The Caesarean Section And The Pregnant Woman’s Right To Refuse Treatment

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Introduction

Until comparatively recently the general public held the medical profession in high esteem, according the consultant an almost godlike status. Adult patients in almost all cases respected the professional advice of the medical team treating them and consented to any treatment recommended, acknowledging that the doctor was the best person to advise them as to what treatment was in their best interests. This was regardless of the fact they had the right to reject the doctor’s advice and refuse the medical treatment offered even if the refusal might prove to be detrimental to their well-being.

More recently, however, patients have begun to exercise their fundamental human right of self-determination and have started to question the doctor’s advice, and have gone on to refuse treatment. When this conflict has occurred, the doctors have endeavoured to resolve it by obtaining legal sanctions from the courts to overcome this refusal and to enable them to carry out the medical procedure.

There have been a plethora of cases which have looked at the relationship between the patient, doctor and the courts over the issue of consent to medical treatment. Clearly, there has been a dramatic change in the attitude of patients towards their doctor. But why this sudden change? What has prompted patients to request a fuller explanation before reaching their decision whether or not to consent to treatment?

One possible influence has been the Patients Charter, which was published by the Government in 1992. It sets out what rights every citizen has with regards to the services expected from the National Health Service. One of these rights is “to be given a clear explanation of any treatment proposed, including any risks and alternatives, before you decide whether you will agree to the treatment.”

Another possible factor was the Cumberledge Report, *Changing Childbirth*, published in 1993.\(^2\) That Report radically changed the provision of maternity services. Its main recommendations were that maternity services should be women-centred, accessible, effective and efficient. Central to the main thrust of the recommendations were patients' choice and patients' autonomy. Women could choose not only their place of confinement but also the professional personnel to carry out the care.

Both the *Patients Charter* and *Changing Childbirth* appear to have dramatically altered the attitude of patients to the provision of care although they have not given patients any additional legally enforceable rights.

However, the basic principles expressed in those two documents took a battering in 1992 when a mother, supported by her husband, refused to have a caesarean section on religious grounds. For the first time a court in the United Kingdom ("UK") ruled that a caesarean section could lawfully be performed despite the woman’s refusal to give consent. As the case was the first of its kind in this country, the court looked for guidance from the United States of America where the courts had, for many years, authorised interventions on pregnant women in order to save the lives of their babies. This case, although much criticised, has been followed by further cases in which a woman’s refusal to give consent has been overridden by a court order which has enabled the doctors to carry out the operation against the woman’s wishes in order to save the unborn child. Clearly the dilemma for the medical team and the courts is the fact that the pregnant woman’s refusal to undergo treatment has major implications for the fetus. It is this highly emotive aspect that has swayed the decision in favour of saving the fetus, and exacerbated the problem.

Although the law appears to be clear regarding refusal of treatment by a competent adult, these cases highlight that there are still areas in this field that have yet to be settled by the courts and Parliament. One such area is whether the rights of a mother refusing to have treatment must prevail against those of her unborn child. Although UK law at present does not afford the fetus any legal rights, a potential limit to the absolute right of a competent adult to accept or reject treatment was recognised by Lord Donaldson MR in *Re T (adult: refusal of treatment)*.\(^3\) He acknowledged the possibility that, if a


\(^3\) [1992] 4 All ER 649 (CA).
woman's choice to reject treatment was to lead to the death of a viable fetus, her absolute right to choose may be curtailed.

The issue of consent or lack of it has become the attention of much media coverage particularly in the emotive area of courts ordering women to undergo caesarean sections against their will. It is clearly important, not only to lawyers but also, to the medical personnel involved in patients' care as well as to the women concerned. This is especially so because in the landmark case, *St. George's Healthcare NHS Trust v S, R v Collins and Others ex parte S (1998)*, the Court of Appeal declared that a hospital acted unlawfully in forcing a pregnant woman to give birth by caesarean section against her wishes.

There has been much written in the past on the subject of consent, with a proliferation of articles in recent years on the topic of the rights of pregnant women to refuse to consent to caesarean section, etc. This article aims to contribute to the literature by looking at, *inter alia*, the rights of both the mother and the unborn child (fetus), to which not much attention has so far been given.

After the introductory section, it (a) focuses on the history and background of the use of the caesarean section as a method of delivering a baby, highlighting the main reasons for its use, from both the maternal and fetal standpoints, and (b) explores how the law stands in relation to consent to medical treatment for competent and incompetent adults, an issue which requires identification of the situations in which a doctor can lawfully treat a patient without consent and what happens if the patient refuses to give consent. Particular reference is made throughout to pregnant women refusing to consent to treatment. The paper also reviews the rights of the fetus from the American and English law perspectives, noting how attempts have been made to use those rights to override the rights of the mother, despite the fact that UK law does not currently afford the fetus any rights. It is argued, finally, that the present position regarding the caesarean section, women's

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4 [1998] 3 All ER 673.

rights and the rights of the fetus requires Parliamentary intervention.

**History and development of the caesarean section**\(^6\)

Nature has devised an almost fail-safe birthing process which enables a baby to be born alive and well. However, when a problem occurs in this birthing process which may endanger the lives of both the mother and the baby or the life of one of them, the medical team can intervene by using the operation of caesarean section to deliver the baby safely.

This part looks at the development of the caesarean operation in its historical context and briefly explores the principal reasons for its use from the standpoint of both the mother and the fetus. It also investigates and discusses some of the major factors that have influenced the operation’s increased use. Although today the operation is considered by many to be one of the safest operations performed, there are still some inherent risks involved to both mother and baby, which will also be explored.

**Brief history of the caesarean section**\(^7\)

The birthing process has worked for centuries, with each stage of the process having a distinct purpose and specific goal. So far as most women are concerned, the delivery process is a unique and wonderful experience, which generally works extremely well, requiring little or no outside assistance. However, when a problem occurs in this birthing process, which may endanger both the mother and the baby, the obstetricians\(^8\) have a variety of procedures available to them, which enables them to correct the problem and assist nature. One such procedure is the operation of caesarean section.

The operation has been carried out for centuries, with there being some evidence that it might have been known by the ancient Egyptians.\(^9\) There are a number of theories as to where the name caesarean originated from. Legend has it that Julius Caesar was delivered by caesarean section and that

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\(^6\) Incision of the uterus (womb) in order to deliver the baby abdominally, as opposed to the normal vaginal route.

\(^7\) For a more detailed history, see *Caesarean Birth in Britain* (Middlesex University Press: London, 1993).

\(^8\) Doctors specialising in maternity care.

the procedure was named after him. Some believe that the name is more likely to come from the ‘lex caearia’ in Roman law, which required that abdominal surgery be performed on a dead or dying woman in the latter part of her pregnancy in order for the baby to be buried separately. However, a more plausible theory is that the name comes from the Latin word, “cedre,” which means to cut, and that “caesarean section” means literally to “cut out.”

What is clear from early mythological references and ancient folklore is that the surgical delivery has been practised for centuries. It was first performed in order to provide a separate burial place for the fetus of a dead woman, rather than to deliver a living baby from a dying mother in order to save its life. It was not until the sixteenth century that surgery was performed with the specific purpose of saving both the mother and baby.

The operation is, therefore, one of the oldest known surgical operations and was originally carried out only as an emergency procedure on women, who were either dying or who had just died during pregnancy or labour, in the hope that the fetus might be extracted alive. Initially, it was performed only as a last resort because it carried with it a great deal of risk. The main principle of obstetric practice was to avoid caesarean section if at all possible and, at any cost, every attempt was made to secure a vaginal delivery. Development of breech extraction, the use of forceps applied to the baby’s head to aid delivery and the use of destructive operations on the fetus are examples of procedures which were adopted in order to secure vaginal delivery. However, with the advent of sterile techniques, improved surgical techniques and anaesthesia, coupled with the availability of blood and antibiotics, the risks were greatly reduced. From being an extremely dangerous operation, it has now become one of the safest of surgical operations.

