 Congenital Disabilities (Civil Liability) Act 1976. This inconsistent provision is justified as loss-spreading since compulsory insurance means that the insurer, rather than the mother, will have to pay the damages.

³⁸⁹ Except for negligent driving.

³⁹⁰ *Re D (A minor)* [1986] 3 WLR 1080. In *Caller v Caller* [1966] 2 All ER 754, the court held that an unborn child could be a child of the family under s.16 Matrimonial Proceedings Magistrate's Court Act 1960.

³⁹¹ Barker, RW. 'Unborn Children and Child Protection - Legal Policy and Practice Issues' [1997] XIX *The Liverpool Law Review* 219.

³⁹² *Op cit.* n.69.

³⁹³ *Ibid.* at 538 per Balcombe LJ.

will discuss whether the current law provides the fetus with adequate protection after I have considered its moral worth.

Chapter Seven: The Moral Status of the Fetus

English law ascribes personhood only to those who have been born alive. As Glazebrook notes: 'It is astonishing what a difference being born makes in English law'.³⁹⁴ Reid and Gillet argue: 'Birth, in particular makes an important difference to the value of the fetus, because of what occurs in our interactions with the fetus. Birth also allows a fetus/child's interests to be considered separately from those of the mother'.³⁹⁵ In determining whether a human being does or does not have moral personhood the only difference between a full-term fetus and a new born baby is one of geography.³⁹⁶ However, moral personhood and moral value are not synonymous and something that is not a moral person can still be worthy of respect. Douglas identifies three approaches to defining the status of the fetus:

1. can the fetus ever be considered a person with all the associated rights;
2. as a potential person does the fetus deserve the same rights as an actual person;
3. it is more important to determine how a fetus/embryo should be treated rather than whether it can be labelled as a person.³⁹⁷

A 4th approach is to consider that all human life is worthy of protection. The sanctity-of-life doctrine 'means that all bodily human life, irrespective of its quality or kind, is equally valuable and inviolable'.³⁹⁸ The doctrine prohibits 'the intentional termination of *innocent* human life'.³⁹⁹ The modern approach views the doctrine as relative such that, '...the principle that life is sacred operates only up to... [the] point where life is perceived as not worth

³⁹⁴ Op cit. n.323 at 20.

³⁹⁵ Reid, MC. Gillet, G. 'The Case of Medea - a View of Fetal-maternal Conflict' (1997) 23 *Journal of Medical Ethics* 19.

³⁹⁶ Barrow, R. *Injustice, Inequality and Ethics* (1982) at 100.

³⁹⁷ Op cit. n.318 at 29.

³⁹⁸ Kuhse, H. *The Sanctity of Life Doctrine in Medicine* (1987) 4.

³⁹⁹ Ibid. at 7.

living'.⁴⁰⁰ However, even under the modified doctrine, human life assumes a certain moral value and determining when human life begins is of moral significance.

The personhood argument denies that it is being human *per se* that is intrinsically valuable. Rather there are certain characteristics, using the adult human as a model, that constitute personhood. As Fortin notes: 'There seems to be little agreement over which properties are essential',⁴⁰¹ but they include:⁴⁰²

1. consciousness (of objects and events external and/or internal to the being), and in particular the capacity to feel pain;
2. reasoning;
3. self-motivated activity (relatively independent of either genetic or direct external control);
4. the capacity to communicate, by whatever means, messages of an indefinite variety of type, that is, not just with an indefinite number of possible contents, but on indefinitely many possible topics;
5. the presence of self-concepts and self-awareness, either individual or racial, or both.⁴⁰³

Because the fetus lacks these characteristics the personhood argument does not support a right-to-life equal to that of a fully-fledged moral person. Even the newborn baby lacks these characteristics which means that it deserves no more protection than the fetus. This has led some authors to claim that 'infanticide is not morally objectionable'.⁴⁰⁴

One way around this problem is to define a 'minimal personhood' required to afford the right-to-life. Some philosophers argue that 'consciousness' is the truly valuable aspect of

⁴⁰⁰ Wilson, W. 'Is Life Sacred?' (1995) 17(2) *The Journal of Social Welfare & Family Law* 131.

⁴⁰¹ Fortin, JES. 'Legal Protection for the Unborn Child' (1988) 51 *MLR* 57.

⁴⁰² A moral person is not required to possess all of these characteristics, but a being that possesses none of them would certainly not qualify.

⁴⁰³ Warren, MA. 'On the Moral and Legal Status of Abortion'. In: Gruen, L. Panichas, GE. (Ed.) *Sex, Morality and the Law* (1997) at 302.

