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Law

Legal Briefing: Unwanted Cesareans and Obstetric Violence

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ABSTRACT

A capacitated pregnant woman has a nearly unqualified right to refuse a cesarean section. Her right to say "no" takes precedence over clinicians' preferences and even over clinicians' concerns about fetal health. Leading medical societies, human rights organizations, and appellate courts have all endorsed this principle. Nevertheless, clinicians continue to limit reproductive liberty by forcing and coercing women to have unwanted cesareans. This "Legal Briefing" reviews recent court cases involving this type of obstetric violence. I have organized these court cases into the following six categories:

1. Epidemic of Unwanted Cesareans
2. Court-Ordered Cesareans
3. Physician-Coerced Cesareans
4. Physician-Ordered Cesareans
5. Cesareans for Incapacitated Patients
6. Cesareans for Patients in a Vegetative State or Who Are Brain Dead

INTRODUCTION

This article focuses on forced cesareans, those performed without consent and usually over the objections of the pregnant patient. There are five ways that clinicians can perform a cesarean without a patient's voluntary consent. First, a clinician can seek a court order authorizing the procedure and compelling a patient's compliance. Second, a clinician can coerce a patient to consent and then perform the procedure pursuant to that (coerced) consent. Third, a clinician can just perform the procedure over a patient's objections with warrant from neither the court nor the patient.[1] Fourth, a clinician can perform a cesarean on an incapacitated patient with authorization from a surrogate or court. Fifth, a clinician can perform a cesarean on a brain-dead or vegetative patient when required by law.

1. EPIDEMIC OF UNWANTED CESAREANS

Four million babies are born in the United States each year.[2] Two-thirds of these babies are delivered by natural childbirth through the vaginal canal. The remaining one-third are delivered by cesarean section.[3] In this procedure, the physician opens the patient's abdomen and slices through muscle, tissue, and the uterine wall to remove the baby.[4]

Some cesareans are necessary for the health of the mother or baby. But the 32 percent rate is generally considered to be substantially higher than is medical necessary or optimal.[5] Expert guidance indicates that a more appropriate rate would be 19 percent.[6] If that figure is correct, then 13 percent of cesareans in the U.S. (or about 200,000 annually) are not medically necessary. Overuse is further suggested by the enormous variability in cesarean rates, from state to state, and even from hospital to hospital in the same city.[7] Indeed, cesareans are often mo-

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tivated by nonmedical concerns such as the convenience of clinicians[8] and legal concerns based in defensive medicine.[9]

Admittedly, these are broad, population-level measures. It is beyond the scope of this article to identify or assess the appropriate specific clinical circumstances under which clinicians should offer or perform a cesarean. Instead, the focus of this article is on the autonomy of patients, consent, and legal rights. Even when a cesarean is medically indicated, that is only a necessary condition, not a sufficient condition, to justify performing the procedure. In addition, a physician must ensure that the woman wants the procedure. In short, a cesarean must be indicated medically and by the patient's preference.[10]

A cesarean is major abdominal surgery that presents risks such as postoperative infection, surgical injury, and potential limitations on the ability to have future children with a vaginal birth.[11] But the probability and severity of the risks are almost entirely irrelevant to legal and ethical analysis. It is both unethical and illegal to perform an unwanted cesarean, even when the procedure poses no physical risks. Even when successful and beneficial, unwanted surgery remains a battery, a tortious wrong, and a compensable legal injury.[12] As the American Congress of Obstetricians and Gynecologists (ACOG) advises: "respect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk,"[13] and "A decisionally capable pregnant woman's decision to refuse medical or surgical interventions should be respected."[14]

The unwanted cesarean was discussed in the very first issue of this journal in 1990.[15] Over the past 27 years, a substantial ethical and legal consensus has solidified: clinicians should not perform a cesarean without the patient's consent. For example, ACOG maintains that the physician "must respect the patient's autonomy . . . and not intervene against the patient's wishes, regardless of the consequences."[16] Moreover, this is not only a patients' rights issue, but also a public health problem. If women cannot trust their clinician, they may be deterred from seeking medical attention.[17] As the American Medical Association (AMA) observed, "while the health of a few infants may be preserved by overriding pregnant women's decisions, the health of a great many more may be sacrificed."[18] But overriding pregnant women's decisions still happens all the time.[19] Furthermore, while the topic is outside the scope of this article, many of the consented cesareans performed are probably materially underinformed.[20]