**Reasons for its use**

The greatly increased safety of the operation has, of course, meant that the indications for its use have widened, and the number of caesarean operations has increased year by year. Because the medical team have a

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12 Delee, op. cit.
reasonably safe alternative to vaginal delivery, they must now decide on a case by case basis whether a vaginal delivery or an abdominal delivery will be the safer option for the mother and her baby. Where there are no complications, i.e., where both the mother and baby are well, there is no doubt that vaginal delivery remains the safest method and should be the one of choice. Where there are complications present, then the obstetrician must taken them into account and balance the advantages and disadvantages of the two modes of delivery.

So, on what occasions would a caesarean operation be absolutely necessary? This part does not intend to include all possible reasons; it rather includes only those reasons which the author considers are absolute indications. These reasons can be subdivided into (a) maternal reasons, (b) fetal reasons and (c) other reasons.

a) Maternal Reasons

Cephalopelvic disproportion

This occurs when there is disparity between the size of the fetal head and the size of the maternal pelvis, in other words, when there is insufficient room for the baby’s head to pass through the bony pelvis. The most common reason for this is that the baby’s head is too large to pass through either because the maternal pelvis is misshapen (due to illness or accident) or it is too small. Women of short stature (under five feet) tend to have small bones although nature compensates for this by producing a small baby. Or it might be that the mother is of average size but the baby she is carrying is large or lying in an awkward position making it difficult for the fetus to pass through the birth canal.

Maternal Health Reasons

Some maternal conditions can also require, for the mother’s own safety, that a caesarean be carried out. High blood pressure is one such disease, the mother may have been suffering from this before pregnancy or she may develop it during the pregnancy. The blood pressure may remain reasonably stable, in which case regular ante-natal check-ups and careful monitoring ante-natally and during labour will be sufficient. However, it may become excessively high, and a condition known as pre-eclampsia may
be diagnosed. This is a specific disease occurring after the twentieth week of pregnancy. The condition can become so severe that the only cause of action is to deliver the baby as the blood pressure usually improves after delivery.

Occasionally other medical conditions, such as heart disease or diabetes or previous history of a stroke, where an increase in the blood pressure may occur due to the stresses of labour and pushing the baby out may be dangerous, may lead the doctors to advise that a caesarean section be performed.

Problems with the placenta

Normally the placenta is situated in the upper part of the womb. However, occasionally, it will form lower down in the uterus and is known as “placenta praevia.” There are varying degrees of placenta praevia with the possibility that the placenta may totally block the passage of the fetus, thus making vaginal delivery impossible. An abnormally situated placenta can also be the cause of heavy bleeding which can be life-threatening to the mother. Another problem associated with the placenta is that it may suddenly peel away from the wall of the womb, causing bleeding and pain (abruptio placenta). The bleeding may only be slight, but it may also become heavy, threatening the life of both mother and baby, and requiring an emergency caesarean to save the two of them.

b) Fetal reasons

Fetal distress

This is a condition where the baby in the womb, for a variety of reasons, is not receiving sufficient oxygen supplies. There are a number of different causes. As already mentioned, one reason may be that the placenta, for whatever reason, is not supplying enough oxygen. This could be due to poor function or separation of the placenta itself.

Fetal distress can occur at any time throughout the pregnancy although it is more likely to occur during labour. It is estimated that fetal distress in

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13 See e.g., M.A. Hickman, An Introduction to Midwifery (Biling and Son Ltd.: London, 1978).
labour occurs in about one birth in one hundred in hospital practice.\textsuperscript{14} If the condition becomes acute, the baby may be left with some degree of brain damage or may in fact die.

Fetal distress usually manifests itself in a number of ways: there may be evidence such as abnormalities in the baby’s heart rate; plus, there may be evidence of fresh meconium, which is further evidence that the child is suffering from a possible reduction in its oxygen supply. However, it can be extremely difficult to diagnose whether the baby is truly distressed because interpretation of the fetal heart recordings is notoriously difficult. Many modern obstetric units now carry out fetal blood sampling, which enables them to determine the baby’s oxygen levels in order to decide whether or not it is a false alarm. Research has suggested that in labour doubtful fetal heart rate should be checked and confirmed by fetal blood sampling.\textsuperscript{15}

Small and occasionally large babies can run into problems, particularly, during labour and delivery. However, smaller babies are more likely to do so than big babies and, therefore, more likely to be delivered by caesarean. Whilst one in fifteen babies are under 2.5 kg in weight, almost 60\% (one in fifteen) of the deaths are accorded to these babies.\textsuperscript{16} Many of them are delivered by caesarean for reasons such as fetal distress, heavy bleeding prior to birth, etc.

Another reason put forward by the medical team for requiring a caesarean section is breech presentation. This is when the baby’s bottom is

\textsuperscript{14} National Institute of Health, 1982, p7.


\textsuperscript{16} Office of Population Censuses and Surveys, 1990.
presenting first instead of the normal cephalic (head) presentation. The reason for this is that there are concerns that the bottom, being soft and malleable, may pass though the birth canal but the larger part of the baby, the head, may not. Before the 1970s it was common practice for obstetricians, on finding such a presentation, to perform an “external cephalic version”. This procedure would turn a breech baby into the normal cephalic position. However, this procedure was not without risk; the cord could become knotted or the placenta damaged. These, coupled with the increasing safety of the caesarean operation, led to a decline in the procedure. So, today, whenever there is breech presentation, a caesarean section is recommended.

Other reasons

Repeat caesarean

In his original lecture on the subject of the caesarean section, Graigin said that the medical profession should be cautious about performing a caesarean on a woman having her first child. During this lecture he made his most famous and remembered statement, “once a caesarean, always a caesarean.” That statement reflected the practice of doctors for many years, particularly, in America. The medical profession’s concern was that the scar in the womb would come apart during labour.17 The majority of doctors in Britain do not hold that view and will allow a woman, who has had a previous caesarean, to have a trial of labour the next time round. Having said that, those obstetricians would only be happy for that to happen if the mother agrees to having the baby in a well-equipped unit.

Prolapsed cord

Another absolute reason for performing a caesarean would be a prolapsed cord, which constitutes a grave risk to the fetus because of the danger of reducing the baby’s blood supply. A prolapsed cord can occur when the waters rupture, when a sudden gush of the amniotic fluid may bring the cord down with it. Other conditions that may predispose a cord prolapse are a small baby, cephalopelvic disproportion (mentioned earlier) or, long cord. Whatever the cause they all require immediate delivery of the fetus.

Factors influencing its increased use

The rate of caesarean section has risen dramatically in almost all countries of the western world over the last 20 years.\textsuperscript{18} There are a number of factors that have increased the use of caesarean section in this country and throughout the world. Probably the most important reason cited for the increased use of the operation is the fear of litigation. It is suggested that this fear has played a key role in increased rates in the U.K. and U.S.A.\textsuperscript{19}

Changing methods of obstetric practice is another influential factor. Changing attitudes of doctors towards delivery clearly play an important role. The dictum, “once a caesarean always a caesarean,” maintained, particularly in America, high levels of operative intervention. However, obstetricians are now not following the dictum quite so rigidly. Training and experience of obstetricians also arguably play their part. As the indications and reasons for the caesarean section increase, so the skills for carrying out alternative procedures are lost. The art of breech delivery, mid cavity forceps delivery, etc., are being eroded away, leaving no other choice but the caesarean.

