

Samantha Burton and the Rights of Pregnant Women Twenty Years after *In re A.C.*

BY HOWARD MINKOFF AND
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In 1987, a young woman named Angela Carder, pregnant and dying from cancer, was ordered by a court of law to undergo a cesarean delivery against her and her family's wishes. She and her baby both died. Three years later, an appeals court took an extraordinary stand: it vacated the order that ended their lives and upheld pregnant women's rights to informed consent and bodily integrity. The "unkindest cut of all,"¹ it seemed, had been condemned by the courts.² Yet shortly before the twenty-year anniversary of this landmark case, the same rights were stripped from another young pregnant woman.

In January of this year, oral arguments were heard in the case of Samantha Burton. She had been twenty-five weeks pregnant in March 2009 when she developed signs of a potential premature birth. She was also a smoker. Her doctor ordered her to quit smoking immediately and to enter a hospital for bed rest. Burton wanted a second opinion and declined to be admitted to the hospital; she had two jobs and two young children at home,

making bed rest problematic at best. Her doctor then contacted the state.

According to the *New York Times*, Ms. Burton was "ordered to stay in bed at Tallahassee Memorial Hospital and to undergo 'any and all medical treatments' her doctor, acting in the interests of the fetus, decided were necessary. Burton asked to switch hospitals and the request was denied by the court, which said 'such a change is not in the child's best interest at this time.' After three days of hospitalization, she had to undergo an emergency C-section and the fetus was found dead."³

Taken together, these cases indicate a worrisome lack of progress with respect to the personhood and rights of women when pregnant. Remarkably, the Burton case came to court almost exactly twenty years after the rendering of an appellate decision in the Carder case, thought by many to have established a clear precedent for protecting the rights of pregnant women in this situation. In the Carder case, decided on April 26, 1990, an appellate court in Washington, D.C., overturned a lower court ruling that had permitted the hospital to supersede Carder's refusal of cesarean section.⁴ Though a victory for her family, the decision came too late for the patient.

Angela Carder, twenty-seven years old when she gave birth, was in the second year of remission from bone cancer when she conceived. Midway through her pregnancy, though, the cancer recurred in her lung. All sides in the Carder case agree that Angela's stated desire was to do everything to prolong her own survival but not to accept interventions for fetal indications before the fetus reached twenty-eight weeks of gestation. Unfortunately, between twenty-five and twenty-six weeks gestation, her condition deteriorated and she became critically ill. The fetus's condition also appeared worse, and its demise seemed imminent. The family was asked if they wanted a cesarean section performed for the sake of the fetus, even though this intervention might further shorten Angela's life and would certainly add to her discomfort in her final days. In accordance with Angela's wishes, the family decided against surgery, and her obstetrician acceded to the family's request. A hospital attorney, however, felt that fetal interests needed stronger consideration, despite the fact that the fetus was at twenty-six weeks gestation

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in an era when survival at that age (let alone intact survival) was uncommon even when the mother was well. In the end, the judge ordered that the cesarean section go forward. The operation was performed, followed in short order by the infant's death and that of its mother.

What happened to Angela Carder was not unheard of at that time. In fact, an article published two years earlier had detailed many cases of "forced" cesarean sections, as well as a pervasive belief among obstetricians that such procedures were justified.⁵ It also revealed a worrisome profile of the women whose right to consent had been abrogated by court orders: they tended to be poor minority women who often didn't speak English. While Angela didn't fit that profile, her ability to advocate for herself was also significantly constrained, albeit for a different set of reasons: because of her illness, she was unable to testify at the hastily assembled hearing to determine her fate.

Ultimately, Carder's family sued the hospital, and the appellate court's ruling in 1990 represented the final word on the case. The language of the court was unambiguous. It held that, "in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus."⁶ In context, this holding left open only a theoretical possibility for an exception, making clear that neither fetal viability, nor a pregnant woman's terminal condition, nor the "relatively minor" nature of an intrusion could justify an exception to the requirement for informed consent.

In re A.C. is now widely cited, and obstetricians have adopted informed refusal and respect for autonomy as core ethical principles. Nevertheless, the last twenty years have witnessed an erosion of pregnant women's rights.⁷ Samantha Burton's case gives testament to a dangerous slide. To some degree, this diminishment can be blamed on two things: first, the unending abortion wars, and second, the view that the relationship between a woman and fetus is paradigmatically adversarial, with the latter requiring protection from the former.

Indeed, many who oppose *In re A.C.* claim that the value and "humanity" of a fetus must be championed regardless of costs to pregnant women, even in the context of a desired pregnancy. And the opposition has continued, despite the fact that all high courts (with the notable exception of South Carolina) have rejected efforts to restrict maternal autonomy or to prosecute pregnant women for fetal harm.⁸ In Burton's

case, the hospital argued that it had a duty to protect the fetus under Florida's child welfare statutes.⁹

In August of this year, Florida's 1st District Court of Appeals disagreed.¹⁰ It reversed the decision of the lower court, indicating that the court was wrong to force Samantha Burton to submit to medical interventions against her will. While one could take this eventual affirmation of a woman's rights while pregnant as reassuring, the Burton case is an example of how, even with legal precedent consistently on their side, pregnant women have nevertheless had their right to refuse surgery,¹¹ their right to be treated like other citizens when prosecuted for drug possession,¹² their right to the information and voluntariness needed for informed consent,¹³ and

even their right to die¹⁴ challenged. Through all of this, pregnant women and those women who might become pregnant have become, under law, a lesser—yet not protected—class of citizen, with the elevation of fetal rights seemingly pursued solely though the diminution of the mother's. In the Burton case, the American Civil Liberties Union noted: "To ignore this fundamental constitutional distinction between the state interest in protecting fetal life and its interest in the protecting the lives and health of people is to risk virtually unfettered intrusion into the lives of pregnant women."¹⁵

