

1-1-2013

## Forced Obstetrical Intervention: The Role of Religion and Culture, and the Woman's Autonomous Choice

Gina Gribow

Follow this and additional works at: <https://repository.uchastings.edu/hwlj>



Part of the [Law and Gender Commons](#)

---

### Recommended Citation

Gina Gribow, *Forced Obstetrical Intervention: The Role of Religion and Culture, and the Woman's Autonomous Choice*, 24 *Hastings Women's L. R.* 177 (2013).

Available at: <https://repository.uchastings.edu/hwlj/vol24/iss1/8>

This Note is brought to you for free and open access by the Law Journals at UC Hastings Scholarship Repository. It has been accepted for inclusion in *Hastings Women's Law Journal* by an authorized editor of UC Hastings Scholarship Repository.

---

---

# Forced Obstetrical Intervention: The Role of Religion and Culture and the Woman's Autonomous Choice

*Gina L. Gribow\**

## I. INTRODUCTION

The significance our society places on an individual's autonomy and right to bodily integrity seems unparalleled as it has been repeatedly noted that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."<sup>1</sup> This right to control one's own person applies equally to every individual, and thus is an inherent right held by pregnant women. In the medical context, a pregnant woman's right to decide what will be done with her body flows from the doctrine of informed consent, as she must agree to the proposed medical treatment.<sup>2</sup>

Though a pregnant woman's right to bodily integrity is supported by various constitutional amendments,<sup>3</sup> many lawsuits have arisen in the medical field challenging a woman's ability to refuse specific medical treatment when the treatment is deemed necessary to improve or save the life of the fetus. Often, religion and culture play a central role in either establishing a basis for why the woman refuses the treatment, or establishing the context that ultimately leads to forced obstetrical intervention. Historically, it seems that when religion or culture is heavily intertwined with the woman's decision to forgo medical treatment, courts

---

\* Executive Symposium Editor, 2012-2013, *Hastings Women's Law Journal*; President of Law Students for Reproductive Justice, 2011-2012; J.D. Candidate, 2013, University of California, Hastings College of the Law; B.S., 2008, University of Southern California. Many thanks to all of the remarkable members of the *Hastings Women's Law Journal*, Professor Jennifer Dunn for her guidance, and to my parents, Dale and Patti Gribow, who taught me to be a strong advocate for others at a young age, and have always been overly supportive of my endeavors.

1. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

2. TOM L. BEAUCHAMP, *Autonomy & Consent*, in *THE ETHICS OF CONSENT: THEORY & PRACTICE* 55, 57 (Franklin G. Miller & Alan Wertheimer eds., 2009).

3. U.S. CONST. amend. I; U.S. CONST. amend. IV; U.S. CONST. amend. XIV; *Roe v. Wade*, 410 U.S. 113, 153 (1973).

---

---

have more strongly favored the interests of the state in protecting the unborn fetus. Though in recent decisions it appears that courts are beginning to place greater emphasis on a woman's inherent right to personal autonomy and bodily integrity, there is still a lack of a general consensus in regard to which rights should be valued more highly.

This paper analyzes the rights of pregnant women to refuse specific medical treatment, and argues that these women become more vulnerable to forced obstetrical intervention when religion or culture play a central role in the woman's decision. The paper proceeds in eight parts. Part II explores the role that informed consent plays in a pregnant woman's personal and informed decision to accept or refuse medical treatment. Part III examines key protections of a woman's right to bodily integrity grounded in the First, Fourth, and Fourteenth Amendments of the Constitution. Part IV looks at the impact of religion in a pregnant woman's decision to forgo medical treatment, and specifically focuses on Jehovah's Witnesses and their aversion to blood transfusions. Part V discusses the effect of culture on a pregnant woman's right to bodily integrity, particularly looking at instances of forced obstetrical intervention for Somali women in the United States, and pregnant women who lack access to comprehensive reproductive health services on the Cheyenne River Sioux Reservation. Part VI analyzes the latest major case on this topic, providing a perspective on how courts are currently addressing maternal-fetal conflict. Part VII suggests that this area of law is difficult to effectively analyze due to inconsistent court decisions and a lack of available data. Part VIII offers proposed solutions and conclusions.

## II. THE ROLE OF INFORMED CONSENT AND PERSONAL AUTONOMY IN A PREGNANT WOMAN'S CHOICE TO ACCEPT OR REFUSE MEDICAL TREATMENT

Informed consent plays a central role in a pregnant woman's decision to comply with or refuse medical treatment. The doctrine of informed consent encompasses various meanings, and includes the:

legal rules that prescribe behaviors for physicians and other healthcare professionals in their interactions with patients and provide for penalties, under given circumstances, if physicians deviate from those expectations; . . . an ethical doctrine, rooted in our society's cherished value of autonomy, that promotes patients' right of self-determination regarding medical treatment; and . . . an interpersonal process whereby these parties interact with each other to select an appropriate course of medical care.<sup>4</sup>

---

4. JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY & CLINICAL PRACTICE* 3 (2d ed. 2001).

Informed consent generally encompasses the idea that decisions about the medical care a person receives should be made in a collaborative manner between the patient and their physician.<sup>5</sup> Thus, from the perspective of a pregnant woman, any medical treatment she receives should be the result of a mutual understanding between herself and her doctor.