Also, increased induction rates and the increased use of epidural anaesthesia, coupled with the introduction of intra-partum care by midwives, have contributed to the increased rates of caesarean section although this may be disputed by some practitioners who feel that over the years rates have been reduced by changes in practice and peer pressure.\textsuperscript{20}

Another major factor in the increase is the introduction of patients’ choice. The introduction of the Patients Charter and Changing Childbirth have led to an increase in patients participating in the management of their care. Both documents actively encourage patients to take a more active role in their treatment. Patients are no longer willing to merely accept what the physician tells them. They increasingly question the management of their care and treatment, and contribute to the decisions made.

Changing Childbirth places great emphasis on a woman’s right to choose. A woman’s wishes may well be influential in the decision of whether or not to have a caesarean section. The actual extent to which women’s demands influence the number of operations performed is undocumented.\textsuperscript{21}


\textsuperscript{20} Savage and Francome, \textit{op. cit.}

has been reported that direct requests for a caesarean section by women are not complied with unless there is an underlying medical reason for operative delivery.\textsuperscript{22} Arguably, very few doctors are likely to be so stubborn as to go against their wishes for fear of litigation should things go wrong.

However, the possible influence that women themselves may have on the decision-making process is mentioned less frequently.\textsuperscript{23} It is, nonetheless, an important factor in the rates of operative delivery, and also extremely important to the women involved.\textsuperscript{24}

A factor influencing the caesarean section in America, and possibly increasingly in this country, is the effect of private care. In the USA the majority of women are cared for by obstetricians in private practices.\textsuperscript{25} In England the number of women being cared for privately is increasing and with it rising intervention rates are resulting. Such patients believe that, if they are paying, they should get what they want.

The rise in caesarean section rates

Over the years the rates of the caesarean section have been increasing steadily.\textsuperscript{26} For example, in England, although the rate increased from 10% in 1988 to 13% in 1991,\textsuperscript{27} by 2000 it had risen to 21.3%, according to the Royal College of Obstetricians and Gynaecologists.\textsuperscript{28}

These increases give an indication that the obstetricians’ ruling body, the Royal College of Obstetricians and Gynaecologists, could be more active in reducing such levels. Improved training and on-going assessment may also help reduce rates. In fact a report, produced jointly by the Royal College of Midwives and the Royal College of Gynaecologists in 1999, acknowledged the need to have increased involvement of more senior


\textsuperscript{23} McFarlane and Chamberlain, op. cit.


\textsuperscript{25} National Institute of Health 1992.

\textsuperscript{26} See, e.g., McFarlane and Chamberlaine, op. cit.

\textsuperscript{27} House of Commons Official Report (Hansard), 1992.

doctors, e.g., consultant obstetricians, on labour wards in the care of women with complex or complicated pregnancies, and in the supervision and education of junior medical staff.\textsuperscript{29}

A further possible solution is the introduction of no-fault compensation. This might serve to reduce the numbers of caesareans performed because the obstetrician, who does not perform a caesarean section on demand, would thereby no longer fear litigation.

It is, today, reassuring that the Government has announced that it intends to clamp down on caesarean sections on demand and, instead, allow the operation only on medical grounds.\textsuperscript{30}

Whatever is done, the rates of caesarean must surely be lowered, if not for this generation, for generations to come. If we are not careful, we are in danger of losing sight of what for nature is a normal process.

The following part considers the question of consent to treatment.

\textbf{Adult patients and consent to treatment}

One of the fundamental principles of health care law is that treatment should be given only with the patient's consent. The requirements that a patient must give a valid consent to medical treatment and that it is the patient's exclusive right to refuse treatment, even that which will save his life, are issues at the heart of medical law.

As a general rule, medical treatment, even of a minor kind, cannot be carried out legally unless the doctor has first obtained the patient’s consent. In the majority of cases adult patients respect the professional advice of the doctors treating them and consent to any recommended medical treatment. Increasingly, however, patients are questioning the advice given and are refusing to give consent to the medical treatment offered.\textsuperscript{31}

The law is clear: every adult has the right to decide whether or not to accept treatment even if that refusal may cause them permanent damage.\textsuperscript{32}

\textsuperscript{29} See \textit{Towards Safer Childbirth} (RGOG Press, 1999). The report recommended, \textit{inter alia}, that (a) all labour wards should have a lead obstetrician responsible for daily management and staff deployment, and the support of medical staff, (b) at least one consultant or equivalent cover should be available in a supervisory capacity for 40 hours during the working week, and (c) a consultant on call should visit the labour ward and conduct ward rounds and, where difficult deliveries were anticipated, should be contacted.


\textsuperscript{31} \textit{Re C (Adult; Refusal of Treatment)} [1994] 1 W.L.R. 290.

\textsuperscript{32} \textit{Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital} (1985) 2 W.L.R. 480.
But, if there is any doubt regarding the patient’s competence to make such a
decision, the decision may be challenged in a court of law. Even a pregnant
woman’s right of self-determination may be challenged if her refusal is likely
to endanger the life of her unborn baby, as was the position in Re S.33

This part explores how the law stands in relation to consent to medical
treatment for competent and incompetent adults, and the principles involved.
It will, in so doing, identify those situations in which the doctor can lawfully
treat without a patient’s consent and problems which may arise if he does so,
with particular reference to pregnant women refusing to consent to caesarean
section.

**Competent Adult**

In order for a doctor to carry out legally any form of medical treatment
on a competent person, the doctor must first obtain the patient’s consent. The
basis for requiring consent is that every person under the common law has the
right to have his/her bodily integrity protected against invasion by others.34
The principle was re-stated by Lord Donaldson in *Re T:* “Primae facie every
adult has the right and capacity to decide whether or not he will accept
medical treatment, even if his refusal may risk permanent injury to his health
or even lead to premature death ... However the presumption of capacity to
decide...is rebuttable.”35 If he/she is touched without consent or other lawful
justification, then that individual has the right of action in the civil courts for
trespass to the person (battery).36 The fact that consent has been given will
normally prevent a successful claim for trespass although it may not prevent
an action for negligence.

Therefore, consent must be given before treatment begins; it may be
implied (by conduct) or express (in writing), but must be given freely by the
patient.37 Although there is no requirement for written consent to be
necessary in most cases,38 it is good practice to do so when reasonably

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34 Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital (1985) 2 W.L.R. 480.
36 See e.g., Cardozo, J. in *Schloendorff v Society of New York Hospital,* 105 NE 92 (NY, 1914).
37 See e.g., *Freeman v Home Office* [1984] 1 All E.R. 1036. and also C.M. Culver and B. Gert, *Philosophy in
38 Written consent is required in a particular format by certain statutes, e.g., the Human Fertilisation and Embryology
Act 1990.
practicable. For any procedure that carries a substantial risk the National Health Service ("NHS") Management Executive recommends that written consent should be obtained.\textsuperscript{39}

An adult is deemed competent to give a legally effective consent if he/she is able to understand the nature and purpose of the treatment.\textsuperscript{40} Plus, the patient must be "mentally and physically capable of exercising choice."\textsuperscript{41} The Law Commission identified three different approaches to determining capacity: status, outcome and function.\textsuperscript{42} Now, according to the Mental Incapacity Bill 2003, currently before Parliament, a person has capacity in relation to a matter and is, therefore, able to make a decision for himself if he/she is able (a) "to understand the information relevant to the decision," (b) "to retain" that information, (c) "to use" that information "as part of the process of making the decision", and (d) "to communicate the decision (whether by talking, using sign language or any other means)."\textsuperscript{43}