The reduced political and clinical fortunes of pregnant women contrast oddly with progress made over the last decades by other marginalized groups. In part because of fear of being associated with a "gay disease," the president of the United States did not address the burgeoning AIDS epidemic until the late 1980s, when twenty thousand people had already died. However, by 2009 the country had committed billions of dollars through the U.S. President's Emergency Plan for AIDS Relief to combat the disease. In the 1980s, the "Bradley effect" was being postulated as a cause of discrepancies between voter opinion polls and election outcomes in a series of races between white and nonwhite candidates. Today, the United States has an African American president. There is much to do, but the last twenty years have mostly been marked by forward movement. Yet twenty years after *In re A.C.*, constraints on the rights of potential mothers for the sake of fetuses often are more pronounced than those on actual parents for the sake of born children. While court orders are still sought to compel cesarean sections—or to punish women who refuse them—the courts have consistently and unambiguously upheld the common law principle that Samaritan acts cannot be similarly compelled. For example, a

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relative cannot be ordered to donate a kidney to save a living child. This has been tested in case law: in 1978, an individual's request for a court-ordered lifesaving marrow transplant from a recalcitrant relative was refused.¹⁶ If, as Martin Luther King noted, "the arc of moral history is long but it bends toward justice," the politics of abortion seem to have caused that trajectory to shift, to the detriment of pregnant women.

Among the most sacred and vehemently defended decisions of a person's life are those around its edges—how we give birth and how we die. Indeed, the public response to health care reform, particularly around end-of-life decision-making, reflects just how dear such decisions are. Yet twenty years after both were stripped from a young pregnant woman, the lessons of her tragedy are continually challenged in delivery rooms and courtrooms. Samantha Burton, in contrast to Angela Carder, was alive to fight back and fortunately won. Her case, however, presses obstetricians to demonstrate their role as advocates for pregnant women. As a society, we need to realize that fetal ends cannot be achieved through the devaluation of mothers. One columnist has advised pregnant women, "Ask your obstetrician directly: Is there any circumstance under which you will refuse to let me make my own medical decisions or will prevent me from leaving the hospital?" then commented, "That is a question no woman should ever have to ask her doctor."¹⁷ We couldn't agree more.

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2. G. Annas, "Foreclosing the Use of Force: A.C. Reversed," *Hastings Center Report* 20, no. 4 (1990): 27-29.

3. L. Belkin, "Is Refusing Bed Rest a Crime?" *New York Times*, January 12, 2010.

4. *In re A.C.*, 573 A.2d. 1235 (D.C. 1990).

5. V.E. Kolder, J. Gallagher, and M.T. Parsons, "Court-Ordered Obstetrical Interventions," *New England Journal of Medicine* 316 (1987): 1192-96.

6. *In re A.C.*

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9. D. Kasdan, "The Best Interests of the Fetus; Court Forces Bed Rest on Pregnant Woman," *Salon*, January 14, 2010.

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12. *Whitner v. South Carolina*, 382 S.C. 1, 492 S.E.2d 777 (1997), *cert. denied*, 523 U.S. 1145 (1998).

13. Z. Lazzarini, "South Dakota's Abortion Script—Threatening the Physician-Patient Relationship," *New England Journal of Medicine* 359 (2008): 2189-91.

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15. R.C. Marshall and C. Kasdan, "Brief of *Amici Curiae*, American Civil Liberties Union, American Civil Liberties Union of Florida and American Medical Women's Association in Support of Appellant in *Samantha Burton v. State of Florida*," A.1d09-1958, http://www.aclu.org/files/pdfs/reproductiverights/burton_v_florida_acluamicus.pdf.

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17. J.M. Appel, "Medical Kidnapping: Rogue Obstetricians vs. Pregnant Women," *Huffington Post*, January 24, 2010.

Baxter and the Return of Physician-Assisted Suicide

BY JOHN ROBINSON

The term "physician-assisted suicide" usefully identifies a practice that is, and should be, a source of considerable controversy these days. Typically, the practice in question involves two crucial actors: a doctor and a terminally ill patient whose death is likely to occur within a short time. Knowing the condition of the patient and responding to the patient's request, the doctor prescribes a drug that should cause the patient's death shortly after it is taken. That's the "physician-assisted" half of the practice. The "suicide" occurs, if it ever does, shortly after the patient ingests the drug.

Physician-assisted suicide is legal in Oregon and Washington. Until very recently, it has been illegal in every other state, and claims to its being a federal constitutional right were rejected by the United States Supreme Court a dozen years ago in the *Glucksberg* and *Quill* decisions.¹ But a recent development in Montana has altered the landscape somewhat. On December 31 of last year, the Montana Supreme Court decided *Baxter v. Montana*, a case that most observers thought would clarify the status of physician-assisted suicide under Montana's constitution.² The court, it turns out, decided not to do that—not now, at least. It decided instead whether a physician who participates in a physician-assisted suicide in Montana—and does so in accordance with the rules that have been developed for this practice in Oregon and Washington—could lawfully be convicted of violating Montana's homicide statute after the patient died from taking the medicine that the physician prescribed.

The court concluded that the physician could not be convicted of violating the homicide statute because the physician

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