The ethical justification for informed consent originates from its promotion of autonomy and well-being.<sup>6</sup> Informed consent is effectively an individual's "autonomous authorization of a medical intervention or participation in research."<sup>7</sup> In order for an individual to authorize a procedure or treatment through an act of informed and voluntary consent, a person must do more than merely show agreement or comply with a proposal by a doctor.<sup>8</sup> Informed consent only occurs if a patient or subject, "with substantial understanding, and in the absence of substantial control by others, intentionally authorizes a professional to do something."<sup>9</sup> In this respect, a pregnant woman who unequivocally refuses to have a medical procedure, such as a cesarean or a blood transfusion, should not be compelled to undergo that procedure, as it would effectively violate the spirit of informed consent.

The heavy focus on autonomy within the doctrine of informed consent reflects the importance of bodily integrity, which has been upheld by the Supreme Court for over a hundred years. In 1891, Justice Gray affirmed the significance of bodily integrity through his opinion in *Union Pacific Railway Company v. Botsford*, quoting Judge Cooley, "[t]he right to one's person may be said to be a right of complete immunity; to be let alone."<sup>10</sup> Justice Cardozo further expounded upon this idea in relation to informed consent in 1914, declaring "[e]very 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, for which he is liable in damages."<sup>11</sup> The assertions of both Justice Gray and Justice Cardozo are illustrative of the personal right to control one's body, which is a right that should apply just as much to a pregnant woman as any other individual.

---

5. BERGET AL., *supra* note 4, at 11.

6. *Id.*

7. BEAUCHAMP, *supra* note 2, at 57.

8. *Id.*

9. *Id.*

10. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

11. *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129–30 (1914).

---

---

### III. KEY CONSTITUTIONAL PROTECTIONS OF A PREGNANT WOMAN'S RIGHT TO BODILY INTEGRITY

#### A. RIGHT TO REFUSE MEDICAL TREATMENT SUPPORTED BY THE FOURTEENTH AMENDMENT

The autonomous right of every individual to refuse medical treatment has been upheld in various Supreme Court decisions, and is directly supported by the Fourteenth Amendment, which provides that no State shall "deprive any person of life, liberty, or property, without due process of law."<sup>12</sup> In *Cruzan v. Director, Missouri Department of Health*, the Court relied upon the Due Process Clause of the Fourteenth Amendment to affirm the right of competent individuals to exercise their right to refuse medical procedures.<sup>13</sup> In a concurring opinion, Justice O'Connor highlighted the individual liberty safeguarded by the Due Process Clause, stating, "[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause."<sup>14</sup> Thus, the Due Process Clause of the Fourteenth Amendment unmistakably protects a pregnant woman's right to accept or refuse certain medical treatment based upon personal beliefs.

#### B. RIGHT OF PRIVACY GRANTED IN THE FOURTH AMENDMENT

An individual's right to privacy is explicitly grounded in the Fourth Amendment of the United States Constitution,<sup>15</sup> and ultimately protects an individual's right to bodily integrity.<sup>16</sup> In *Superintendent of Belchertown State School v. Saikewicz*, the Court avowed the notion of the right to privacy, stating:

arising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy found in the penumbra of specific guaranties of the Bill of Rights. As this constitutional guaranty reaches out to protect the freedom of a woman to terminate pregnancy under certain conditions, so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances.<sup>17</sup>

This declaration supports the idea that a pregnant woman, in the role of a patient, has an implicit right to refuse unwelcomed physical intrusions by

---

12. U.S. CONST. amend. XIV, § 1.

13. *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 281 (1990).

14. *Id.* at 287.

15. U.S. CONST. amend. IV.

16. *See Roe v. Wade*, 410 U.S. 113, 168, n.2 (1973) (Stewart, J., concurring).

17. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977).

a doctor. Furthermore, a pregnant woman's interest in protecting her body is safeguarded by certain expectations of privacy found within the Fourth Amendment, specifically "the individual's legitimate expectations that in certain places and at certain times he has 'the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.'"<sup>18</sup>

C. RIGHT TO DETERMINE ONE'S DESTINY ESTABLISHED BY THE FIRST AMENDMENT FREEDOM OF RELIGION

Along with a right to privacy, the United States Constitution protects an individual's right to religious freedom.<sup>19</sup> The First Amendment provides that, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."<sup>20</sup> The Supreme Court has thus explicitly recognized two concepts embodied in the Free Exercise Clause: the freedom to have a specific religious belief and the freedom to act in accordance with that religious belief.<sup>21</sup>

In *Cantwell v. Connecticut*, the Court affirmed the belief-action dichotomy intrinsic in the First Amendment, which signaled a trend that the Court would continue to protect certain religiously motivated conduct from government interference.<sup>22</sup> In *Cantwell*, the justices unanimously maintained that a Connecticut statute denied the petitioner his religious liberty without due process of law, thereby violating both his First and Fourteenth Amendment rights.<sup>23</sup> The Court further expanded upon the importance of protecting the right to religious freedom in *In re Estate of Brooks*.<sup>24</sup> In that case, the Court held that an adult may refuse medical treatment for religious reasons, even if the decision may seem "unwise, foolish, or ridiculous."<sup>25</sup> In line with this reasoning, pregnant women thereby hold the right to decline medical treatment based upon personal religious beliefs, as that right is safeguarded by the First Amendment of the Constitution.

---

18. *Winston v. Lee*, 470 U.S. 753, 758 (1985).

19. U.S. CONST. amend. I.

20. *Id.*

21. *Id.*

22. *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940).

23. *Id.* at 305.

24. *In re Estate of Brooks*, 205 N.E. 2d 435, 442 (1965).

25. *Id.* at 442.