In England,\textsuperscript{44} unlike America, there is no principle of "informed consent," whereby it is the doctor's duty, "at a minimum," to inform the patient of "the nature of the proposed treatment, any alternative treatment procedures and the nature and degree of risks and benefits inherent in undergoing and abstaining from the proposed treatment."\textsuperscript{45}

At present the doctor's only responsibility is to inform the patient of those risks involved with having or refusing the treatment, which a reasonable body of medical opinion would confirm as acceptable practice.\textsuperscript{46} Although this stance was confirmed by Lord Diplock in \textit{Sidaway},\textsuperscript{47} Lord Scarman, delivering a dissenting judgement, accorded with the American approach. More recently there are indications \textsuperscript{48} that the courts will in the

\begin{itemize}
\item \textsuperscript{39} BMA Professional Division, \textit{Rights and Responsibilities of Doctors} (BMA Publishing Group, 1992).
\item \textsuperscript{40} Lord Brandon in \textit{F v West Berkshire Heath Authority} [1989] 2 All E.R. 545.
\item \textsuperscript{41} \textit{Re T(Adult;Refusal of Treatment)} [1993] Fam Law 95.
\item \textsuperscript{43} Clauses 1 and 2 of the Bill.
\item \textsuperscript{44} See e.g., \textit{Freeman v Home Office} [1987] 1 All E.R. 1036.
\item \textsuperscript{45} \textit{Crain v Allison}, 443 A. 2d at p.562.
\item \textsuperscript{46} \textit{Bolam v Friern Hospital Management Committee.} (1957) 1 W.L.R. 582.
\item \textsuperscript{47} \textit{Sidaway v Board of Governors of the Bethlem Royal Hospital And Maudsley Hospital and Others} [1985] 1 AC 871.
\end{itemize}
future move towards a true doctrine of informed consent. However, if the patient specifically asks the doctor to explain the risks, the doctor must answer truthfully.\textsuperscript{49}

**Possible consequences of treating without consent**

A person’s right to self-determination and autonomy are so highly respected that he/she may sue for damages for assault or may make a claim based on negligence if a doctor treats him/her without consent.\textsuperscript{50} The medical profession may unwittingly believe that, so long as they have obtained a patient’s written consent, they will be protected from liability. But, unless a patient understands the exact nature and purpose of the proposed treatment, a signed consent form is invalid and the patient may still be able to sue.

**Patient’s capacity to decide**

How can a doctor be sure a patient has the capacity to agree or to refuse to consent to treatment? There are several issues doctors have to be satisfied about before they can accept a patient’s refusal of treatment. Doctors need to ensure the patient has the capacity to decide, that the patient’s decision is a genuine refusal of the treatment or procedure proposed in those exact circumstances, that the patient is aware of the consequences of refusal, and that the decision was the patient’s own, not unduly influenced by a third party.\textsuperscript{51} If any of these factors raise a doubt that the patient did not have the capacity to decide, then the doctors may come to the conclusion that the patient’s refusal was not a true refusal. In an emergency situation the doctor would owe a duty of care to treat the patient in spite of his/her refusal. However, in a non-urgent situation, the doctor should apply to the court for assistance.\textsuperscript{52}

**Incompetent adults**

A doctor who treats a patient without a legally valid consent may still

\textsuperscript{49} Blyth v Bloomsbury Health Authority [1993] 4 Med L Rev 151.

\textsuperscript{50} See e.g., Mason and McCall, \textit{op. cit.}, p. 219.

\textsuperscript{51} Re T (Adult: Refusal of Treatment) [1993] Fam Law 95.

\textsuperscript{52} Ibid.
not be liable in an action if he can raise the defence that he acted in the patient’s best interests (i.e., what a reasonable body of medical opinion would regard as being in the patient’s best interest), or out of necessity. A patient may be incompetent due to unconsciousness, confusion, mental disorder, or the effects of fatigue, shock, pain or drugs.\(^{53}\) For a mentally disordered patient, Part 11V of the Mental Health Act 1983 contains provisions concerning treatment of their mental disorder. For incompetent patients who are not mentally disordered, a doctor must rely on the common law to lawfully treat them without consent.

In these situations treatment will be lawful so long as it is in the patient’s best interests, that is, the treatment is necessary to preserve life or “ensure improvement or prevent deterioration in their physical or mental health.”\(^{54}\) For any other proposed treatment which does not fall within the ambit of best interests of the patient, e.g., sterilisation, or caesarean section, a doctor should approach the court for a declaration that in the opinion of the court the treatment would be in the best interests of the patient, which would then make the doctor’s actions lawful.\(^{55}\)

**Emergency Situation**

In an emergency situation, according to the principle of necessity, a doctor is lawfully able to treat a patient without their consent in what they believe to be the patient’s best interests if the patient “has made no choice and, when the need for treatment arises, is in no position to make one.”\(^{56}\) But there are limitations to the principle of necessity in that the medical team can only give treatment, which is essentially necessary in the circumstances.\(^{57}\) In these situations it was thought at one time that the doctors could seek the consent of a relative following the dictum of judge Robinson in *Canterbury v Spence* (1972)\(^{58}\) that “even in situations of that character where the patient is unconscious or otherwise incapable of consenting the physician should.... attempt to secure a relative’s consent if possible”. There is, however, no

\(^{53}\) Re T (Adult: Refusal of Treatment) [1993] Fam Law 95.


\(^{55}\) Ibid.

\(^{56}\) Re T (Adult: Refusal of Treatment) [1993] Fam Law 95.


\(^{58}\) 464 F 2d 772, at 789.
general doctrine that a relative is empowered to give or refuse consent on the patient’s behalf. Any information they give to the doctor may determine how the doctor should treat his patient. For example, if the next of kin made a doctor aware that the patient was a Jehovah’s Witness but the patient was not carrying a medical alert card, “he would avoid or postpone any blood transfusion for as long as possible.”

Refusal of Treatment

The traditional view is that a competent adult patient is entitled to refuse medical treatment for rational or irrational reasons or for no reason. Adults can decline medical advice even when the consequences are that they will die. In this country the right of self-determination is regarded as “a basic human right protected by the common law.” In America this right is protected by a written Constitution. So highly respected is the patient’s autonomy that the right to be free from unwanted physical invasion is deemed to include the right to refuse life sustaining care. However, as already mentioned, unlike America, this country does not recognise the concept of informed refusal. What is required here is that the patient understands the nature and purpose of the proposed treatment to which consent or refusal is given. In the event of refusal of consent the British Medical Association (“BMA”) recommends that doctors explain the nature of the illness in detail, why the treatment is necessary and possible consequences if treatment is refused. If the patient continues to refuse, their decision should be respected.

Refusal of obstetric intervention


60 Ibid., p.787.

61 Re T, ante.


63 Sidaway v Board of Governors of the Bethlem Royal Hospital and The Maudsley Hospital [1985] 2 W.L.R. 480 at 488.

64 Re AC (1990) 573 A 2d. 1252 (DC, CA).

65 See, e.g., BMA Professional Division, Rights and Responsibilities of Doctors (BMA Publishing Group, 1992), p.3.
One of the most controversial and problematic area of health care in respect of a patient’s refusal to consent to treatment is in obstetrics. Should a woman be able to decline to consent to medical intervention which the doctors tell her is essential to prevent serious harm occurring to her baby?