⁴⁰⁴ Op cit. n.401.

human life.^{405,406} The first signs of consciousness equate to when the fetus first experiences sensation and thus a sentient fetus has 'minimal personhood' and a right-to-life.⁴⁰⁷

Consciousness requires a functioning neo-cortex which: 'completes its inclusion into the neuraxis after mid-gestation'.⁴⁰⁸ This places 'minimal personhood' at 19-22 weeks gestation although, on the basis of Electroencephalographic recordings, it arguably arises later at 30-35 weeks.⁴⁰⁹ However, the main problem with equating sentience with personhood is that many animal species would have an equally strong right-to-life as a human. The claim that a mouse has the same right-to-life as a human person seems intuitively wrong.⁴¹⁰ However, because sentient creatures appreciate pain, sentience justifies minimal rights such as the right not to be treated cruelly. A basic right-to-life might also be appropriate but it would be easier to justify overriding this right than the adult human's right-to-life. Thus, a fetus may not be destroyed on a whim but might be killed when its continued existence threatens the mother's well-being. The newborn baby need not have any greater right-to-life than the sentient fetus but, because it is no longer *in utero* it's right-to-life is less likely to conflict with the mother's rights.

An alternative view is that personhood merely requires the membership of a species: 'typified by rationality or self-consciousness or both'.⁴¹¹ This places embryos on a moral par with adult humans which means that abortion would not be morally permissible even where the mother's life was at risk. Harris dismisses this position because: 'It would be like arguing that

⁴⁰⁵ Gillet, G. 'Consciousness, the Brain and What Matters' (1990) 4 *Bioethics* 181.

⁴⁰⁶ Burgess, JA. Tawia, SA. 'When Did You First Begin to Feel It? - Locating the Beginning of Human Consciousness' (1996) 10 *Bioethics*, 1.

⁴⁰⁷ Sumner, LW. *Abortion and Moral Theory* (1981).

⁴⁰⁸ Flower, MJ. 'Neuromaturation of the Human Fetus' (1985) 10 *The Journal of Medicine and Philosophy* 248.

⁴⁰⁹ Op cit., n.406 at 23. When the EEG recordings '... could plausibly be regarded as ancestors of adult waking states'.

⁴¹⁰ Strong, C. 'The Moral Status of Preembryos, Embryos, Fetuses, and Infants' (1997) 22 *The Journal of Medicine and Philosophy* 457 at 462.

⁴¹¹ Teichman, J. 'The Definition of Person' (1985) 60 *Philosophy* 175 at 181.

Fred who is tone deaf and musically illiterate, but who comes from a family of musical prodigies, whose parents are famous virtuosi and whose siblings are all concert musicians, should be valued *as a musician* for the musical ability possess by the typical members of his family but not by him'.⁴¹²

Some ethicists avoid the personhood argument by claiming that human life is intrinsically valuable.⁴¹³ The problem is then to determine when human life begins. The Roman Catholic Church believes that life begins at conception.⁴¹⁴ The difficulty here is that there is no particular reason why conception should be chosen over other points in the human life cycle. Davies equates the moment of conception with the creation of a genetically human individual. However, a fertilised egg may develop into a cancerous teratoma, conjoined twins, a fetus-in-feto or an anencephalic fetus. As Beller and Zlatnik note: 'individualisation apparently depends, in practice, on the presence of a brain. If not, resection of the brainless part of a conjoined twin would constitute murder'.⁴¹⁵ Admittedly, the fertilised egg has the *potential* to develop into a human individual but 2/3rds of all pre-embryos are lost before implantation.⁴¹⁶ The sperm and the unfertilised egg also have potential to develop into a human individual.⁴¹⁷ Why should life not be considered to start there? Furthermore, as human cloning becomes a reality, any human cell may have the potential to become a human individual. Does every cell in our bodies have the right-to-life?

⁴¹² Harris, J. 'Not All Babies Should be Kept Alive as Long as Possible'. In: Gillon, R. Lloyd, A. (Ed.) *Principles of Health Care Ethics* (1994) 643 at 651.

⁴¹³ Davies, A. 'All Babies Should be Kept Alive as Far as Possible'. In: Gillon, R. Lloyd, A. (Ed.) *Principles of Health Care Ethics* (1994) 629.

⁴¹⁴ Soane, B. 'Roman Catholic Casuistry and the Moral Standing of the Human Embryo'. In: Dunstan, GR. Sellar, MJ. (Ed.) *The Status of the Human Embryo* (1990) 74.

⁴¹⁵ Beller, FK. Zlatnik, GP. 'The Beginning of Human Life: Medical Observations and Ethical Reflections' (1992) 35(4) *Clinical Obstetrics and Gynecology* 720.

⁴¹⁶ Ibid.

⁴¹⁷ Admittedly this potential is less than that of the fertilised egg and only exists while there remains the possibility that the two will meet.