This article focuses on forced cesareans, those performed without consent and usually over the objections of the pregnant patient. But it is useful to appreciate the broader context. An unwanted cesarean is just one type of "obstetric violence."[21] One lawyer describes obstetric violence as only the "most egregious indication in a larger underlying pattern of disrespect and abuse" against pregnant and birthing mothers.[22] Other forms of obstetric violence include: (1) physical violence, (2) disrespect, (3) lack of confidentiality, (4) nonconsensual episiotomy, and (5) failures of informed consent.[23] This concept of "obstetric violence" is now defined and prohibited by law in some jurisdictions.[24]

2. COURT-ORDERED CESAREANS

Performing a nonconsensual but court-ordered cesarean poses the lowest legal risk to the clinician.[25] If the court issues an order authorizing or compelling a cesarean, then the clinician has *ex ante* (before the event) permission to proceed. This used to be standard practice. During the 1980s, courts across the U.S. routinely granted orders authorizing cesareans and other interventions over the objections of pregnant women.[26] One report found that courts granted 86 percent of clinicians' petitions.[27] But while this legal logic of court-ordered cesareans remains solid, courts have become increasingly less willing to grant such orders. As illustrated by the cases discussed below, since 1990, the clear trend has been against issuing such orders. Indeed, every fully briefed appellate case has held that clinicians may not override a woman's right to refuse. Clinicians may not proceed without consent, even when they have serious concerns for the fetus.

This same position is supported not only by appellate courts, but also by leading relevant medical societies[28] and human rights organizations.[29] For example, ACOG "opposes the use of coerced medical interventions for pregnant women, including the use of the courts to mandate medical interventions for unwilling patients."[30] Furthermore, ACOG "strongly discourages medical institutions from pursuing court-ordered interventions or taking action against obstetrician-gynecologists who refuse to perform them."[31] The AMA similarly maintains that "judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus."[32]

In re A.C. (D.C. 1990)

Perhaps the most famous of the court-ordered cesarean cases is the 1990 District of Columbia Court

of Appeals decision, *In re A.C.* The case stands as a key development in U.S. jurisprudence, establishing the rights of informed consent and bodily integrity for pregnant women. It has been described as a "landmark"[33] and "seminal"[34] case.

In June 1987, Angela Carder was pregnant when a childhood cancer recurred.[35] Clinicians at George Washington University Hospital (GWUH) soon diagnosed her as terminally ill. To save the life of Carder's fetus, GWUH clinicians wanted to perform a cesarean section. When they were unable to obtain Carder's consent, GWUH sought an order from the D.C. Superior Court. Heavily influenced by "important and legitimate interests in the potentiality of human life," the court issued the order. That same evening, a three-judge panel of the D.C. Court of Appeals affirmed the order.[36] Clinicians then performed the cesarean, but both Carder and the fetus died.

After the surgery, Carder's family and the ACLU (American Civil Liberties Union) asked the D.C. Court of Appeals to vacate the order. While Carder's case was already moot, the plaintiffs wanted to eliminate the 1987 case as binding or persuasive precedent. They argued that the order violated both Carder's right to informed consent and her constitutional rights of privacy and bodily integrity. Rather than just a panel of three judges, the judges of the D.C. Court of Appeals heard the case *en banc* (all eight judges), and vacated the trial court order.

The appeals court held that the trial judge had failed to balance appropriately the rights of Carder not to consent to the procedure against the interests of the state. The D.C. Court of Appeals held that a "fetus cannot have rights in this respect superior to those of a person who has already been born."[37] Therefore, 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." It must be a truly "extraordinary case" to justify overriding the patient's wishes.