---

---

#### IV. THE ROLE THAT RELIGION PLAYS IN A PREGNANT WOMAN'S DECISION TO COMPLY WITH MEDICAL PROCEDURES

##### A. JEHOVAH'S WITNESSES' AVERSION TO BLOOD TRANSFUSIONS

###### 1. The Religious Rationale

Jehovah's Witnesses are a unique challenge to the medical community because they are bound by religious belief to refuse blood and blood products,<sup>26</sup> which ultimately complicates medical decisions for pregnant women. Even though Jehovah's Witnesses accept medical and surgical treatment, they strongly believe that blood transfusions are forbidden based upon Biblical passages, such as the passage from Genesis stating, "[o]nly flesh with its soul—its blood—you must not eat,"<sup>27</sup> and the passage from Acts stating, "[a]bstain from . . . fornication and from what is strangled and from blood."<sup>28</sup> While these Biblical verses are not written in explicit medical terms, "[w]itnesses view them as ruling out transfusion of whole blood, packed RBC's, and plasma, as well as WBC and platelet administration."<sup>29</sup> According to Witnesses' religious understanding, though, the use of specific components of blood is not expressly prohibited, and therefore it is up to each individual to make the decision whether or not they will choose to accept them.<sup>30</sup>

###### 2. Early Cases Involving Pregnant Jehovah's Witnesses Refusing Blood Transfusions: The Triumph of State Interests

Though recent decisions involving the actual rights of pregnant Jehovah's Witnesses in medical decisions seem to be grounded in the autonomy of the individual, early cases are reflective of the notion that the religious interests of Jehovah's Witnesses are trumped by other interests held by the state. In the 1964 case *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, a hospital sought the authority to administer blood transfusions to a pregnant woman who was opposed to having the transfusions due to her religious convictions as a Jehovah's Witness.<sup>31</sup> The court ultimately held that the unborn child was entitled to the protection of the law, and that an order would be made to ensure that that woman would receive blood transfusions if the physician in charge at the time made the qualified determination that blood transfusions were necessary to save the

---

26. J. Lowell Dixon & M. Gene Smalley, *Jehovah's Witnesses: The Surgical/Ethical Challenge*, 246 JAMA 2471, 2471 (1981).

27. *Genesis* 9:4 (Jehovah's Witnesses New World Translation of the Holy Scriptures).

28. *Acts* 15:20 (Jehovah's Witnesses New World Translation of the Holy Scriptures).

29. Dixon & Smalley, *supra* note 26, at 2471.

30. *Id.*

31. *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537, 537 (N.J. 1964).

woman's life or the life of her child.<sup>32</sup> In reaching this conclusion, the court relied upon previous decisions that emphasized that the concern of the state for the welfare of an infant justified blood transfusions notwithstanding the objection of its parents who were also of the Jehovah's Witness faith.<sup>33</sup> Moreover, in the case *Smith v. Brennan*, the same court had held that a child could sue for injuries that were negligently inflicted upon it prior to birth.<sup>34</sup> Based on these decisions, the court was satisfied that the unborn child was assured protection by the law, and since the "welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them with respect to the sundry factual patterns which may develop," blood transfusions should be administered to the mother if it is necessary to save her life or that of the child.<sup>35</sup>

Twenty years following the decision in *Raleigh*, the Supreme Court in New York delivered a similar opinion in *In re Jamaica*.<sup>36</sup> In that case, a hospital sought an order to compel a woman who was eighteen weeks pregnant and in critical condition to have a blood transfusion.<sup>37</sup> The woman had previously refused the transfusion based on her beliefs as a Jehovah's Witness even though the procedure had been deemed necessary to stabilize her condition and ultimately save the life of her unborn child.<sup>38</sup> The Supreme Court held that the patient's interest in exercising her religious beliefs was not sufficient to override the state's significant interest in protecting the life of a midterm fetus, which the court classified as a human being in need of protection.<sup>39</sup> The Justice who authored this opinion noted that although he recognized that:

[T]he fetus in this case is not yet viable, and that the state's interest in protecting its life would be less than 'compelling' in the context of the abortion cases, this is not such a case. In this case, the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds.<sup>40</sup>

Thus, early court decisions that involved the autonomy rights of pregnant Jehovah's Witnesses were grounded in the states' interest in the protection of the fetus.

---

32. *Raleigh Fitkin-Paul Morgan Mem'l Hosp.*, 201 A.2d at 538.

33. *Id.*

34. *Smith v. Brennan*, 157 A.2d 497, 504 (N.J. 1960).

35. *Raleigh Fitkin-Paul Morgan Mem'l Hosp.*, 201 A.2d at 538.

36. *In re Jamaica Hosp.*, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985).

37. *Id.* at 898.

38. *In re Jamaica Hosp.*, 491 N.Y.S.2d at 899.

39. *Id.* at 899-900.

40. *Id.* at 900.