Other authors have argued for different starting points of human life. However, human life is a continuum - from gamete to adult to gamete - interrupted only by the death of an individual who has not reproduced. Essentially, these authors are attempting to determine when a human life attains sufficient moral significance⁴¹⁸ to allow a right-to-life equivalent to that of the paradigm moral person. Points at which this may occur are:

1. conception;
2. implantation (6-7 days post-conception);
3. unity and uniqueness (coinciding with development of the primitive streak at about day 14);
4. when the fetus outwardly resembles the human form (from 6 weeks post-conception);
5. the first detectable electrical impulses in the brain (about 8 weeks);
6. Quickening (about 16 weeks);
7. viability;
8. the development of sentience (the earliest possible time for this is 19-22 weeks);
9. birth;
10. the ability to experience, to remember the past and envisage the future, to communicate etc.⁴¹⁹

The last two of these milestones are not relevant to the fetus and all of the others may be criticised as insufficiently important to justify conferring a full right-to-life. I have already considered conception and using implantation as the point at which a new human being comes into existence raises similar objections; cancerous change may still occur and part of the blastocyst that reaches the uterine endometrium will develop into the fetal part of the

⁴¹⁸ I use 'moral significance' to mean that point at which the entity's moral value demands a right-to-life equivalent to the paradigm moral person.

⁴¹⁹ Bok, S. 'Ethical Problems of Abortion'. In: Shannon, TA. (Ed.) *Bioethics* (1987) 19 at 22; Schenker, JG. 'The Rights of the Pre-embryo and Fetus to In-vitro and In-vivo Therapy'. In: Bromham, DR. et al (Ed.) *Ethics in Reproductive Medicine* (1992) 33.

placenta. The true significance of implantation is that it is the beginning of pregnancy rather than the beginning of a new human being.⁴²⁰

Although development of the primitive streak is the point at which a unique individual comes into existence - the formation of identical twins or a chimera is no longer possible - that new human being is far from fully formed. The creation of a new human being is morally important, but a human being's moral value is considerably less than that of a fully-fledged moral person. Its right-to-life is minimal and may be overridden with little justification.

The point at which an embryo begins to resemble a person is anachronistic and probably religious in origin. From a secular viewpoint, resemblance to man may justify a conferred moral worth but is of no intrinsic moral value.

The beginning of brain activity has been proposed as the start of morally significant life because this would introduce a symmetrical definition of life: since brainstem death is the criterion for death, so brainstem life should be the criterion for life.⁴²¹ The argument for brainstem life can be criticised because:

1. a pre-brainstem embryo does not require a brainstem to be a fully functioning individual whereas an adult human does;⁴²²
2. a pre-brainstem embryo has the potential to develop a brainstem whereas the adult with brainstem death has no such potential.

The development of brain activity is of moral importance only because it is another step on the ladder to moral personhood.

⁴²⁰ Op cit. n.415.

⁴²¹ Ibid.; Kushner, T. 'Having a Life Versus Being Alive' (1984) 1 *Journal of Medical Ethics* 5.

⁴²² Downie, J. 'Brain Death and Brain Life: Rethinking the Connection' (1990) 4 *Bioethics* 216.

Quickening marks the point at which the mother first becomes aware of fetal movement. This is relevant only because it may increase social interaction between the fetus, its mother-to-be and other persons allowed to 'feel the baby kicking'. Fetal movement is used as an indicator of fetal well-being and the mother-to-be may relate periods of activity to the fetus 'being awake'. Quickening may therefore be a reasonable point at which to allow the fetus a greater moral value than the embryo at implantation or at the point of first brain activity but it does not equate to personhood.

Viability arises when the fetus is capable of surviving outside the womb. The U.S. Supreme Court accepted viability as justifying a 'compelling' state interest in the fetus, 'because the fetus then presumably has the capability of meaningful life outside the mother's womb'.⁴²³ Although - based on this judgment - the District of Columbia Superior Court allowed a 26 week fetus' right-to-life to override its competent mother's refusal of a caesarean section, the decision was reversed on appeal.⁴²⁴ Furthermore, in *Roe v Wade* the Supreme Court held that the right to preserve the mother-to-be's health and life overrides the right-to-life of even a viable fetus. Having sufficient surfactant in its lungs and access to more advanced medical facilities does not increase the intrinsic moral value of the viable fetus. The moral significance of viability arises because the act of terminating a pregnancy can potentially be achieved without killing the fetus.

The final milestone relevant to the fetus is sentience. I have already discussed its significance as affording a minimal personhood and arguing that sentience is the beginning of morally significant life is essentially no different. Thus none of the milestones proposed allow the fetus a right-to-life equivalent to the paradigm moral person.

⁴²³ Op cit. n.372.

⁴²⁴ Op cit. n.6; re AC, 533 A.2d 611 (App. D.C. 1987), reh'g granted, judgement vacated, 539 A.2d 203 (App. D.C. 1988).