***Stoners v. George Washington* University Hospital (D.C. 1990)**

At the same time that the ACLU and Carder's parents brought the *en banc* D.C. Court of Appeals case, they also filed a lawsuit against GWUH in D.C. Superior Court, claiming: (1) deprivation of human rights, (2) discrimination, (3) wrongful death, and (4) malpractice.[38] In November 1990, days before the scheduled trial was to begin, the hospital settled out of court for an undisclosed amount of money and a promise of new hospital policies protecting the rights of pregnant women.[39] The new policy provides that it is "almost never" appropriate to go to court to override a patient's refusal.

***In Re Baby Boy Doe* (Ill. App. 1994)**

The decision in *In re A.C.* has been followed by every other appellate court to consider the same issue. For example, in 1993, an obstetrician/gynecologist at St. Joseph's Hospital in Chicago determined that Doe's 35-week-old fetus was receiving insufficient oxygen. He recommended immediate delivery by cesarean. Because of her personal religious beliefs, Doe refused. The hospital sought a court order. The trial court found that the chances of the child surviving natural childbirth were close to zero and that the chances of the child surviving a cesarean were close to 100 percent. Despite that dramatic risk-benefit trade-off, the court denied the petition. The Illinois Court of Appeals affirmed, holding that "a mother cannot be forced to undergo a cesarean section to benefit her viable fetus."[40]

***Pemberton v. Tallahassee Memorial Regional Center* (N.D. Fla. 1999)**

While *In re A.C.* has been followed by every appellate court, there is one outlier trial court ruling that went the other way. Laura Pemberton planned a home birth with a midwife. However, Pemberton later became dehydrated and went to the emergency department at Tallahassee Memorial Regional Center (TMRC) for intravenous infusion of fluids. At the hospital, clinicians insisted that she have a cesarean. She refused and went back home. But the TMRC clinicians did not give up. They sought and obtained a state court order to bring Pemberton back to the hospital. That order was enforced. Pemberton was taken to the hospital, where clinicians performed a cesarean against her will.[41]

Pemberton later sued TMRC in federal court. But the district court dismissed her case, finding that the state court order was valid.[42] The court held that the state's interest in preserving the life of an unborn child at or near birth outweighed Pemberton's constitutional interest in bodily integrity.[43] There was a roughly 5 percent risk that Pemberton's fetus would die during vaginal delivery due to uterine rupture. The court held that the cesarean was medically necessary to avoid this risk.

Notably, the court tried to reconcile its holding with *In re A.C.* In that case, the D.C. Court of Appeals did not grant pregnant women an absolute right to refuse a cesarean. Instead, it held only that in "virtually all cases" must clinicians adhere to the patient's desires. In other words, *In re A.C.* left open the possibility that the patient's interest in bodily in-

tegrity could yield to a more compelling countervailing interest in an "extremely rare and truly exceptional case." The *Pemberton* court then held that this was just such a case.[44]

***Burton v. Florida* (Fla. App. 2010)**

The significance of *Pemberton* is largely diminished by another Florida case, involving the same hospital, that is both more recent and issued by an appellate court. In March 2009, Samantha Burton went to Tallahassee Memorial Hospital (TMH). Clinicians there sought and obtained a court order from the Leon County Circuit Court that required Burton to undergo "any and all medical treatment" that TMH clinicians deemed necessary.[45] Pursuant to the order, TMH clinicians confined Burton and performed a cesarean.

Like the plaintiffs in *In re A.C.* and *Pemberton, Burton* challenged the trial court order after it had already been implemented.[46] And like the D.C. Court of Appeals, the Florida Court of Appeals reversed the trial court's order. It held that the trial court did not apply the appropriate test. Not only must the state establish a compelling state interest to override a pregnant patient's right to determine her course of medical treatment, but also the state must then show that the method for pursuing that compelling state interest is narrowly tailored in the least intrusive manner possible to safeguard the rights of the pregnant woman. That is such a demanding test that judges and legal scholars often describe it as "strict in theory, fatal in fact."[47] Applying these constitutional law principles to the cesarean situation, a justifiable forced intervention would have to entail: (1) extreme fetal risk, (2) very low maternal risk, and (3) minimal bodily invasion. An unwanted cesarean may sometimes satisfy the first two conditions, but will never satisfy the third.