Because of the controversy just mentioned, it is worth giving a brief account of some of the cases leading to the present position that the mother’s rights prevail over those of the fetus, as shown by St. George’s Healthcare NHS Trust v S. In Re T 66 Lord Donaldson MR expressly left the question open as to whether the presence of a viable fetus could override the fundamental principle that a competent adult patient has the right to accept or refuse treatment. In that case a pregnant woman was in need of a blood transfusion to save her life, following the stillbirth of her baby. She refused the transfusion on religious grounds, having been brought up by her mother who was a fervent Jehovah’s Witness. Her father, who was opposed to her beliefs, sought a declaration from the court, that it would be lawful for the doctors to administer a blood transfusion as she was now unconscious. The court held that her refusal was invalid because it had been given under duress from her mother. The Court of Appeal, however, went on to consider the central issue, that of a competent adult’s right to refuse treatment. Lord Donaldson MR said:

An adult patient who...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 treatments being offered. The only possible qualification is where the choice may lead to the death of a viable foetus. That is not the case here and if and when it arises, the courts will be presented with a novel problem of considerable legal and ethical complexity.

Having recognised this limitation, Lord Donaldson gave no indication as to the legal foundation on which the exception was based. Although the basis of his statement might be drawn from his conclusion, he said that, though an individual had a right to self-determination, this was to be balanced against society’s interest of preserving the sanctity of life; and that any doubt should fall in favour of society’s interest. This is similar to the society interests expounded by the American courts.

However, this potential limit to self-determination of pregnant women,
mooted by Lord Donaldson, was soon put under the spotlight in _Re S_. That was the first case brought before an English court in which a declaration was sought to authorise a caesarean section without lawful consent. The case became a _cause celebre_ and provoked great debate about the rights and wrongs of forcing pregnant women to undergo surgical operations against their wishes. Mrs. S was a 30 year old 'born-again Christian' expecting her third child. The baby was lying in a transverse position and could not be born vaginally. The mother refused, on religious grounds, to give consent to a caesarean section, saying that ‘God will provide’. The President of the Family Division of the High Court granted an order authorising the health authority to carry out the operation. Both the judge and the Health Authority contended that they were doing it in the interests of both Mrs S and her unborn child. The judge, Sir Stephen Brown P, acknowledged that the fundamental issue of whether a pregnant woman could refuse to have treatment was left open by Lord Donaldson. There was no English authority for intervention so he based his decision on the American authority. In looking at the American authority he believed that, had the case been heard in the United States, the courts would have found in favour of authorising the operation. There were those who in hindsight suggested that the assumption based on _Re AC_ was correct.

Insofar as the decision was taken to protect the rights of the unborn child, it would seem to be in direct conflict with the Court of Appeal in _Re F_. In this case the local authority had made an application to have a schizophrenic woman, detained in hospital, to undergo a caesarean section and for her baby to be made a ward of court. The Court of Appeal firmly refused the application on the grounds that the fetus had no legal identity and could not be made a ward of court. The court also saw “the case as an attempt to create a new jurisdiction to protect foetuses by orders which controlled pregnant women.” The court held that “without Parliamentary authority, English courts have no jurisdiction to restrict pregnant women’s civil liberties in

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69 _Re AC_ (1990) 573 A 2d 1252 (DC, CA).


71 _Re F_(In Utero) (Wardship) [1988] 2 All E.R. 193

72 Ibid.
It could be argued that the decision of the court was based on the broader issue of public interest or, as Lord Donaldson suggested, “society’s interest.” This approach has been recognised by a number of cases including *Re F* and *Re T*, in which Lord Donaldson suggested that “in case of doubt, that doubt falls in favour of the preservation of life for if the individual is to override the public interest he must do so in clear terms.” Clearly it would be very tempting for the courts to “come down on the side of life” but, in doing so, the judge compromises the state’s integrity by acting coercively albeit in a good cause. The judgement of Sir Stephen Brown P was extremely brief and gave no clues as to which approach he might or might not have adopted. Suffice to say that the case generated a great deal of interest and criticism from academics, interested groups, and feminists, prompting the Royal College of Obstetrics (“RCO”) to issue guidelines which suggested that doctors should respect the competent mother’s wishes. All this was before the Court of Appeal’s decision to the contrary in 1998.

In 1996 there was a spate of cases which came before the English courts requiring declarations authorising caesarean section. In every case it was declared that the treatment would be lawful. In each case the judge’s decision was based on the fact that the women were incompetent and that the treatment could be made lawful on the grounds that it was in their best interests.

*Tameside and Glossip Acute Services Trust v CH (1996)* involved a schizophrenic woman who had been detained under the Mental Health Act 1983. Wall J declared that a caesarean section could be performed without consent as treatment for mental disorder under the Mental Health Act 1983,


Such as AIMS and NCT.


section 63. In doing so the judge controversially manipulated the statute construing induction of labour and caesarean section as treatment for mental disorder. Wall J developed a three-stage test in order to judge a patient's competence to consent: (a) the capacity to understand and retain the treatment information, (b) believing it and (c) weighing it to make the choice. Sadly the woman was in a no-win situation because, although she understood the information, she did not believe it. So, she failed the test.

It is unclear just how many of these cases have come to court but a number have followed, two of which came to court on the same day. Both were heard by the same judge who decided in both instances that the women were incapable of making a decision about consent. In the first case, Norfolk and Norwich (NHS) Trust v W, the judge reasoned that the woman "was making the decision at a time of acute emotional stress and physical pain in the ordinary course of labour" and, in the second case, Rochdale NHS Trust v C, that the basis of the woman's incompetence to decide was "the emotional stress of pain and labour." Where does this leave women who are in labour generally? Does it mean that they are all incapable of making decisions? Does it mean that the medical team can override a woman’s decision just because of the normal stresses and strains of labour? Clearly women threatened with court-ordered caesarean section have, as one author suggested, a number of choices: 'injunct, flee, fight, acquiesce, appeal, litigate.'

The issue was addressed again in Re MB (Adult: Medical Treatmen), where a caesarean section was required to save the life of the fetus from death or serious handicap. The woman involved had a needle phobia and, although she originally agreed to the operation, once in the anaesthetic room her needle phobia caused her to panic and subsequently refuse to go through with the operation. Yet again, the court declared that it would be lawful to provide the treatment in her own best interests. However, on appeal, the Court of Appeal, when considering the issue of competence, endorsed the principle that, where competent, the woman’s autonomy must prevail over her own

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84 [1997] 1 FCR 274, where the judge disregarded evidence from the woman’s obstetrician and psychiatrist that she was in fact competent.

85 See e.g., Barbara Hewson, "Ethical triumph, or surgical rape?" Solicitors Journal, November 1993, p.1183.

best interests and those of her fetus. Unfortunately this was only obiter. Therefore, the whole issue was left to be finally considered in *St Georges Healthcare Trust v S*,\(^87\) where the Court of Appeal reversed the decision of Sir Stephen Brown, President of the Family Division of the High Court, and concluded that, even when her own life depended on receiving medical treatment, an adult of sound mind was entitled to refuse it. That right of a pregnant woman was not diminished merely because her decision to exercise it would result in the death of an unborn child. The Court of Appeal actually agreed with the reasoning of the majority of the Supreme Court of Canada in *Winnipeg Child and Family Services (Northwest Area) v DFG*\(^88\) (a case concerning solvent abuse by a pregnant woman) that, *inter alia*, the fetus was not a legal person and it would be undesirable to create fetal rights to conflict with maternal rights.

**Comment**

The striking thing about all the pre-1998 cases mentioned thus far is not only that all of them were decided in favour of proceeding with the operation, but also the fact that they all lacked procedural due process.