### 3. *In re Brown*: The Triumph of Personal Autonomy and Liberty

In a 1997 case that addressed the issue of balancing the rights of a pregnant Jehovah's Witness who refused medical treatment based on her religious convictions against the state's substantial interest in the welfare of the viable fetus, an appellate court in Illinois declared that the paramount interest at stake was that of the liberty and personal autonomy of the woman.<sup>41</sup> *In re Brown* involved a twenty-six-year-old woman Darlene Brown, a Jehovah's Witness, who was thirty-four weeks and three days pregnant.<sup>42</sup> During a procedure to remove a urethral mass, Brown lost more blood than her physicians had anticipated, causing her doctor to order a blood transfusion.<sup>43</sup> Brown, who was fully conscious and alert at the time the blood arrived, refused the blood, noting that she was a Jehovah's Witness.<sup>44</sup> Since the doctors believed that Brown competently refused the transfusion, they finished the surgery using other techniques to control the bleeding.<sup>45</sup> Following the surgery, Brown had an extremely low level of hemoglobin and although Brown's doctor tried various alternative medical procedures, her hemoglobin level continued to drop.<sup>46</sup> At the time, her doctor was of the opinion that if she did not have the blood transfusion, then her chance of survival, along that with that of the fetus, was only five percent.<sup>47</sup>

On account of Brown's refusal to have a blood transfusion, the State filed a petition for adjudication of wardship as well as a motion for the temporary custody of Brown's fetus.<sup>48</sup> The trial court granted the State's petition and provided the hospital administrator with the temporary custody of Brown's fetus, thereby conferring upon the administrator the right to consent to a blood transfusion should one of the attending physicians deem it necessary.<sup>49</sup> In the end, the hospital made the decision to proceed with the blood transfusion, even though Brown adamantly resisted.<sup>50</sup> Once it had been established that Brown had given birth to a healthy baby boy, the court vacated the temporary custody order, and the case was closed.<sup>51</sup>

Nonetheless, the appellate court in the First District in Illinois came to the opposite conclusion, relying on decisions in *Stallman v. Youngquist* and *In re Baby Boy Doe*.<sup>52</sup> In *Stallman*, the court held that a pregnant woman

---

41. *In re Brown*, 689 N.E.2d 397, 401 (Ill. 1997).

42. *Id.* at 399.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* at 400.

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 405.

owes no legally cognizable duty to her developing fetus, as a fetus cannot have superior rights to that of its mother.<sup>53</sup> Expanding upon the reasoning in *Stallman*, the *Baby Boy Doe* court determined that the “Illinois courts should not engage in a balancing of the maternal and fetal rights such that ‘a woman’s competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus.’”<sup>54</sup> Furthermore, the court highlighted that a “woman’s right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy.”<sup>55</sup>

Though the opinion in *Brown* relies heavily upon the arguments established in *In re Baby Boy Doe*, it is important to note that the court departs from *In re Baby Boy Doe*’s suggestion that a blood transfusion merely constitutes a “relatively noninvasive and risk-free procedure.”<sup>56</sup> The *Brown* court found that a blood transfusion is, in fact, an invasive medical procedure that directly interrupts a competent adult’s bodily integrity.<sup>57</sup> Thus, the Supreme Court of Illinois declared that *Brown* should not have been compelled to undergo the blood transfusion for the benefit of her viable fetus, thereby upholding a pregnant woman’s right to refuse medical treatment based upon religious beliefs.

#### B. THE IMPLICATIONS OF *IN RE BROWN* AND OBSERVATIONS REGARDING THE WAY RELIGION IMPACTS OBSTETRICAL INTERVENTION

The decision in *In re Brown* is monumental not only because it established a new precedent for a line of cases in Illinois on the subject of a woman’s right to personal autonomy and bodily integrity, but also because no other appellate court at the time had held that a pregnant woman had the right to refuse a blood transfusion, particularly due to religious reasons. While the decision is not binding upon any other state outside of Illinois, it is likely that the principles enunciated in the *Brown* decision will be relied upon by other appellate courts.

Despite the laudable decision in *Brown*, however, an analysis of the few decisions that have been published in this line of cases suggests that a woman’s religious beliefs may ultimately make the woman more vulnerable to obstetrical intervention. As it was not until 1997 that a court recognized a woman’s right to refuse medical treatment due to religious reasons, it seems physicians and courts in these types of cases are inclined to view a woman’s refusal of specific medical treatment as being grounded solely in religion, as opposed to personal autonomy. Although this theory

---

53. *Stallman v. Youngquist*, 531 N.E.2d 355, 359 (Ill. 1988).

54. *In re Baby Boy Doe*, 632 N.E.2d 326, 330 (Ill. 1994).

55. *Id.* at 332.

56. *Id.* at 333.

57. *In re Brown*, 689 N.E.2d at 405.

is not explicitly stated in any recent opinions, it should be noted that “deep religious discord has been part of America’s social DNA”<sup>58</sup> and, therefore, it is possible that a general lack of understanding or acceptance for certain religions has served as the driving force behind medical court-orders.

## V. THE ROLE THAT CULTURE PLAYS IN AFFECTING A PREGNANT WOMAN’S RIGHT TO BODILY INTEGRITY

### A. SOMALI WOMEN’S AVERSION TO CESAREANS

#### 1. Cultural Norms that Shape Somali Women’s Views Regarding Cesareans

Similar to the way in which religion has caused pregnant women to be more vulnerable to certain medical decisions made by their physicians and the courts, cultural norms have also played a role in making women more susceptible to obstetrical intervention. This has particularly been evidenced through cases involving Somali women. Unlike Jehovah’s Witnesses who refuse to accept blood transfusions, Somali women have a general aversion to cesareans, which seems to be grounded in their cultural beliefs.