Some philosophers suggest the fetus has moral value as a potential person. The usual argument against potential is; destroying an acorn is not the same as destroying an oak tree. Harris states: 'The argument from potentiality involves the idea that we are not valuable for what we are but for what we will become'.⁴²⁵ His view is wrong and the true argument for valuing potentiality is; we are not *only* valuable for what we are but are *also* valuable for what we will become. Thus, an entity's value comes mostly from its present state and its potential to become something more valuable merely adds to that entity's inherent value. As Gillon notes: 'There seems little doubt that if something has the potential to be valuable then there is good prima facie reason to value it... ..however the value of the initial entity is not generally as great as the value of the entity it has the potential to become'.⁴²⁶

The main difficulties with potentiality come when it is used to afford the *same value* to the potential entity and the entity itself. This was noted by Poplawski and Gillett:

1. giving an embryo rights that it may have at a later stage only makes sense if its potential is an intrinsic property that confers those rights. An entity should be valued on the basis of what it is not what it might be;
2. the potentiality of an embryo may never be achieved, i.e. it may never become a fully-fledged moral person;
3. how far back in a human life cycle should those rights be extended?⁴²⁷

Their solution is to deny the fetus intrinsic moral worth because of its potential but allow a conferred moral value because it will be justified at some potential point in that individual's life span. However, potentiality is an intrinsic characteristic with a moral value of its own. There is no need to argue for conferred moral value except to try and justify an equal right-to-life for the fetus and moral person alike. It makes little sense to argue that the full value of an

⁴²⁵ Op cit. n.412 at 652.

⁴²⁶ Gillon, R. 'Human Embryos and the Argument from Potential' (1991) 17 *Journal of Medical Ethics* 59.

⁴²⁷ Poplawski, N. Gillett, G. 'Ethics and Embryos' (1991) 17 *Journal of Medical Ethics* 62.

oak tree should be conferred on an acorn simply because one stage of its life-cycle is to be an oak tree.

Because of potentiality's intrinsic value, the greater the potential an entity has to become something of moral value the greater it should be valued. A neonate has a greater potential to become a moral person than does a fetus at term because it has survived an event (birth) that might have destroyed that potential and is nearer to achieving its potential. Likewise a full-term fetus, which has survived the gestation period, has a greater moral value than a fetus at an earlier stage of pregnancy. This gradual increase in potential,⁴²⁸ and hence moral value, is neither completely smooth nor stepped but is a combination of the two. Each day the fetus survives is a day nearer moral personhood but equally there are certain events that increase its potential significantly beyond the gradual, day-to-day, change. These events include; conception, implantation, development of the primitive streak, development of brain activity, viability, development of sentience and birth. However, it is important to note that the fetus has intrinsic value because of both its actual characteristics and its potential characteristics. Also, although full moral personhood confers full moral rights and responsibilities, that does not mean some moral rights cannot exist before full personhood is achieved.

The right-to-life is a fundamental moral right and without its protection full moral personhood may never be achieved. Because of this life must be protected before moral personhood is reached. A limited right-to-life begins at conception, but at this stage it is a very weak right and can be overridden simply because a new life would be 'inconvenient' to the responsible moral person. As the embryo/fetus develops, so its right-to-life becomes stronger. Up until birth the fetus' continued existence may be detrimental to the pregnant woman's health or life and thus conflict with her rights. At this stage her rights outweigh

⁴²⁸ Op cit. n.395.

those of the child and if there is no alternative she has the moral right to terminate the pregnancy even if it kills the fetus. However, after birth, the child, although not yet a full moral person, has a right-to-life that cannot be so overridden. This is not because its moral right-to-life is greater than that of the full term fetus, but simply because there will be ways of resolving any conflict of rights without needing to kill the child. Thus, it is only where there is no alternative to destroying the fetus that the pregnant woman, when her health is threatened, has the moral right to destroy a late gestation fetus.

Some authors have suggested that the fetus has moral worth because that value is conferred on to it by fully-fledged moral persons.⁴²⁹ Strong argues that conferring moral value on non-persons, like fetuses, engenders 'good' qualities such as 'sympathy and care for human life'.⁴³⁰ Unlike other authors who emphasise the social role of entities, Strong argues that: '...focusing on social role is too narrow an approach. Rather, it is the *overall degree of similarity* that an individual has to the paradigm of human persons - to self-conscious human beings - that matters in the consequentialist argument'.⁴³¹ Social interactions begin well before birth and are encouraged by ultrasound pictures of the fetus, amplified fetal heartbeats, fetal movement, the ability of doctors to treat the fetus as a patient in its own right and the encouragement of mothers to begin their child's educational experiences while it is still *in utero*. These social interactions, along with the similarities of the fetus to the paradigm moral person, justify the conferring of moral worth on the fetus. However, allowing a conferred moral value 'that is close to, although not quite as strong as, that of persons in the strict sense... [does not mean] ...that fetuses near term should have legal rights *equal* to those of women'.⁴³²

⁴²⁹ Op cit. n.410.

⁴³⁰ Strong, C. Anderson, GD. 'An Ethical Framework for Issues During Pregnancy'. In: Gillon, R. Lloyd, A. (Ed.) *Principles of Health Care Ethics* (1994) 587 at 589.

⁴³¹ Op cit. n.410 at 466.

⁴³² Op cit. n.430 at 590.