3. PHYSICIAN-COERCED CESAREANS

Court-ordered cesareans are now less common.[48] Presumably, because courts are less likely to issue such orders, clinicians are less likely to seek them. Today, most court cases challenge clinicans who administer cesareans with coerced consent. Clinicians are reluctant to perform a cesarean over a patient's objections. So, they try to get the patient's permission. Most women consent to the clinician's recommendations. For the few who refuse, it is appropriate for the clinician to provide "directive counseling,"[49] by making strong recommendations, using persuasion, and even getting the endorsement of a second clinician.[50] As Nelson and Milliken note, "Neither the principle of patient's autonomy nor the doctrine of informed consent requires physicians to accept a patient's refusal passively and without inquiry, protest, or argument."[51]

But some physicians go beyond persuasion to employ manipulation and coercion.[52] This takes various forms, including: (1) magnifying estimates of risk, (2) exaggerating benefits, (3) demeaning the woman, (4) threatening to withhold care, and (5) asserting that the woman's decision makes her a bad parent. Many clinicians also threaten (6) to get a court order or (7) to report the woman to Child Protective Services.[53] In short, while motivated by concerns for fetal health, some clinicians use threats or deception to "convince" the patient to change her mind.[54]

Manipulation and coercion are ethically and legally illegitimate. ACOG advises: "obstetrician-gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision."[55] Legally, consent obtained through coercion or duress is invalid. But translating this right into a remedy has proven challenging.

***Goodall v. Comprehensive Woman's Health Center* (M.D. Fla. 2014)**

In July 2014, Jennifer Goodall had already had three cesareans. But she wanted to have a trial of labor and attempt delivering her fourth baby vaginally. The hospital would have none of it. Bayfront Health Port Charlotte informed Goodall that it intended to report her to Child and Family Services and to seek a court order to perform a cesarean.[56] A hand-delivered letter stated that the hospital's ethics committee had reviewed her case, and that the hospital intended to (1) "contact the Department of Children and Family Services about [Ms Goodall's] refusal to undergo a Cesarean section," (2) "begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures . . . relating to the delivery of [her] child," and (3) perform a cesarean section "with or without [Ms. Goodall's] consent" in the event that she presented to the hospital in labor.[57]

Goodall sought a temporary restraining order to prevent the hospital from carrying out these threats.[58] But the court denied her motion, explaining that Goodall had "no right to compel a physician or medical facility to perform a medical procedure in the manner she wishes against their best medical judgment." Capitulating, Goodall then de-

livered her baby by cesarean. She voluntarily dismissed the lawsuit a few days later.[59]

***Mitchell v. Brooks* (Augusta County, Va. 2015)**

In Virginia, physician Mark Brooks threatened to call a judge and Child Protective Services unless Michelle Mitchell consented to a cesarean.[60] Mitchell acquiesced, and Brooks performed the cesarean. Mitchell later sued for battery, arguing that her consent was invalid, because it was made under duress. In November 2015, a jury found in favor of Brooks.[61] Mitchell sought appellate review. But, in April 2017, the Virginia Supreme Court declined to hear the case.

***Switzer v. Rezvina* (N.J. Superior Court 2015)**

Like Goodall and Mitchell, Lindsay Switzer also signed a cesarean consent form. But her consent was not free and voluntary. Physician Natalia Rezvina misrepresented the risks. Rezvina threatened to call the "legal people," including a magistrate, to compel the surgery. Rezvina even alluded to a possible removal of Switzer's older child by Child Welfare Services. Faced with all these threats and misrepresentations, Switzer finally signed the consent form. In 2014, Switzer, herself an attorney, filed a lawsuit for battery, negligence, and intentional infliction of emotional distress. The case settled for an undisclosed sum in 2015.[62]

***Murphy v. El Paso Health System* (Tex. 2017)**

In 2004, a teenaged mother was reluctant to have a cesarean and was apparently concerned that her physician was pushing for one. Murphy, a nurse anesthetist, encouraged the patient to ask questions before signing the consent form. When the physician next spoke to the patient, Murphy was in the hallway. When the physician emerged from the patient's room, he was angry that Murphy had (he thought) tried to discourage the patient from consenting. The physician told Murphy that he told the patient if she wanted a "brain dead or dead baby" it would not be his fault, but hers. The patient apparently consented to the cesarean during that encounter.