Somali women place a significant emphasis on pregnancy due to their religious beliefs, and feel that pregnancy is a blessing from God.<sup>59</sup> In accordance with these beliefs, many Somali women refuse cesareans as they believe that cesareans may impede subsequent pregnancies and lead to death.<sup>60</sup> The general fear of maternal death is readily substantiated by the fact that the maternal mortality rate for Somali women is among the highest in the world.<sup>61</sup> Data gathered by the World Health Organization indicates that in 2006 it was estimated that out of one hundred thousand live births, one thousand six hundred Somali women would die from childbirth.<sup>62</sup>

The high maternal mortality rate is reflective of the severe lack of adequate medical care for Somali women. In Somalia, two-thirds of women receive no prenatal care, and less than a third have a professional birth attendant present during birth.<sup>63</sup> In a study involving thirty-four Somali women which focused on the general resistance to common

---

58. Kenneth C. Davis, *America’s True History of Religious Tolerance*, SMITHSONIAN, 1, 4 (Oct. 2010), <http://www.smithsonianmag.com/history-archaeology/Americas-True-History-of-Religious-Tolerance.html>.

59. *E-Newsletter*, KANSAS PUBLIC HEALTH ASSOCIATION, (Feb. 2006), <http://www.kpha.us/documents/newsletters/2006WinterNewslet.pdf> (last visited Sept. 2, 2012) [hereinafter KANSAS PUBLIC HEALTH ASSOCIATION].

60. Elizabeth Brown et al., “*They Get a C-Section . . . They Gonna Die*”: *Somali Women’s Fears of Obstetrical Interventions in the United States*, 21 J. TRANSCULTURAL NURSING 220, 224 (2010).

61. *Id.* at 220.

62. *Country Statistics: Somalia*, WORLD HEALTH ORGANIZATION, <http://rho.emro.who.int/rhodata/?theme=country&vid=18300#> (last visited Sept. 2, 2012).

63. Brown et al., *supra* note 60, at 220–21.

prenatal and obstetrical intervention techniques, a young woman stated, “They have [seizures in Africa] a lot. [Seizures] cause a contraction and [the woman] don’t have a doctor. The baby is not coming, and they don’t have any c-section. If [the baby] die or the mother die, that is what happens.”<sup>64</sup> This statement reinforces the concept that cesareans are not routine medical procedures for Somali women, as whatever may happen to the child or the mother is believed to be God’s will.<sup>65</sup>

The study also revealed that most Somali women delivered at home, and only went to a hospital if there were complications, which is another prominent reason why Somali women tend to express fears of dying from cesareans.<sup>66</sup> Typically, Somali women only seek hospital care after three to four days of labor, and only accept obstetrical intervention, such as cesareans, in rare cases of prolonged labor and when other methods have failed.<sup>67</sup> Furthermore, the predominant belief among the female participants in the study was that doctors in the United States heavily push for surgery, as opposed to natural birth.<sup>68</sup> One of the women from the study corroborated this view, stating:

Back home with a midwife, if the kid has a big head and he can’t come out, [midwife] makes a cut and the kid comes out. [Somali women] believe here that [doctors] just want to do the surgery. [Doctors] don’t want to help the baby come out. Back home [if women] are in labor even for two days, they still have to wait until the baby comes out. But over here, [doctors] think it’s an emergency and they just do the c-section; they don’t wait until the baby come out.<sup>69</sup>

## 2. Reported Instances of Court-Ordered Cesareans for Somali Women in the United States

It is difficult to find actual court orders or case law regarding instances of forced obstetrical intervention with Somali women in the United States, particularly as most of the court orders appear to be under seal and are not accessible to the public.<sup>70</sup> Additionally, doctors and hospital employees are unable to discuss the cases due to potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).<sup>71</sup>

---

64. Brown et al., *supra* note 60, at 222.

65. *Id.* at 223.

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. See discussion *infra* Part VII.

71. E-mail from Kristi Boldt, M.D., Obstetrics and Gynecology at the Mayo Clinic, to author (Feb. 14, 2012, 12:41 PST) (on file with author).

---

---

Nevertheless, accounts of court-ordered cesareans have surfaced through studies that have gathered Somali women into focus groups.<sup>72</sup>

At the American Public Health Association's 133rd Annual Meeting and Exposition in 2005,<sup>73</sup> various accounts of court-ordered cesareans were described. During a medical presentation of a Somali study, one of the presenters discussed an instance in which a Somali woman had recounted that she originally refused to be induced as she felt that "God-willing the baby would come when it was time," yet was compelled to have a cesarean.<sup>74</sup> A separate instance was additionally described in which another woman also initially refused a cesarean based upon her convictions, but was eventually ordered to have the cesarean by her doctors.<sup>75</sup> Following the cesarean, the women's baby was taken away from her as she was deemed to be an "unfit" mother on account of her original refusal to have the cesarean.<sup>76</sup>

### 3. Observations Regarding the Differences in Beliefs that Exist Between American Physicians and Their Somali Patients

The purpose behind forming focus groups specifically tailored to Somali women and their pregnancy was to identify the reasons for the differences in beliefs and opinions that exist between American physicians and their Somali patients.<sup>77</sup> As Somali women are not native to the United States, their cultural views are not well understood, nor do they appear to be well respected. The general lack of understanding of the Somali culture displayed by American physicians may lead to Somali women feeling helpless in resisting medical treatment. Thus, though documented accounts of forced obstetrical intervention with Somali women in the United States have been challenging to find, it is readily apparent that the cultural beliefs of these women make them vulnerable to certain American medical practices.

## B. THE CHEYENNE RIVER SIOUX RESERVATION: LACK OF REPRODUCTIVE HEALTH SERVICES ON THE RESERVATION AND COERCED INDUCED LABOR

### 1. Allegations of Insufficient Reproductive Health Services and Coerced Induced Labor

Analogous to the way that Somali women may feel powerless to challenge medical decisions in the United States based upon a difference in

---

72. KANSAS PUBLIC HEALTH ASSOCIATION, *supra* note 59.

73. Julka Almquist, MPH, Division of Epidemiology, Address at the American Public Health Association's 133rd Annual Meeting and Exposition (Dec. 12, 2005).