It remains only to consider whether the approach taken by the Warnock committee is justifiable. They stated: 'Although the questions of when life or personhood begin to appear to be questions of fact susceptible of straight forward answers, we hold that the answers to such questions in fact are complex amalgams of factual and moral judgements. Instead of trying to answer these questions directly we have therefore gone straight to the question of *how it is right to treat the human embryo*'.⁴³³ However, when they considered the question of the time limit on research on human embryos they referred to the formation of the primitive streak as marking 'the beginning of individual development of the embryo'.⁴³⁴ This can only be because they regarded that point as being when the moral value of the embryo outweighed the benefit to society of any research carried out on it. Thus, although it is not necessary to determine whether the fetus should ever be considered a moral person it is not possible to consider how the fetus should be treated without at least determining its moral worth.

I do not believe the fetus could ever justifiably be considered a fully-fledged moral person. However, it is not necessary to prove that it is a person in order to allow the fetus moral value and associated rights. The right-to-life is one such right that does not depend on personhood. However, rights are rarely absolute and, in a conflict, the right-to-life of a moral person outweighs that of a non-person. The fetus gains its moral value from three sources: intrinsically from its actual characteristics; intrinsically from its potentiality; and extrinsically from moral value conferred by fully-fledged moral persons. The combined moral worth of the fetus gradually increases with superimposed steps due to significant events in its development. As the fetus develops so the three sources of its moral value combine to give the fetus an increasingly strong right-to-life. If the right-to-life of the full-term fetus is to be overridden then there must be good justification. Thus, the refusal of medical treatment that

⁴³³ Warnock, M. (Chairperson) *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (1984) 60.

⁴³⁴ *Ibid.* at 66.

would benefit the fetus is justified only if that treatment would significantly harm the mother, either physically or psychologically.

Part Three: Conclusions

The English experience of the caesarean section debate highlights two areas of concern.

Firstly, despite emphasising the primacy of autonomy over the sanctity of life, the Court of Appeal in both *Collins* and *Re MB* has left a number of loopholes that allow doctors - or the court - to circumvent the pregnant woman's refusal of consent. These 'get-out' clauses include the flexibility of competence assessment and the largely undefined effect of temporary incapacitating factors such as pain, stress or drugs. The fact that labour itself is included as such a factor emphasises the scope for subjective analysis of a pregnant woman's competence. The problem is exacerbated because the Court of Appeal, while accepting that a competent woman may make an irrational decision, has allowed that competence be tested against the actual decision rather than against the person's capacity to make such a decision. However, since this thesis is aimed at the caesarean conflict rather than the problems associated with competence I will not discuss these problems any further.

The second area of concern relates to the one-sided way in which the law weights the balancing of rights in favour of the woman. That the scale may be tipped too far in favour of the woman is exemplified by the 'strained reasoning' that the courts-at-first-instance have resorted to in trying to protect the fetus. There is obviously a reasonable body of opinion, certainly amongst the Family Division judges, that believes the fetus worthy of stronger legal protection than it currently receives. The fetus - especially at full term - although not a full-fledged moral person cannot be dismissed as having no moral worth or right-to-life. Thus, its rights to-life and bodily integrity still deserve legal protection. The question that remains is whether there is a point at which it is morally justified to override a competent woman's decision, and whether that moral justification warrants a change in the law, to protect the fetus.

Mair notes: 'Morally, a society may consider that a pregnant woman is responsible for the well-being and development of her foetus'.⁴³⁵ Thus, some authors contend that, by planning pregnancy or by rejecting the option of termination, a woman voluntarily assumes a duty-of-care to her fetus.⁴³⁶ Although this view may be criticised,⁴³⁷ it is uncontroversial to suggest that it would be morally good for a pregnant woman to act in the 'best interests' of her fetus. However, this does not mean that it would be morally bad to act against those 'best interests': firstly, there may be disagreement as to what constitutes the fetus' 'best interests'. Thus, the woman may be acting in the way that she feels is in the fetus' 'best interests' but her viewpoint may conflict with the doctor's opinion; secondly, although morally good, it is not morally required for the woman to act as a good Samaritan, especially where it harms the woman. Few would condemn a parent who fails to rescue a child from a burning house and a caesarean certainly causes significant trauma and even risks the woman's life. As Weinrib notes: 'Respect for another's physical security does not entail foregoing one's own'.⁴³⁸

The moral pressure on the woman is further lessened by the lack of reliability of clinical judgement in obstetrics.⁴³⁹ One study demonstrated that in 30% of cases at least 4 of the 5 assessors disagreed with the decision to perform an immediate caesarean where the indication was 'fetal distress'. Further, they found that unanimity only occurred in 28% of cases.⁴⁴⁰ The problem may be compounded by the doctor's desire to avoid the worse possible outcome regardless of how rarely that outcome will actually be realised.⁴⁴¹ This means that a non-consensual caesarean is equivalent to demanding a parent enters a burning house *in case* their child requires rescuing.