Murphy filed a report with the hospital's ethics and compliance manager, alleging that the physician did not get the teenaged patient's informed consent. Murphy was terminated almost immediately. She then successfully sued the health system for wrongful retaliation. A jury awarded Murphy over $600,000. That verdict was upheld by the Texas Court of Appeals.[63] But in April 2017, the Texas Supreme Court ruled that only violations reported in good faith are protected. Since Murphy was not in the room when the patient consented, she could not have had a "reasonable belief" that the physician's conduct violated the law.[64] Instead, her report was based on mere conjecture and surmise. The physician's admitted use of charged language does not necessarily imply that he did not obtain the patient's informed consent. This holding may be good policy. The law should protect patient safety whistleblowers. But to avoid disruptive and unnecessary investigations, whistleblowers must base their reports on reasonable evidence.[65]

4. PHYSICIAN-ORDERED CESAREANS

Clinicians usually want some authorization to perform a cesarean. If they cannot get that authorization from a court, then they try to get it from the patient. Nevertheless, clinicians sometimes proceed to perform a cesarean with no authorization whatsoever.

***Cooper v. Lankenau Hospital* (Pa. Super. 2012)**

In 2001, while 27 weeks pregnant, Denise Cooper fell down some stairs. At the hospital, clinicians recommended a cesarean. Cooper, who was a pediatric cardiology anesthesiologist, refused to consent. Clinicians performed the cesarean anyway. Cooper sued for battery. However, she lost, because the jury apparently believed the hospital's evidence that Cooper ultimately did consent. Cooper appealed, arguing that the jury was not properly instructed. But she lost the appeal too.[66] The Pennsylvania Supreme Court held that a plaintiff in a medical battery case need not prove that the defendant surgeon performed the unauthorized operation with any intent to harm the patient. It is sufficient for the plaintiff to establish that the "touching" was intentional and not consented to. The court held that jury charge accurately conveyed those concepts.

***Dray v. Staten Island University Hospital* (N.Y. Supreme Court 2017)**

In July 2011, Rinat Dray had already had two children by cesarean. She planned her third to be a vaginal birth after cesarean (VBAC) at Staten Island University Hospital (SIUH). Yet, after several hours of labor, the physician said, "I don't think it's going to be natural. I don't have all day for you." Dray begged the physician not to perform a cesarean. However, the physician determined that the fetus was at risk and that the benefits of cesarean outweighed the risks. The physician explored obtaining a court order, but never made a formal request.[67]

Instead, he proceeded to perform the cesarean, noting in Dray's chart, "The woman has decisional capacity. I have decided to override her refusal to have a c-section."[68]

In January 2014, Dray sued for negligence, malpractice, lack of informed consent, and other causes of action. However, in orders issued in May 2015 and October 2015, the trial court denied nearly all of Dray's claims.[69] Despite what she named her claims, the court held that, at bottom, she was alleging battery. Those claims were time barred, because the New York statute of limitations for battery is only one year. Those orders are on appeal.[70] But the case is moving forward.[71] The trial court allowed a separate claim, that SIUH was negligent for not offering an ethics consult or a patient advocate. Of course, Dray must prove not only that the hospital had a legal duty to offer those services, but also that their intervention would have changed the result.

Other Unwanted Treatment Cases

While the outcomes in *Cooper* and *Dray* appear to suggest that it is difficult to successfully litigate a case of unwanted treatment, the obstacles in those cases are specific to their unique facts. Cooper's jury believed that she eventually consented. Dray filed her lawsuit after the statute of limitations. Indeed, a broader examination of just three other recent unwanted treatment cases in the birthing context shows that patients can and do succeed. While these three cases did not involve cesareans, they are similar and instructive.

