



## When Courts Fail: Physicians' Legal and Ethical Duty to Uphold Informed Consent

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### *Abstract*

Informed consent is a fundamental precept of modern medical care and pertains in those situations when a patient rejects a physician's recommended treatment. This article reports on the case of a pregnant woman in labor who refused the Caesarean section urged by her doctor. The physician involved a consultant and the hospital attorney, and they decided to perform the surgery against her explicit wishes. The arguments used to justify this unconsented intervention invoked fetal wellbeing. This article discusses the conflation of focus on the fetus, derived from anti-abortion argumentation, with the rights of the autonomous adult pregnant woman. This article explores the implications of such forced surgery for the status of pregnant women as competent adults, the ethical underpinnings of the physician-patient relationship, and the law.

On July 25<sup>th</sup>, 2011 Rinat Dray arrived in early labor at the hospital where she had chosen to deliver because of its low cesarean section rate. She had had two prior cesarean sections, wanted more children, and understood that a third surgery would pose increased risks to her, likely making it impossible to find a physician who would provide care for subsequent vaginal deliveries. She had received prenatal care from a doctor who had agreed to attempt a vaginal delivery. The partner covering for her doctor immediately told her to have a cesarean because of the risks attendant upon having had two prior sections, but she objected. Eventually, he agreed that cesarean surgery might not be immediately necessary but as her labor progressed, the physician became increasingly insistent that she have surgery. When Ms. Dray did not agree, he called a maternal-fetal specialist for a consultation who reiterated the recommendation that she should have surgery. Ms. Dray declined. The specialist consulted the hospital's counsel and noted in Ms. Dray's

record, "I find the woman has decisional capacity.... I have decided to override her decision not to have a cesarean section, her physician . . . and hospital attorney . . . are in agreement."<sup>1</sup> The physicians performed the surgery over Ms. Dray's protests. She delivered a healthy child, but sustained bladder bisection.

Obtaining consent from a competent patient is not only an ethical obligation in medicine, but also a legal one. With very few exceptions, the law vests the final decision-making authority in patients. Performance of a medical intervention, even a lifesaving one, against the patient's wishes is a battery; failure to adequately inform the patient of risks and benefits with the intervention constitutes negligence. Indeed, New York law requires all hospitals to post a "Patient's Bill of Rights" that includes the right to "refuse treatment and be told what effect this may have on your health."<sup>2</sup> Even so, for the most part, the underlying notion that patients are the final arbiters about treatment involving their bodies

rides low under the radar of both physicians and patients, and only emerges when physician and patient disagree and when the physician or medical institution takes action in defiance of the patient's expressed wish. The law speaks to those difficult rare moments when the physician considers the patient's decision to be wrong but nevertheless must abide by the patient's decision.

Soon after Ms. Dray's cesarean section, she decided to sue the physicians and hospital involved. By the time she had obtained her medical records and was able to find an attorney who would take her case, the one-year statute of limitations on battery had expired, so she sued for malpractice instead. The defendants argued that Ms. Dray's claims amounted to a battery, not malpractice, and should therefore be dismissed as untimely. They did not dispute that the surgery had been performed without consent. Instead, they argued that because the state has an interest in the protection of potential life, physicians have an independent duty to act in what they believe is the best interest of a fetus, even if it were to mean risking the life of a competent but unwilling woman. This duty, they argued, need not be overseen by a court: a pregnant woman's rights may be suspended upon the approval by the hospital's risk management counsel.<sup>3</sup>

While the court agreed that "the state cannot intervene to require lifesaving medical care over a competent adult's refusal of care and that imposition of such care over a competent adult forms a basis for civil liability," it went on to rule that when an "individual's conduct threatens injury to others, the State's interest is manifest and the State can generally be expected to intervene."<sup>3</sup> The trial court's decision— which is currently being appealed and is not binding legal precedent -- raises two important questions. First, whether continuing a labor is "conduct" that threatens injury to others and therefore can or should be stopped by force of law. The court treated Ms. Dray's refusal of the recommended surgery as "conduct," even though her labor was a biological process not subject to voluntary

control. In other words, their interpretation means that for a pregnant woman with a history of prior cesareans, merely continuing to exist without surgical intervention is an offense warranting state intervention. Second, it raises the question of whether the state's interest in the protection of potential life permits private parties to appoint themselves as guarantors of fetal well-being. If so, pregnant women become a unique class of adults for whom informed consent — which has long been recognized as a common law right with roots in the United States Constitution<sup>4</sup>— does not pertain.

To a clinician, the notion that one can predict possible harm with the level of certainty necessary to deprive a person of their constitutional rights must seem untenable. Even with the great strides that have been made in diagnosis and treatment in obstetrics, there are limits to what a physician can predict. For example, in one high profile case<sup>5</sup>, an Illinois woman was told that her baby had a "zero percent" prognosis for a good outcome from a vaginal delivery. Her healthcare providers urged the State's Attorney to seek a court order to compel immediate surgery. The Appellate Court of Illinois refused to grant the order, ruling that even if the woman's decision would lead to fetal demise, her constitutional rights protected her from being forcibly restrained, sedated, and operated upon.<sup>5</sup> Ms. Doe went on to give birth to a healthy baby. Fortunately, every court with the power to create binding precedent, ruling with the benefit of a full hearing and record, has held that pregnant women have constitutional rights that are not abridged by pregnancy. Ms. Doe's case was not the only one revealing the limitations of rigidly applying statistical probability to individuals. But, as the courts make clear, the woman's rights and our society's protection of individual dignity - not medical certainty - are determinative, even if the doctor's prediction had been fulfilled.