74. E-mail from Mary Barger, Assistant Professor, Department of Family Health Care Nursing to author (Jan. 30, 2012, 04:30 PST) (on file with author).

75. *Id.*

76. *Id.*

77. KANSAS PUBLIC HEALTH ASSOCIATION, *supra* note 59.

cultural views, pregnant women on the Cheyenne River Sioux Reservation feel defenseless to challenge the terms of their labor and delivery which are dictated by Indian Health Services (IHS).<sup>78</sup> For more than a decade, pregnant women who reside on the Cheyenne River Sioux Reservation have not only faced the burden of having to travel more than ninety miles for labor and delivery, since there is no birthing unit on the reservation, but have also been consistently induced without sufficient consideration.<sup>79</sup> On account of the challenges faced by pregnant women on the Cheyenne River Sioux Reservation, the American Civil Liberties Union (ACLU) filed a Freedom of Information Act (FOIA) lawsuit against IHS on September 29, 2010.<sup>80</sup> The FOIA suit was filed in an effort to obtain information regarding the reproductive health care services available to women on the Cheyenne River Sioux Reservation so that appropriate changes could be made to provide women with the services they need.<sup>81</sup>

The actual complaint explicitly notes that IHS has failed to meet the United States government's treaty obligations regarding providing appropriate health care services to American Indians and Alaska Natives.<sup>82</sup> Although IHS is entrusted with fulfilling certain duties to provide specific health care services, there has been a significant lack of comprehensive obstetrical care at any IHS facility on the reservation since 2001.<sup>83</sup> Moreover, though there had originally been plans to build a new birthing unit on the reservation, the plans never came to fruition.<sup>84</sup> Since the birthing unit has not been built, the majority of pregnant women on the reservation who would be eligible for care under IHS are forced to travel ninety miles to a healthcare center in South Dakota for labor and delivery.<sup>85</sup> Due to poor road conditions, this trip can take over two hours.<sup>86</sup>

In addition to the fact that women on the reservation are compelled to travel long distances for delivery, "some of these women report that they are being told they must forgo natural labor and delivery, and instead take medication to induce labor—with little or no notice, explanation, or counseling, and at a time selected exclusively by their doctor (sometimes even before their due date)."<sup>87</sup> Since these women are beholden to IHS for medical services, they typically feel powerless to refuse to be induced on

---

78. Complaint for Injunctive Relief at 1–2, *ACLU v. Indian Health Serv.* No. 10-07388 (S.D.N.Y. Sept. 27, 2010), available at <http://www.aclu.org/reproductive-freedom/aclu-v-indian-health-services-complaint>.

79. *Id.*

80. *Id.*

81. *Id.* at 2.

82. *Id.* at 1.

83. *Id.* at 4.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at 2.

the terms laid out by their physician.<sup>88</sup> Furthermore, the fact that the physician authorizes the induction on his/her own terms leads to instances where families are not able to be present during delivery because of insufficient advance notification.<sup>89</sup>

While labor, in other contexts, is sometimes induced for logistical reasons, no medical group or organization recommends mandatory inductions for rural women without taking into account their personal preferences or circumstances.<sup>90</sup> This argument is asserted in the American College of Obstetricians and Gynecologists' (ACOG) August 2009 clinical guidelines regarding inductions, which state that a patient should always be counseled regarding the indications for induction and the possible need for repeat induction, or cesarean delivery as a result.<sup>91</sup> Additionally, ACOG recommends that at least twelve to eighteen hours of latent labor should be allowed before elective induction in order to reduce the risk of cesarean delivery.<sup>92</sup>

## 2. The Outcome of the Lawsuit and Current Status for Pregnant Women on the Reservation

The ACLU's FOIA filing did not gain much momentum and the lawsuit did not lead to any actual changes in the way that pregnancies are handled on the Cheyenne River Sioux Reservation.<sup>93</sup> Alexa Kolbi-Molinas, the staff attorney who filed the complaint on behalf of the ACLU, claims that the only response she received from IHS was an IHS manual, which details IHS-specific policies and also includes procedural instructions.<sup>94</sup> As there is no written policy in the manual that provides for comprehensive reproductive health services on a reservation, this proved to be a major contributing factor to the defeat of this lawsuit.<sup>95</sup> Nevertheless, Kolbi-Molinas still believes that this issue is actionable since there is a treaty obligation to provide services.<sup>96</sup>

Though no further actions are being filed at the moment, it is likely that this issue will be relitigated.<sup>97</sup> The federal government does not have the right to deprive Native American women of the ability to make an informed and autonomous decision regarding their medical care based upon the fact that they live in a rural area and are obliged to rely on IHS for

---

88. Complaint for Injunctive Relief, *supra* note 78, at 5.

89. *Id.* at 6.

90. *Id.* at 5.

91. *Clinical Management Guidelines for Obstetrician-Gynecologists*, ACOG PRAC. BULL. (Comm. on Practice Bulletins—Obstetrics, The Am. Coll. of Obstetricians & Gynecologists, Washington, D.C.), Aug. 2009, at 4.

92. *Id.*

93. Telephone Interview with Alexa Kolbi-Molinas, ACLU Counsel (Feb. 6, 2012).

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

health care. The practice of coercing women to take medication to induce labor undoubtedly violates both a woman's fundamental right to privacy and bodily integrity.