In August 2016, an Alabama jury awarded Caroline Malatesta $16 million for nonconsensual procedures that clinicians administered during the birth of her baby.[72] Clinicians forcefully put Malatesta into an uncomfortable position, wrestling her onto her back and holding her baby's head inside her body for six minutes until the physician arrived. When she protested, the physician responded: "Listen, I am the expert here." The verdict consisted of $10 million compensatory damages for nerve damage and $1 million loss of consortium for Malatesta's husband. It also included $5 million for punitive damages for reckless fraudulent promotional material. Malatesta had specifically chosen that hospital because it advertised itself as a place that would accommodate mothers who wanted natural birth.

In January 2017, Kimberly Turbin settled a case that she brought against physician Alex Abbassi. In May 2013, Turbin was vaginally delivering her baby when Abbassi performed an episiotomy against her express wishes. A disturbing video of the encounter is available on YouTube.[73] Turbin filed a lawsuit for battery in April 2015.[74] Abbassi argued that this was a medical malpractice claim subject to California's shorter statute of limitations. But in June 2016, the Los Angeles Superior Court ruled that this was intentional, not negligent, conduct. Therefore, the longer statute of limitations for battery applied.[75]

Finally, in 2012, a Chicago jury awarded Catherine Skol $1.4 million.[76] In 2008, physician Scott Pierce had delivered Skol's baby in a violent and rough manner. For example, he chastised Skol for not calling first and denied her pain medication because he was angry. He allegedly told a nurse that Skol deserved the pain because she had not called ahead: "Sometimes pain is the best teacher." Notably, not only did Pierce lose the lawsuit, but he was also disciplined by the Illinois Medical Board.[77]

5. CESAREANS FOR INCAPACITATED PATIENTS

All of the above cases, with the possible exception of *In re A.C.,* involved patients with decision-making capacity. Administering treatment over the objections of a capacitated patient is illegitimate hard/strong paternalism. In contrast, overriding an incapacitated patient's refusal is often ethically and legally justified soft/weak paternalism.[78] While the incidence of court orders for capacitated patients may be decreasing, the orders appropriately continue for mentally ill or decisionally impaired patients.[79]

Several recent court cases from the United Kingdom have authorized clinicians to perform a cesarean on a patient who was incapacitated by mental illness. In 2012, Italian Alessandra Pacchieri was traveling in the U.K. while 39 weeks pregnant. Pacchieri had mental health problems, and during her visit suffered a schizophrenic episode, psychotic in nature. The Court of Protection ordered that clinicians could perform a cesarean without her consent.[80] In 2014, another U.K. court similarly ordered a cesarean for an incapacitated woman with bipolar affective disorder.[81]

In 2016, U.K. courts ordered a cesarean for at least two more mentally disabled women. In the first, the incapacitated woman was suffering from a drug-related psychosis. While she wanted to have her baby as naturally as possible, the court ruled that a caesarean section could be performed if specialists thought it necessary for the safety of mother and baby. The judge said he would not "micro-manage" the birth and was giving her doctors power to make decisions. The judge would not authorize the use of handcuffs or leg straps—as called for by her doctors in a possible care plan—but approved the use of

"chemical restraint" if her doctors thought it proportionate and necessary.[82] In the second 2016 case, the court ruled that clinicians could perform a cesarean section on a pregnant woman with learning difficulties who wanted to give birth naturally at home. Despite her contrary expressed preferences, the judge concluded that a cesarean would be in the woman's best interests.[83]

An earlier appellate U.K. court-ordered cesarean case is particularly well reasoned.[84] There, the patient consented to the cesarean, but was ruled incapacitated because of her irrational fear of needles, preventing anesthesia. The court provided 10 points of guidance on when the medical profession should seek judicial intervention. Among these points, the court noted that it is "unlikely to entertain an application . . . unless the capacity of the patient . . . is in issue."