The state's interest in protection of potential life is generally invoked in the context of abortion. The U.S. Supreme Court ruled in *Roe v. Wade* that this state interest can be invoked to prohibit

abortion after fetal viability, unless the pregnant woman's life or health is at stake.<sup>6</sup> However, Paltrow and Flavin have documented hundreds of cases in which prosecutors and hospital attorneys asserted such an interest to justify arrests, detentions, and forced medical interventions on pregnant women whose conduct or situation disturbed those bringing the charges.<sup>7</sup> These included women who use controlled substances, women with uncontrolled diabetes, Jehovah's Witnesses who refused blood transfusion, and women who wished to deliver vaginally after cesarean surgery. While there is no law or legal precedent suspending women's constitutional rights during pregnancy in the name of fetal well-being, these deprivations of liberty persist to present day and now number in the thousands. Worse, they create an atmosphere of fear and distrust among pregnant women, who fear that their physicians will turn them over to law enforcement or institute legal proceedings against them during labor.<sup>8</sup> Paltrow and Flavin thereby concluded that these deprivations of liberty fail to protect fetal health, and instead promote a second-class status for pregnant women.

No other class of persons in our society can be forced to undergo a medical procedure for the benefit of another person. In one frequently cited case, *McFall v. Shimp*, a Pennsylvania court refused to grant an order forcing a man to donate bone marrow to his cousin even though the marrow would save the cousin's life.<sup>9</sup> The court distinguished moral obligation from legal obligation — the man's refusal was "morally indefensible," but "for our law to compel defendant to submit to an intrusion of his body would change every concept and principle, upon which our society is founded." This principle applies even if the person who would benefit is the child of the person being compelled. Indeed if Ms. Dray had given birth to a baby in need of a kidney, neither she nor her husband could be compelled to give one of their own. Nobody would argue that the hospital has the right to devise a policy by which it could approve and

carry out a forced organ donation over the objection of the patient.

With the law firmly on Ms. Dray's side, it is curious and troubling that the court went so far astray in its decision. It flouts legal precedents and sends a message to hospitals and physicians that in the name of fetal interests, they are free to defy maternal self-determination in a way that would be unthinkable for any other type of patient. Under this reasoning, virtually any cesarean could be performed without consent. From serious complications like cord prolapse or placental abruption to failure to progress, the risks might be deemed sufficient to allow an obstetrician ordering a cesarean section to make the case that they are standing for fetal rights. In fact, according to the court, "the risk to the mother's well being is also relevant as to whether it was appropriate to override her desires," implying that a patient might be forced to undergo surgery for her own good. And if a hospital can claim that it lacked sufficient time to consult a court when the woman was in labor for hours in broad daylight, any circumstance can be called exigent. Such scenarios do not align with the ethics of a profession dedicated to serving women's health with dignity.

The status of the fetus is clearly highly contested in contemporary American society, and the fact that Ms. Dray's fetus was hours away from birth likely heightened the surrounding emotions during her delivery. However, while it can be upsetting when patients make decisions with which we profoundly disagree, the physician's fiduciary duty is to the laboring woman, and thus to honor her legal right to bodily integrity and to make decisions about her own medical treatment. These difficult and troubling situations are precisely the ones that call for physicians to heed the law and ACOG's ethical practice guidelines.<sup>10</sup> Ms. Dray's case shows that the law may fail women; it is critical, then, that their physicians do not.

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**Conflicts of Interest**

These authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

<sup>1</sup>Amended Complaint, *Dray v. Staten Island University Hosp. et al.*, No. 500510/14, (N.Y. Supreme Court Kings County, Apr. 11, 2015).

<sup>2</sup>N.Y. Public Health Law 2803 (1)(g); N.Y. Public Health Law 2803-c(3)(a), (e).

<sup>3</sup> Decision and Order, *Dray v. Staten Island University Hosp. et al.*, No. 500510/14, (N.Y. Supreme Court Kings County, May 12, 2015).

<sup>4</sup> *Schloendorff v. Soc’y of New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

<sup>5</sup> *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

<sup>6</sup> *Roe v. Wade*, 410 U.S. 113 (U.S. 1973)

<sup>7</sup> Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. Health Pol., Pol’y& L. 299 (2013).

<sup>8</sup> Chavkin W, Breitbart V. Reproductive health and blurred professional boundaries. *Womens Health Issues*. 1996 Mar-Apr;6(2):89-96

<sup>9</sup> *McFall v. Shimp*, 10 Pa.D. & C.3d 90 (Allegheny County Ct. 1978).

<sup>10</sup> Am. Coll. Obstetricians & Gynecologists Committee on Ethics, Opinion No. 321, Maternal Decision Making, Ethics, and the Law (2005).