⁴³⁵ Op cit. n.173 at 87.

⁴³⁶ Op cit. n.341 at 329; See p.109.

⁴³⁷ Op cit n.42 at 14.

⁴³⁸ Weinrib, EJ. 'The Case for a Duty to Rescue' (1980) 90 *The Yale Law Journal* 247 at 289.

⁴³⁹ Op cit. n.11 at 268. Also see n.4 at 2011.

⁴⁴⁰ Barrett, JFR. Jarvis, GJ. Macdonald, HN. Buchan, PC. Tyrrell, SN. Lilford, RJ. 'Inconsistencies in Clinical Decisions in Obstetrics' (1990) 337 *Lancet* 549.

⁴⁴¹ Op cit. n.4 at 2017.

Although it is not morally bad for a person to refuse to 'rescue' someone when there is a reasonable risk of harm, the situation is different where there is no risk to the 'rescuer'.

Weinrib argues: 'Because his claim to that freedom [to pursue his projects as a moral right] implies a right to the physical integrity that is necessary to its exercise, he must concede to others the right to physical integrity that he implicitly and inevitably claims for himself'.⁴⁴² A caesarean indicated on both maternal and fetal grounds confers a direct physical benefit on the woman. Thus, 'rescuing' the fetus can be achieved without the woman risking harm. Since the woman can 'rescue' her fetus without harming herself there is a greater moral pressure on her to be a good Samaritan. However, even though it may be morally good to consent to a caesarean this does not mean that she should be required to do so by legal coercion.

Given the divergent views in the materno-fetal conflict, it is unlikely that moral debate will solve the issue. Honore notes: 'to ensure, or try to ensure, justice between moral communities which are seriously at variance with one another is something that only a political entity can do. If the State does not intervene, justice is not well served... Law here acts as a determinant of justice.

Given that justice provides the motive for political intervention, laws do not usually rule on moral conflicts directly... What they are ruling on is whether to permit certain behaviour...'.⁴⁴³ In order to determine the behaviour acceptable to society as a whole the legislature must consider the moral conflict in light of practical considerations such as the likely consequences of judicial intervention, the cost of intervention and the ability of the state to police the behaviour. It is perhaps these practical issues that provide the strongest argument against overriding the competent pregnant woman's decision.

⁴⁴² Op cit. n.438 at 288.

⁴⁴³ Honore, T. 'The Dependence of Morality on Law' (1993) 13 *Oxford Journal of Legal Studies* 1 at 16.

Plomer states: 'The moral ideal of respect for human life cannot justify the use of legally sanctioned forcible invasions of women's bodies... the concern is that judicial legitimation of medically coerced Caesareans could gradually lead to a brutalization of medical care with a resulting and inevitable erosion of fundamental civil liberties'.⁴⁴⁴ Examples of this brutalization are aptly demonstrated by the U.S. experience: viewing the fetus as worthy of protection *at the expense of* the woman has resulted in some frightening scenarios such as that involving Pamela Monson who was arrested for, *inter alia*, disobeying her doctor's instructions and having sexual intercourse with her husband.⁴⁴⁵ In another case, a Nigerian woman was forcibly restrained in leather straps to enforce a court ordered caesarean. Other women have gone into hiding or had the police sent out to transport them back to hospital.⁴⁴⁶

Oberman concludes that state intervention: 'threatens the medical and ethical integrity of the doctor-patient relationship'.⁴⁴⁷ She argues that mandatory care may cause patients to avoid the health care system and notes that in South Carolina: 'rates of women delivering babies in abandoned buildings and bus stations soared following the implementation of a mandatory prenatal drug-screening policy, accompanied by criminal sanctions for those women who used drugs'.⁴⁴⁸ This point is interesting because protecting the ethical integrity of the doctors was one of the state interests in *Robb*⁴⁴⁹ that may justify overriding a person's autonomy. Oberman's argument suggests that, far from protecting it, not respecting a patient's autonomy may destroy that doctor's ethical integrity.

Oberman further claims that another reason for avoiding state intervention is: 'From bloodletting to thalidomide, the history of pregnancy-related medical innovations is rife with

⁴⁴⁴ Op cit. n.11 at 271.

⁴⁴⁵ Op cit. n.42 at 13.

⁴⁴⁶ Op cit. n.4 at 2004.

⁴⁴⁷ Op cit. n.168 at 72.

⁴⁴⁸ Ibid. at 75.