6. CESAREANS FOR PATIENTS IN A VEGETATIVE STATE OR WHO ARE BRAIN DEAD

A final category of unwanted cesareans concerns patients who are in a persistent vegetative state or who are brain dead. Laws in many states require that clinicians continue life-sustaining or organ-sustaining treatment if a fetus can be delivered.[85] For example, in Georgia, in June 1986, Donna Piazzi was found comatose from a drug overdose in a restaurant rest room. She was soon diagnosed as brain dead. But she was 21 weeks pregnant. Piazzi's husband asked University Hospital to withdraw life-sustaining treatment. But an Augusta County, Georgia, judge ordered the hospital to continue treatment until the baby could be delivered by cesarean. Six weeks later a baby boy was delivered, and Piazzi's life support was turned off. The baby survived one day.[86]

States take four different approaches to the effect of an advance directive if a patient is pregnant. Depending on the jurisdiction, the woman's advance directive will have: (1) no effect; (2) no effect, if it is probable that the fetus will develop to live birth; (3) no effect, if the fetus is viable; and (4) no effect, unless rebutted by the patient's instructions.

Some of these limitations apply whether the woman is alive or dead. For example, in May 2017, Nevada amended its Determination of Death Act to prohibit withdrawal of organ-sustaining treatment from a person who is determined to be brain dead, if that person is pregnant and it is probable that the pregnancy will result in a live birth with continued use of life-sustaining treatment.[87]

In contrast, Texas law requires continued treatment only if the woman is still alive.[88] This was tested in a high-profile case. On 26 November 2013, 33-year-old Marlise Muñoz apparently suffered a fatal pulmonary embolism. She was found by her husband, Erick Muñoz, unconscious on their kitchen floor. She had lain there, not breathing, for some minutes. She was taken to nearby John Peter Smith Hospital, where doctors put her on a ventilator and restored a heartbeat. But doctors soon determined that Muñoz was brain dead.[89] Her husband asked that physicians stop physiological support. But the hospital staff refused. At the time, Muñoz was 14 weeks pregnant. The hospital's position was that it had no choice but to maintain her body artificially. Texas law, hospital officials said, does not permit removing organ-sustaining treatment from a woman who is pregnant. Indeed, the Texas Advance Directives Act provides that "a person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient."[90]

But the Texas law, like similar laws in other states, is almost always applied when the woman is incapacitated and terminally or irreversibly ill. It does not apply to a pregnant patient who has died. The Texas Advance Directives Act defines "life-sustaining treatment" as that which "sustains the life of a patient and without which the patient will die."[91] Because Muñoz had died, neither cardiopulmonary nor any other form of support was or could be "life-sustaining." New 2017 legislation in Texas aims to require treatment of even dead pregnant women.[92] But at the time of the Muñoz case, the plain language of the law required only that a living pregnant woman be kept alive.[93]

Erick Muñoz filed a lawsuit charging the hospital with "cruel and obscene mutilation of a deceased body."[94] The court held that the Texas Advance Directives Act did not apply to Marlise Muñoz because she was dead.[95] Two days later (exactly two months after Muñoz's hospital admission), the hospital followed the court's order and stopped physiological support.[96]

All these different types of limitations remain controversial and problematic for incapacitated pregnant patients. Lawsuits in Washington State and North Dakota have challenged similar statutes as unconstitutional, in that they impose undue burdens on the right to terminate pregnancy, deprive women of liberty without due process, and discriminate on the basis of gender, in violation of the equal protection guarantee.[97] But those cases were brought by healthy, nonpregnant women. They were not "ripe" for adjudication, because there was not yet a live

case or controversy.[98] In short, the status of these statutory limitations on the rights of incapacitated pregnant women to refuse life-sustaining treatment (through an advance directive or surrogate) remains ethically and constitutionally uncertain.

CONCLUSION

A woman's right to refuse a cesarean is clearly established in both appellate court opinions and codes of medical ethics. However, that right too often remains just theoretical. It has been difficult to translate this right into remedy.[99] Tort liability is only one tool for protecting patient safety and patient rights, but it is not working so well here. "Attorneys cannot be expected to mount cases without both clear precedent and the prospect of adequate reimbursement."[100] The precedent is very clear. But the prospect of money damages is not.[101] The cases discussed above are only the tip of a deep iceberg of other cases that exist "below the surface," never filed. To adequately protect against unwanted cesarean, we may need not only better training and institutional policies, but also new statutory legal theories.[102]

NOTES

1. I owe this conceptual organization to Deborah Fisch, with whom I had the pleasure of co-authoring an article on home birth in this journal. T.M. Pope and D. Fisch, "Legal Briefing: Home Birth and Midwifery," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 293-308; D. Fisch, "Signed Off: Unconsented-to-Cesarean Section, A Quarter Century after A.C.," *MSU Bioethics in the News,* 7 April 2016, *https://msubioethics.com/2016/04/07/unconsented-to-cesarean-sections.*

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10. T.M. Pope, "Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law," *Journal of Law, Medicine & Ethics* 45, no. 1 (2017): 12-40.