The majority of the applications were made *ex parte*, with the woman being unrepresented in court. The applications were all made in an emergency situation under strict time restraints, where the judges had to make their decisions in a very short period of time, having been presented with a one-sided argument from the obstetricians involved.

This can be one of the few occasions that the courts have been prepared to make such an important decision as to an individual’s rights without a proper hearing. Why in so many cases were the judges prepared to forego procedure to save the life of an unborn child who certainly under English law has no legal rights?

In the American case of *Re AC* the court noted and highlighted the effect of lack of procedure, stating:

\[...\text{they undermine the authority of the decisions themselves, posing serious questions as to whether judges can in the absence of genuine notice, adequate representation, explicit standards of proof and rights of appeal realistically frame principled and useful legal response to the}\]


\(^88\) (1996) 10 WWR 111.
dilemma with which they are being confronted." 89

Academics too have expressed their doubts that, given the circumstances of these cases, judges have been able to “realistically frame principled and useful legal responses to the dilemma with which they are faced.” 90

The issue of lack of procedure was considered for the first time in an English court by the Court of Appeal in Re MB. The case was the first of its kind to come to an appeal, giving the their Lordships an opportunity to consider the cases in detail. In delivering their reserve judgement, Butler-Sloss LJ highlighted that “all the decisions made in the caesarean section cases ... arose in circumstances of urgency or extreme urgency ... the evidence was in general limited in scope and the mother was not always represented.” The Court of Appeal, in making its decision, enunciated a number of useful procedural guidelines to be followed in caesarean section cases, which have now been incorporated in the Department of Health Circular. 91

In St. Georges NHS Trust v S the Court of Appeal went on to issue guidelines for medical staff involved in these cases to follow should a patient refuse consent to medical treatment when there may be doubts about his/her capacity to consent to or refuse surgery. The court suggested that they could apply to all medical practitioners and other healthcare professionals. However, the court went on to stress in its conclusion that in certain, especially, urgent cases, where delay presented a serious risk to life or health, “formulaic compliance with the guidelines would be inappropriate.”

In this section has been illustrated the range of different scenarios where the accepted principle is that a competent adult has an overwhelming right to determine what is done to their body. However, although there are clear exceptions to this rule, the court in Re T was prepared to add a fourth, that of protection of an unborn child despite the fact that the fetus has no rights to protect until it is born.

The courts have now clarified the law in the most controversial area, namely, that of the right of a competent woman to determine what is done to her own body. The courts have offered procedural guidelines for both the legal and medical professions as to when obstetric treatment cases should be brought to court and have discouraged unjustified urgent ex parte


applications without proper evidence. 92

These cases, referred to above, demonstrate some of the strengths and weaknesses of judge-made law. Judges make new law whenever a case comes before them. Occasionally they will make radical changes to the law by the conclusions and decisions they make. Understandably, the judiciary are driven by a paternalistic desire to save lives unfortunately at the expense of another person’s civil liberties. In this highly emotive and controversial area, is it not time for Parliament to step in once and for all and resolve the issue?

Having considered the issue of consent and the woman’s right to refuse treatment even if that refusal may jeopardise the life of the fetus, the rights of the fetus, if any, will now be looked at. The dilemma for doctors and midwives caring for a woman in such circumstances is that they see themselves as having a dual role. 93 On the one hand they have an obligation to the mother and undoubtedly want to respect her wishes. Yet, on the other hand, they feel they have a professional and moral obligation to protect the fetus from harm. However, although this dual role is appreciated by the medical profession, with guidance from the Royal College of Obstetricians, 94 the law does not have the same attitude to the problem.

Rights of the Fetus

This part reviews the rights of the fetus from both the American and English law perspectives, bearing in mind the difference between them and, in particular, the extent to which American case law has in the past given the fetus an entity. This American standpoint clearly played an important part in influencing the High Court’s decision in Re S, 95 where the English court relied on the American authority 96 as there was no English authority on the issue at the time, which led the court to find in favour of the fetus. The Court of Appeal, of course, as already mentioned, reversed this position in 1998.

Before considering the law as regards the fetus, we shall briefly


93 See, e.g., Royal College of Obstetricians and Gynaecologists’ Guidelines, Ethics, No. 1, April 1994.

94 Ibid.


consider the fetus itself, its development and growth from the embryonic stage of development to the point at which it assumes a human shape and is known as the fetus. This is because the point at which the fetus becomes viable has a great deal of significance not only for the pregnant woman but also for how the law relates to the fetus and its subsequent protection.

It is usual to think of the duration of a pregnancy from the number of weeks that have elapsed from the first day of the last menstrual period. It is, therefore, generally accepted that the last menstrual period is used as a baseline to calculate the gestational period of the pregnancy, which is normally expected to be forty weeks. Conception occurs upon the successful fertilisation of the female egg (ovum) by a male sperm and denotes the beginning of embryonic life. During fertilisation the female egg (ovum) and the male sperm fuse together to form the zygote or fertilized egg, which, having travelled through the fallopian tubes, eventually implants itself in the uterus of the mother, the woman.

By about eight weeks of intra-uterine life, the embryo assumes a recognisably human form,97 with recognisable human features, as all the organs are formed although they are functionally grossly immature. At this stage the word fetus is substituted for that of embryo and from then on the development and growth of the fetus consists of an increase in both size and complexity of all its organs.

From the twenty-fourth week of pregnancy the organs may be sufficiently well developed to function and sustain life independent from the mother. It is at this point that the fetus becomes legally viable, i.e., capable of leading a separate existence and, therefore, capable of being an individual in its own right. It is important to note at this point that, to be viable, the fetus must be capable of, not only being born alive but also of, being able to survive outside the womb albeit with some medical assistance. This will involve care in a well-equipped specialist neo-natal unit which is able to provide life support, i.e., mechanical ventilation of the lungs, etc., until the baby is able to support itself. The chances of survival at this period of gestation is not good but they improve steadily with each succeeding week of intra-uterine life up to thirty-six weeks of pregnancy.

However, the establishment of the viability of the fetus is a critical point in a woman’s pregnancy both medically and legally. Until such time the fetus is provided with a measure of protection by a number of statutes.

The Offences Against the Persons Act 1861 makes it illegal for a woman, being with child, to unlawfully administer to herself any poison or use any instrument unlawfully with intent to procure a miscarriage. It is also unlawful for any other person to attempt to cause a miscarriage by similar means. Section 59 of the Act makes it illegal for anyone to supply a poison or instrument knowing that it is to be used unlawfully to procure the miscarriage of any woman, whether or not she is with child. Section 60 of the Act makes it an offence to conceal the birth of a child.

The unborn child is also specifically protected under the criminal law by the Infant Life (Preservation) Act 1929. This statute makes it an offence for any person, with intent, to destroy the life of a child, capable of being born alive, by any wilful act which causes the child to die before it has an existence independent of its mother. The aim of the Act was to protect the fetus in the course of delivery.

Moreover, the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, prevents lawful abortion of a fetus after twenty-four weeks of pregnancy, unless it is determined necessary to protect the life or health of the mother.

Clearly the criminal law protects the unborn child against acts which may cause it to suffer harm. The civil law, by means of the Congenital Disabilities Act 1976, also protects the unborn child against harm caused by negligent actions to the father or mother which resulted in the child being born disabled. This right only comes into existence if the child is born alive and survives for at least forty-eight hours. The courts have been reluctant to recognise the unborn child as having the rights of a person.