## VI. MOST RECENT CASE INVOLVING MATERNAL-FETAL CONFLICT AND MEDICAL-DECISION MAKING DURING PREGNANCY

### A. BURTON V. FLORIDA (2009)

There is still no consensus regarding the way courts treat cases that pit a woman's right to refuse medical treatment against the state's interest in protecting fetal health. The most recent decision in this line of cases, *Burton v. Florida*, surfaced in a Florida state court in March of 2009.<sup>98</sup> In *Burton*, Samantha Burton, who was pregnant and who already had two children, voluntarily sought medical treatment after she developed complications during her twenty-fifth week of pregnancy.<sup>99</sup> Her attending physician strongly recommended that she follow a course of care that would postpone her pregnancy, which included medication, inpatient monitored bed rest, and physician supervision of physical activity, smoking, and diet.<sup>100</sup> Instead of following these recommendations, Ms. Burton sought to be discharged from the hospital, prompting the hospital to seek assistance from the state to attempt to force her to comply with the recommended form of care.<sup>101</sup> In response, the state appointed a private lawyer to act as special assistant state attorney in the case, and the lawyer filed an emergency petition seeking judicial authorization to force Ms. Burton to comply with the recommended treatment.<sup>102</sup> Later the same day, the court initiated an emergency hearing by telephone with Ms. Burton in which Ms. Burton represented herself from her hospital room without the assistance of counsel.<sup>103</sup> Shortly following this telephone hearing, the court granted the state's petition as the court reasoned that the state had *parens patriae* authority to ensure that children receive medical treatment that is necessary for the preservation of their life and health, and further that between a parent and a child, the ultimate welfare of the child is the controlling factor in any decision.<sup>104</sup>

On account of the court's decision to recognize the state's *parens patriae* authority, Ms. Burton's providers were authorized to bestow upon her the medical care and treatment that they deemed necessary to preserve

---

98. Kate Wevers, *Burton v. Florida: Maternal-Fetal Conflicts and Medical Decision Making During Pregnancy*, 38 J.L. MED. & ETHICS 436, 436 (2010).

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

the life and health of the unborn child.<sup>105</sup> Within the context of appropriate medical treatment and care, the providers were permitted to mandate permanent bed rest, administer necessary medication, and ultimately perform a cesarean delivery a few days following the court's order.<sup>106</sup>

Following the cesarean, which resulted in a stillbirth, Ms. Burton promptly appealed the original court order.<sup>107</sup> Even though the issue as it applied to Ms. Burton was moot, her appeal raised issues concerning the rights of pregnant women that are likely to reappear in future litigation.<sup>108</sup> In the appeal, The Florida District Court overruled the *Burton* trial court, effectively ruling that Ms. Burton's rights had been violated when she was forced to remain hospitalized against her will after she disagreed with the prescribed treatment.<sup>109</sup> In reaching its decision, the appellate court found that the trial court misapplied the law from *M.N. v. Southern Baptist Hospital of Florida* when it rested its decision upon the holding "that as between parent and child, the ultimate welfare of the child is the controlling factor."<sup>110</sup> Unlike *Burton*, *M.N.* did not involve the rights of a pregnant woman, but rather a parents' refusal of consent for a blood transfusion and chemotherapy for their son.<sup>111</sup>

The appellate court in *Burton* further noted that "[t]he test to overcome a woman's right to refuse medical intervention in her pregnancy is whether the state's compelling state interest is sufficient to override the pregnant woman's constitutional right to the control of her person, including her right to refuse medical treatment."<sup>112</sup> The compelling interest must be "narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual,"<sup>113</sup> and the state's interest does not become compelling until viability.<sup>114</sup> Thus, the court enunciated a strict test that must be met before restricting a woman's freedom to personal autonomy, and since the state did not show any evidence of viability, the balancing test was not triggered.

#### B. THE IMPLICATIONS OF *BURTON*

Though the recent *Burton* decision upholds a pregnant woman's autonomous right to bodily integrity, the decision is not binding upon any state outside of Florida. As the *Burton* case was ultimately decided by a Florida District Court of Appeal, its decision only established precedent for

---

105. Wevers, *supra* note 98, at 436.

106. *Id.* at 437.

107. *Id.*

108. *Id.*

109. *Burton v. Florida*, 49 So. 3d 263, 266 (Fla. Dist. Ct. App. 2010).

110. *M.N. v. S. Baptist Hosp. of Fla.*, 648 So. 2d 769, 770 (Fla. Dist. Ct. App. 1994).

111. *Id.*

112. *Burton*, 49 So. 3d at 266.

113. *Id.*

114. *Roe v. Wade*, 410 U.S. 113, 163 (1973).

---

---

the courts under its jurisdiction. Nevertheless, other states can look to this recent decision as a basis for continuing to uphold a pregnant woman's right to accept or refuse medical treatment, whether their decision is based upon religious, cultural, or merely personal reasons.

### VII. CHALLENGES THAT ARISE IN THIS AREA OF LEGAL ANALYSIS

When researching previous cases that deal with obstetrical intervention and a woman's inherent right to bodily integrity, numerous challenges arise which make it difficult to effectively conduct a proper analysis of the issues at hand. One of the main problems is that there are not many published decisions to rely upon. The lack of published decisions is probably the result of many factors, but the main problem is likely that there is not enough time for a judge to actually write the decision. When a hospital files a motion to allow doctors to perform a medical procedure without the consent of the woman, it is normally under circumstances where there is a time-sensitive medical procedure at stake. For example, in instances of court-ordered cesareans, if a doctor determines it is necessary for a woman to have a cesarean immediately in order to save the life of the baby, an entire lawsuit cannot unfold. A decision by a judge needs to be made as quickly as possible. Therefore, an articulate and expansive decision by a judge is not feasible.