⁴⁴⁹ Op cit. n.222.

treatments that ultimately have proven ineffective and even harmful to pregnant women and developing fetuses'.⁴⁵⁰ Related to this is the acknowledged lack of certainty in the obstetrician's clinical opinion. I have already argued that this uncertainty reduces the moral pressure on the woman to follow the advice and, similarly, it weakens any justification for legal coercion. Thus, Annas states: 'In three of the first five [U.S.] cases in which court-ordered caesarean sections were sought, the woman ultimately delivered vaginally and uneventfully. In the face of such uncertainty - uncertainty compounded by decades of changing and conflicting expert opinion on the management of pregnancy and childbirth - the moral and legal primacy of the competent, informed pregnant woman in decision making is overwhelming'.⁴⁵¹ Furthermore, Nelson and Milliken state that: 'Incompleteness of medical knowledge and the unavoidable uncertainty of medical diagnostic and therapeutic techniques make it impossible to define a clear, precise, and accurate model on which society could base a fair and uniformly applied legal policy that would sanction the use of force against pregnant women'.⁴⁵²

Compounding these issues is the reality that, since most women will accept their doctor's advice, these cases are uncommon. Even though individual cases are tragic, to change the law to protect those few fetuses at risk would require the devaluing of all pregnant women to the point where they are treated as 'fetal containers'.⁴⁵³ As Nelson and Milliken note: 'situations in which fetuses may die or be born damaged as a direct result of maternal behaviour are likely to be rare. This being so, the price of intervention to woman's liberty and privacy seems too high'.⁴⁵⁴

⁴⁵⁰ Op cit. n. 168 at 72.

⁴⁵¹ Annas, GJ. 'Protecting the Liberty of Pregnant Patients' (1987) 316 *NEJM* 1213.

⁴⁵² Op cit. n.38 at 1065.

⁴⁵³ Op cit. n.42 at 13.

⁴⁵⁴ Op cit. n.38 at 1065.

I have argued that to legally coerce pregnant women into submitting to non-consensual treatment would be unjust and cause more harm than it prevents. Such a change in the law would not be justified on utilitarian grounds. Likewise, Kantian principles also run counter to overriding the pregnant woman's autonomy. To treat the woman as a 'fetal container' is to treat her as a means to an end rather than an end in herself. Since the woman is a fully-fledged member of the moral community, while the fetus is not, her rights must be hierarchically superior. In conflict the woman's rights must trump those of the fetus. However, seeing the caesarean section debate as a conflict between the woman and her fetus is misleading and potentially damaging. As Mair notes: 'The conflict model stifles communication. In the presentation of the conflict the loudest voice, and sometimes the only voice, is that of the doctor. The foetus cannot speak and the woman is often not heard'.⁴⁵⁵ Since the fetus - unlike the child - is totally dependant on its mother, every action of the pregnant woman potentially affects the fetus. Likewise, all the risks of childbearing are borne by the pregnant woman and any treatment of the fetus must infringe both the woman's liberty and her bodily integrity. For these reasons, and because - in most cases - the woman is highly motivated to act in the fetus' best interests, the law should allow her to decide what is in *both* their best interests. The law should not favour one member of society over another, let alone favour a potential member over a current one, and thus, the state should not protect the fetus at the expense of the pregnant woman. The situation following birth is different: when a court overrides a parental treatment decision they are restricting the parent's *power*, not their right, to decide on their child's medical care. The parent's own rights of self-determination and bodily integrity are not infringed. In this case, treatment of the fetus is *also* treatment of the pregnant woman. As the only autonomous partner in this unique relationship she must be allowed to make the decisions about their care. There is, however, one instance where it may

⁴⁵⁵ Op cit. n.173 at 95.

be justifiable for the law to intervene and that is where the competent pregnant woman refuses consent for a wholly irrational reason.

A decision based entirely on irrational reasons (a whim) does not further the woman's autonomy. The only valid interest served by protecting the woman's right to whimsy is her liberty. In some circumstances, and the need for a caesarean may be one of them, overriding a whimsical decision will further the woman's autonomy.⁴⁵⁶ It may be argued that autonomy is the valuable component of liberty and that the law should, if necessary, protect autonomy even at the expense of liberty. However, restriction of liberty is itself a harm and must be justified. Where the person making the decision is capable of autonomy our legal system holds that self-harm is not sufficient to justify restricting liberty. Further justification, such as the corruption of morals, is required.⁴⁵⁷ One such justification is to prevent harm to others.⁴⁵⁸

Although the fetus is not a legal person it still has a limited right-to-life that warrants a degree of legal protection. Thus, if the law could protect the fetus without harming the woman - except by restricting her liberty to make irrational decisions - it would be justified in so doing. However, a woman should not be compelled to undergo a non-consensual caesarean because: firstly, there is often significant uncertainty that the fetus will be harmed by the woman's refusal of consent. Her decision may increase the risk to the fetus but 'risk cannot be regarded as harm in its own right';⁴⁵⁹ secondly, overriding her refusal infringes, not only the woman's liberty but also, her right to bodily integrity, and risks her right-to-life. Thus, it potentially limits her future autonomy. For example, a caesarean increases the likelihood that her future children will also have to be delivered via caesareans and thus her choice of

⁴⁵⁶ See p.74.

⁴⁵⁷ R v Brown [1993] 2 All ER 75.

⁴⁵⁸ Feinberg, J. *Harm to Others* (1984).