Historically, the English legal system has treated the fetus as being an integral part of the woman carrying it and, therefore, have afforded it no rights as an entity separate from her. In fact it is an established principle in English common law that a fetus has no legal rights until it is born and has a separate existence from its mother. This stance reiterated that made by the Supreme Court of America in 1973, which stated "that the unborn have never

98 Section 58.
99 This excludes an abortion legally carried out under the Abortion Act 1967.
101 Section 37.
been recognised as persons in the whole sense.”

However, modern legal developments have promoted granting the fetus increased legal status and protection as it develops towards viability and eventual birth. In fact a State in America actually has legislation which provides that “the life of a human being starts at conception”.

The important issue of viability of the fetus and whether or not it is entitled to legal protection was acknowledged by the European Commission when it recognised the fact that it is at the point of viability that the State has a legitimate right to protect a potential human life. In *Paton v UK* it was stated that “with respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability.”

For example, practising Jehovah’s Witnesses are strongly opposed to both surgical abortion and blood transfusions. Therefore, if a mother were to need blood before the fetus was viable, she would be more likely to risk her own life and allow the fetus to abort naturally. However, once the fetus becomes viable, her wishes to abide by the tenets of her faith in refusing a transfusion would probably be set aside by the State in the interests of preserving the life of her unborn child. As the Jehovah’s sect was first established in America and their membership is significantly greater in America than in England, most of the cases highlighted are American.

**American Case Law**

In *Raleigh Fitkin-Paul Morgan Hospital v Anderson*, the first case of its kind, the plaintiff hospital sought authority from the Chancery Division of the Supreme Court to administer a blood transfusion to Mrs. Anderson against her wishes. She was thirty-two weeks pregnant and a practising Jehovah’s Witness. The doctors felt that the need for a blood transfusion was likely to arise during the pregnancy. They believed that, if this treatment were to be refused, both Mrs. Anderson and her unborn child would die. The trial judge felt the judiciary could not intervene, but the superior court decided that it could grant the order that the blood transfusion could be given

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107 (1964) 201 A.2d 537.
if necessary, declaring that an unborn child was entitled to the law’s protection.

Although the court identified that the issue of compelling an adult to undergo treatment for the sake of an infant was a difficult one, they overcame the issue of the mother’s constitutional right to privacy and freedom of religion in favour of the child, by stating that it did not require consideration because the lives and welfare of the mother and baby “were so linked and intertwined that it would be impracticable to try and distinguish between them.”

Even though the court considered Mrs. Anderson’s profound religious beliefs, they were seemingly unconcerned that they were denying her her rights in favour of the fetus. Clearly the rights of the unborn child were of paramount importance.

Some fifteen years later this view was again expressed in *Jefferson v Griffin Spalding County Hospital Authority*, where the court considered the issue whether the unborn child had any legal rights to the protection of the court. The court, as in *Raleigh Fitkin-Paul*, considered the matter that, although the infant was capable of independent life, it was at the time inseparable from its mother. The court decided to grant an order authorising the hospital to carry out treatment. The judgement revealed the balancing exercise the court had to undertake between the rights of the mother to refuse surgery against the right of her unborn child to live. Again the court felt that the child’s right took precedence.

This case and *Raleigh Fitkin-Paul* gave a clear indication that the American courts were prepared to restrict the right of self-determination of a pregnant woman when it imposed a threat to her unborn child and its right to life. Although the court recognised it was an intrusion on the woman by the state, such an intrusion was a valid one.

In another American case *Scrieber* highlighted what the courts had identified as being the State’s interests, namely, the preservation of life, the prevention of suicide, the preservation of the ethical integrity of the medical profession and the protection of dependent third parties. The

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108 Ibid. p.538.


110 (1981) 274 SE 2d 457 (Supreme Ct of Georgia).


112 *Satz v Perlmutter* 362 So. 2d 160 (Fla. Dist Ct. App. 1878).
protection of dependent third parties restates the principle that the state has a duty to protect any unborn child and any other child the patient may have. The crucial question is the weight to be placed on the relevant state interest. The protection of dependent third parties is very problematic and yet very relevant to the issue of court-ordered caesarean sections. It is the one that the judges have used to justify their decisions in order to protect the fetus.

Clearly there are a number of precedents where the State’s interest (otherwise known as society’s interest) in protecting innocent third parties has prevailed over the interests of the mother. The most significant case was *Re AC*, where a caesarean section was ordered on a woman who was moribund and suffering from terminal cancer in order to save the twenty-six-week-old fetus. The unfortunate result was that operation failed to save the child who only lived for two and a half hours and led to a rapid deterioration in the mother’s condition, resulting in her subsequent death.

However, this case was to prove a turning point in America for the rights of the fetus. The Court of Appeal reversed the original decision stating that the pregnant woman’s right to refuse treatment will be conclusive and would outweigh any interests of the unborn child. This decision rejected the argument of the state’s interest in protecting the lives of third parties. However, the court did leave open the possibility that, for “truly extraordinary or compelling reasons,” the parent’s right must give way.

In the *State of Illinios v Bricci*, the last of the American cases to be considered here, the court dismissed the State’s application for an injunction to compel Mrs. Bricci to undergo a caesarean section, despite medical evidence that the fetus had a “close to zero” chance of surviving a vaginal delivery and a substantial chance of brain damage if it did survive such a delivery. The court held that the State had “failed to demonstrate that there is statutory or case-law support justifying the intrusive procedure requested”. Mrs. Bricci subsequently gave birth to an apparently healthy baby boy by normal vaginal delivery.

**English Case Law**

Up until 1992 some cases of this sort had occurred in England and there

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113 See also *Mcmillan v State* 258 Md. 147, 152.

114 533 A 2d 611 (DC,1987).

115 Filed in the Supreme Court of Illinios on 15th December 1993 Reference No 76560.
was little evidence to suggest that the courts would follow the approach taken by the American courts, which was to regard the viable fetus as a person, to be granted “personhood” status. In *Re S (Adult; Refusal of Treatment)*\(^{116}\) the President of the Family Division granted a court order for a caesarean section to be performed on Mrs. S despite her refusal on religious grounds to give her consent. The judge was influenced by the possible exception identified by Lord Donaldson in *Re T*,\(^{117}\) in which the Court of Appeal acknowledged that a patient suffering from no mental incapacity has an absolute right to choose whether or not to consent or refuse consent to treatment. This was, however, qualified in terms of the relative rights of a pregnant woman and her fetus. The Master of the Rolls, Lord Donaldson, stated that “the only possible qualification is a case in which the choice may lead to the death of a viable fetus.”

The court in *Re S* noted that the ‘fundamental question’ was whether the right of the mentally competent adult to refuse treatment might not apply where that refusal could lead to the death of a viable fetus. Having decided that this might be the case, Sir Simon Brown, President of the Family Division, referred to and followed the American precedent\(^{118}\) that suggested the order should be granted.

Insofar as the decision was taken to protect the interests of the fetus, it was in complete conflict with the Court of Appeal decision in *Re F*,\(^{119}\) in which the court, relying heavily on *Paton*,\(^{120}\) concluded that the fetus had no individual personality and that, therefore, could not be made a ward of court. But, of course, as already mentioned, the Court of Appeal, in 1998, in *St. George’s Healthcare NHS Trust v S*, held that a pregnant woman of sound mind has the right to refuse medical treatment, regardless of any moral repugnancy surrounding her decision; the Court also approved the decision of the Canadian Supreme Court in *Winnipeg* that, *inter alia*, it was undesirable to create fetal rights that would conflict with maternal rights.

**Protecting the rights of the fetus by wardship.**

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\(^{117}\) [1993] Fam Law 95, 102.

\(^{118}\) *Re AC* (1990) 573 A 20 1253.