As decisions tend to be made in the moment, many are ultimately reversed through appeals. A clear example of this is the *Burton* case in which the trial court originally made an emergency decision declaring that Ms. Burton could be compelled to comply with her physician's orders based solely upon a phone conversation with the judge.<sup>115</sup> This instantaneous ruling did not afford the judge ample time to efficiently analyze the facts of the case, resulting in Ms. Burton being forced to have a cesarean. In the appeal, however, the court had both the necessary resources and the time to fully weigh the interests at hand, ultimately ruling that Ms. Burton's initial autonomous decision to refuse medical treatment should have been respected.<sup>116</sup> Despite the fact that Ms. Burton was successful in her appeal, for patients like Ms. Burton, the damage had already been done. Thus, the appeals process proves to be ineffective in restoring a woman's right to bodily integrity once it has already been violated.

Another issue that may arise in researching this type of case is that documents or court orders are sealed, and therefore not accessible to the

---

115. Wevers, *supra* note 98.

116. *Id.*

public.<sup>117</sup> Courts will sometimes decide to keep parts of proceedings confidential if they have a justifiable basis for doing so.<sup>118</sup> Such bases often arise in the medical context.<sup>119</sup> If a proceeding is made confidential, then any transcript made of the proceedings will be regarded as a sealed record.<sup>120</sup> Moreover, potential violations of HIPAA prevent doctors and other hospital employees from discussing certain cases, such as evidenced with court-ordered cesareans with Somali women.<sup>121</sup> It is likely that due to the personal nature of many of the cases involving forced obstetrical intervention, records are sealed, thereby making it difficult to ascertain the frequency of and reasoning behind forced obstetrical interventions.

## VIII. PROPOSED SOLUTIONS AND CONCLUSIONS

### A. PROPOSED SOLUTIONS

Despite the numerous challenges that arise in researching this line of cases, viable solutions exist that would not only alleviate these challenges, but also directly address the problem at hand regarding the need to uphold a pregnant woman's right to bodily integrity. One solution is to implement mandatory annual education sessions on recent appellate decisions in this line of cases for the obstetrics and gynecology divisions within hospitals. Doctors and nurses working in the obstetrics and gynecology divisions, for instance, should be well versed in the recent decisions in both *In re Brown* and *Burton*. If they were provided with this knowledge, it is likely that these hospital employees would feel less inclined to compel pregnant women to undergo certain medical procedures. Moreover, this may lead to doctors having a better understanding of different religious and cultural views, thereby creating more respect for their individual patients.

Not only should hospital staff within the obstetrics and gynecology divisions be knowledgeable in recent appellate decisions, but judges nationwide should also be well-educated in these decisions. Biannual judicial education programs should be mandated in an effort to ensure that judges are cognizant of the movement towards upholding a pregnant woman's right to autonomy. As cases in this area of the law tend to be complex, particularly when religion or culture play a role, judges need to be well-informed of recent decisions in order to distinguish between sound and invalid arguments. Furthermore, it is important that judges have a comprehensive understanding of various religious and cultural views.

---

117. ROBERT TIMOTHY REAGAN, SEALING COURT RECORDS AND PROCEEDINGS: A POCKET GUIDE 1–2 (Federal Judicial Center ed. 2010).

118. *Id.*

119. *Id.*

120. *Id.*

121. E-mail from Kristi Boldt, *supra* note 71.

The most effective solution, apart from mandating educational programs, is to have Congress, or each separate state legislature, pass a law explicitly stating that pregnant women have an inherent right to bodily integrity. If a law actually existed that conferred upon all pregnant women the right to choose whether to refuse or accept medical treatment, courts and hospitals would no longer need to engage in a balancing test between the interests of the state in protecting the fetus and the woman's interest in maintaining her right to autonomy.

#### B. CONCLUSIONS

As the cases discussed above reveal, the courts have not reached a general agreement in regard to the way they weigh a pregnant woman's right to bodily integrity against the state's interest in protecting the life of her fetus. When religion or culture play a role in the decision or context of the medical decision at stake, the court's interests appear to shift towards protecting the life of the fetus, ultimately making the woman more vulnerable to obstetrical intervention. Though it is reassuring that some of the most recent decisions in this field of the law have ultimately upheld a woman's right to choose whether to accept or refuse medical treatment based on personal or religious reasons, it seems highly likely that this issue will continue to arise as there has been no precedent established by the Supreme Court which is directly on point.

The current challenges that arise in this area of legal analysis demonstrate that the nature of these lawsuits may continue to prove to be irresolvable, as decisions are made in a very short period of time without being given sufficient consideration, and documents tend to be sealed. Given this information, it follows that there are likely many more instances of court-ordered obstetrical interventions in the United States, yet the decisions are not documented or made available to the public.

In conclusion, though it seems that a woman's right to bodily integrity is being emphasized more heavily, courts need to establish, and consequently follow, a uniform procedure of analysis when approaching these cases, particularly when religion and culture are involved. Should the proposed solutions listed above not be implemented, courts should look directly to the recent decisions in *In re Brown* and *Burton* and use them as models for upholding a woman's right to autonomy and bodily integrity.

\*\*\*