⁴⁵⁹ Perry SR. 'Risk, Harm and Responsibility'. In: Owen, DG. (Ed.) *Philosophical Foundations of Tort Law* (1995) 321 at 339.

delivery may be limited, not only in this case but also, in all of her future pregnancies. The price of restricting her liberty may be much more than 'just' a single operation.

Therefore, even where the woman's decision is wholly irrational, the law should never authorise a caesarean in the face of a competent woman's refusal. However, this does not mean that she should not be legally responsible for her decision. Criminal sanctions would be a draconian way of protecting the fetus that might disrupt the doctor-patient relationship, enflame any adversarial conflict between woman and fetus and 'brutalize' medical care. Furthermore, criminal sanctions would, arguably, act to indirectly coerce women to submit to a non-consensual caesarean. Possibly the only justifiable way of making the woman legally responsible would be in liability in tort.

Liability would be for any harm caused to the child as a result of a 'negligent' decision. Liability should not be strict because this would penalise women, whose decisions were reasonably based on beliefs (e.g. religious beliefs) acceptable to society, for following their beliefs. This would be contrary to religious tolerance and the freedom of religion protected by the ECHR. Liability for negligence allows the woman to refuse the advice where her decision is 'reasonable'. However, where it is unreasonable she should be responsible for her choice. This would be just and fair to the child who would be able to claim monetary recompense for any harms caused by the woman's decision while still allowing the woman to make the decision without the risk of state intervention or the stigma of criminal liability. As Honore states: 'The argument for holding people responsible to others for harmful outcomes is that it is fair to make the person to whom the advantages will flow from an uncertain situation over which [s]he has some control (or which [s]he has chosen to enter into) bear the

losses that may likewise flow from that situation'.⁴⁶⁰ It may be that, in most cases, simply the fact that a caesarean carries a greater maternal risk than a vaginal delivery is sufficient reason to negate the woman's liability. However, this does not mean that the woman should not be responsible where this is not the case.

One argument against holding the woman responsible for her decision is that of the slippery-slope. If a woman should be responsible for her medical decisions then she should also be responsible for her other behaviour during pregnancy. Thus she should be liable for drug-taking and if she should be liable for the effects of her drug taking then the same holds for smoking, drinking alcohol, a poor diet etc. Likewise, if she is responsible to her child for ante-natal behaviour then why not for her pre-conception behaviour? Furthermore, if the woman should be responsible for the post-natal effects of her ante-natal behaviour then so should her partner and indeed anyone, including the state, whose actions cause harm to the child.

Perhaps the strongest argument against liability in tort is: the only way for the woman to ensure that she avoids tortious liability would be for her to submit to the caesarean. This means that to avoid liability she would have to allow her bodily integrity to be infringed. There is no other area in tort law, or in law generally, that requires one person to submit to an infringement of bodily integrity for the sake of another. Although tort law liability may often only be avoided by inconvenience or monetary expense these are far smaller burdens than the infringement of bodily integrity required of the woman. It may be argued that the physical harm to the fetus is far greater if the refusal is upheld than the physical harm to the woman if the refusal is overridden. This may be defeated on two points. Firstly, a caesarean will always put the woman's life at risk. Thus it is by no means certain that the harm to the fetus will be

⁴⁶⁰ Honore, T. 'The Morality of Tort Law - Questions and Answers'. In: Owen, DG. (Ed.) *Philosophical Foundations of Tort Law* (1995) 73 at 83.

greater. Secondly, there are no other instances in English law where an 'innocent' party is expected to allow themselves to be harmed for the sake of another even where the overall harm is reduced. For these reasons tort liability is not justified, even where the woman's decision is wholly irrational.

In conclusion, where the woman is competent, a non-consensual caesarean should never be authorised even if her decision is wholly irrational. Although the right to liberty in decision making carries with it responsibility for one's actions, criminal sanctions would be too draconian. Likewise, tortious liability would be unjustifiable. This is because the state has no right to expect one 'innocent' individual to submit to physical harm for the sake of another. Nelson and Milliken argue that the woman has an ethical obligation to the fetus but agree that 'legal enforcement would create more harm than it could prevent'.⁴⁶¹ The current law rightly emphasises the primacy of autonomy but, by allowing too great a scope for finding the woman incompetent, is still deficient in its protection of autonomy. The risk-related standard, adoption of overly vague temporarily incapacitating factors and the subjective nature of the *Re C* test all need addressing in order to tighten the loopholes. Only when these problems have been solved will the pregnant woman be properly respected as an autonomous person who, simply through her role as child-bearer, already sacrifices her liberty to a significant extent for the sake of her fetus. Protecting the fetus is best served through education and engendering a good doctor-patient relationship which allows the woman to trust the advice she is given. Conflict and adversarial relationships are generally destructive and risk exacerbating the very harm the doctors are trying to prevent by driving the women away from the healthcare system.

⁴⁶¹ Op cit. n.38 at 1066.

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