Attempts have been made to use the wardship jurisdiction to protect the unborn child from harm by limiting the mother’s behaviour.\textsuperscript{121} This could involve her being ordered to stop smoking or inhibiting her alcohol intake. In fact it would be possible to limit any activity that would be hazardous to the fetus. In \textit{D v Berkshire C.C.},\textsuperscript{122} a case which concerned a baby born with drug withdrawal symptoms as a direct result of the mother’s dependency on drugs, the House of Lords ruled that the social services were in fact entitled to take the child into care at birth, because of the mother’s neglect during the pregnancy. The court was clearly willing to consider the ante-natal behaviour of the mother and stated that in certain circumstances, the law might properly concern itself with the appropriate treatment of unborn children.\textsuperscript{123}

Yet in \textit{Re F},\textsuperscript{124} the use of wardship in order to protect the fetus was firmly rejected, as it was in the later unreported case, \textit{Re P}.\textsuperscript{125} In \textit{Re F} the local authority were seeking to make the fetus a ward of court in order to protect it from its mother who was leading a nomadic existence and who went missing when the child was due. The court refused to extend the law so as to “impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child.”\textsuperscript{126} A similar approach was taken by the High Court of New Zealand in which the court had to deal with an application “for authorising a blood transfusion or other medical treatment to a child as yet unborn but expected to be born almost immediately.”\textsuperscript{127} The order was made authorising the carrying out of the medical treatment to the child if born alive. The judge, as in \textit{Re F}, expressed “considerable doubt as to whether or not there was jurisdiction to place an unborn child under the guardianship of the court.”

However, a significantly different view was taken in the American case of \textit{Jefferson v Griffin Spalding County Hospital},\textsuperscript{128} where the court held that,

\begin{itemize}
  \item \textsuperscript{121} See, e.g., N. V. Lowe, “Can You Ward a Fetus”, \textit{(1987) L.Q.R.}, vol. 96, p. 772.
  \item \textsuperscript{122} [1987] 1 All E.R. 20.
  \item \textsuperscript{123} See, e.g., J. E.S. Fortin, “Legal Protection of the Unborn Child”, \textit{(1988) MLR}, vol. 51, pp.54-83.
  \item \textsuperscript{124} [1988] 2 All E.R. 193
  \item \textsuperscript{125} Unreported: a decision of Ewbank. J., 28\textsuperscript{th} March 1988. In which based his decision on that of \textit{Re F}, which had established that “as a matter of principle there is no jurisdiction at the present time in the High Court to make an unborn child a ward of court.”
  \item \textsuperscript{126} See judgement of Balcombe LJ in \textit{Re F} [1988] 2 All E.R. 193, at 200-201.
  \item \textsuperscript{127} \textit{Director General of Social Welfare v Ulutau} (1988) NZFLR 631.
  \item \textsuperscript{128} (1987) 247 Ga 86, 274 SE 2d 457.
\end{itemize}
a fetus of thirty-nine weeks was a viable human being and, as a matter of law, was entitled to the protection of the Juvenile Code of Georgia. The Supreme Court ordered temporary custody of the unborn child to the State of Georgia Human Resources and County Department of the Family and Children Services, which were granted full authority to act on behalf of the fetus until such point as the fetus was separated from its mother.

There have been other attempts made to protect the fetus. For example, in C v S\textsuperscript{129} a father sought to prevent his girlfriend and the local authority from terminating a pregnancy of 18-21 weeks. The court held that he did not have any legal standing to prevent the abortion, either as the father or as the next friend of the child. The unborn child also had no \textit{locus standi} to prevent the abortion. Helilbron J said that the child’s legal right to be a party to an action “crystallises upon the birth, at which date, and not before, the child attains the status of a legal person... and can then exercise a legal right.”\textsuperscript{130}

The traditional view is that the fetus is not considered to have any status or rights as a separate legal entity until it has been born. Yet, in some of the early American cases, the courts were prepared to posit a so called State’s interest in protecting potential but viable fetuses. Concerns to save the life of a fetus have lead the courts to consider other things such as wardship. Those concerns have also led the family law courts to misinterpret the law, and on occasion manipulate it by way of the Mental Health Act 1983, in favour of the fetus. However, the fact remains that the fetus is not an independent person with legal rights; therefore, no action can be brought on its behalf until it is born. Moreover, the courts have recently confirmed that a pregnant woman has an absolute right to refuse treatment, even when this may compromise the life of a viable fetus.

\textbf{Conclusion}

This paper has identified the dilemma, both medico-legal and ethical, concerning the pregnant woman and considered whether or not her refusal of medical treatment may be judicially overridden either in her interests or those of the fetus. It has also looked at the history and development of the caesarean section and focused on a range of different scenarios, where the accepted principle that competent adults have the absolute right of self determination (to decide what is done to their body) has first been restricted,

\textsuperscript{129} (1988) QB 135.

\textsuperscript{130} \textit{Ibid.}, p.140.
and later affirmed, by the common law.

In both America and England the courts earlier on tended to authorise many intrusive surgical procedures on non-consenting pregnant women, ranging from blood transfusion to the more invasive operation of caesarean section. However, later on, in America Re AC emphasised patients’ autonomy and self-determination. The English judiciary followed suit when the Court of Appeal in St. George’s Healthcare NHS Trust v S reversed the decision of the High Court in Re S on the issue of court-ordered caesarean section.

Judges make new law whenever a case comes before them. Occasionally they will make radical changes to the law by the conclusions and decisions they make in each individual case. One interesting area is the court-ordered caesarean section, where a number of high court judges established a new medico-legal concept, the notion of temporary insanity caused by pain and stress of labour. Judges have manipulated the law to enable them to decide that women in labour are not mentally competent to make decisions. Decisions have also been made in the face of extreme urgency, with little or no time to examine the complexities of the case. The majority of such applications were made ex parte, in an emergency under strict time constraints, with the court being presented with a one-sided argument. Academics131 and courts132 have expressed their concerns as to whether judges “can in the absence of genuine notice, adequate representation, explicit standards of proof and right of appeal, realistically frame principled and useful responses to the dilemma” with which they were faced.

The Court of Appeal133 has strongly criticised such action and reaffirmed some elementary points about declaratory relief, stating that declarations could not be made on an interim basis, but only after investigation of the evidence put forward by both sides, that ex parte applications did not protect medical and midwifery personnel from trespass claims, and that the declaration did nothing to protect the maternity hospital.

The court also went on to restate the common law principle of autonomy outlined in the Bland case, and noted that the fetus was human but not a separate person. The court also acknowledged that “pregnancy

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133 St. Georges Healthcare NHS Trust.
increased the personal responsibilities of a woman” but that it did not diminish her right to decide whether or not to undergo treatment.

This ruling, although adding clarity to the situation, has arguably done little to ease the anxieties of doctors and midwives caring for these women, many of those doctors and midwives feeling that the fetus should be treated in law as a person and protected, and that it is morally wrong that a mother should be able to decline treatment that would assist the fetus.

Both the RCOG and the United Kingdom Clinical Council (now Nursing and Midwifery Council), the governing bodies of obstetricians and midwives, respectively, have laid down guidelines to assist the professionals in the care of such women. The courts, too, have issued guidelines to assist both the medical and legal professions.

Also, the number of caesarean sections performed has been rising steadily over the years. Unsurprisingly, the United Kingdom Government has quite recently announced its intention to allow the section to be performed, no more on demand by patients but rather, only on medical grounds.

The moral pressure to act to save or protect life is great, and the anxieties caused by doing so cannot be underestimated. Is it not time, as many have argued, for Parliament to step in and put an end to the maternal rights-fetal rights debate?

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