11. Saint Louis, "Cesarian Delivery," see note 4 above.

12. T.M. Pope, "Clinicians May Not Administer Life-Sustaining Treatment without Consent: Civil, Criminal, and Disciplinary Sanctions," *Journal of Health & Biomedical Law* 9, no. 2 (2013): 213-96; T.M. Pope, "Legal Briefing: New Penalties for Ignoring Advance Directives and Do-Not-Resuscitate Orders," *The Journal of Clinical Ethics* 28, no. 1 (Spring 2017): 74-81.

13. American College of Obstetricians and Gynecologists, "Practice Bulletin 115: Vaginal Birth After Previous Cesarean Delivery," *Obstetrics & Gynecology* 116, no. 2 (2010): 450-63.

14. American College of Obstetricians and Gynecologists Committee on Ethics, "Refusal of Medically Recommended Treatment During Pregnancy," Opinion No. 664, June 2016.

15. C. Obade, "Compelling Treatment of the Mother to Protect the Fetus: The Limits of Personal Privacy and Paternalism," *The Journal of Clinical Ethics* 1, no. 1 (Spring 1990): 85-8.

16. American College of Obstetricians and Gynecologists, "Maternal Decision Making, Ethics, and the Law: ACOG Committee Opinion No. 321," *Obstetrics and Gynecology* 106, no. 5 (2005): 1127-37.

17. American College of Obstetricians and Gynecologists Opinion 664, ("court-ordered and other coercive interventions may result in fear on the patient's part . . . which could discourage the pregnant patient from seeking care"), see note 14 above.

18. AMA Board of Trustees, "Legal Interventions during Pregnancy," *Journal of the American Medical Association* 264, no. 20 (1990): 2663-70; M. Goodwin, "Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront," *California Law Review* 102, no. 4 (2014): 781-875, 830-5.

19. H. Goer, "Cruelty in Maternity Wards: Fifty Years Later," *Journal of Perinatal Education* 19, no. 3 (2010): 33-42; E. Declercq et al., *Listening to Mothers II: Report of the Second National Survey of Women's Childbearing Experiences* (New York: Childbirth Connection, 2006); Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 23 December 2014), 6 (collecting statistics). Unwanted cesarean and obstetric violence cases

are monitored by a number of organizations: *http://birthmonopoly.com*; *http://vbacfacts.com*; *https://improvingbirth.org; http://birthrightsbar.org*; *http://advocatesforpregnantwomen.org*.

20. J.E. Moore, "Women's Voices in Maternity Care: The Triad of Shared Decision Making, Informed Consent, and Evidence-Based Practices," *Journal of Perinatal and Neonatal Nursing* 30, no. 3 (2016): 218-23; S. Lally and V. Lewis, "Maternity Care Patient Engagement Strategies," *Integrated Health Association Issue Brief* no. 2 (2014); C. Keirns, "Watching the Clock: A Mother's Hope for a Natural Birth in a Cesarean Culture," *Health Affairs* 34, no. 1 (2015): 178-82. ("The principles of shared decision making seem highly theoretical from the hospital bed.")

21. E. Frisch, "Obstetric Violence and Modern American Medical Jurisprudence," *Medical Malpractice Law and Strategy* 33, no. 4 (1 February 2016); C. Pearson, "Inside the Lonely Experience of Birth Trauma," Huffington Post, 7 June 2016.

22. F. Diaz-Tello, "Invisible Wounds: Obstetric Violence in the United States," *Reproductive Health Matters* 24, no. 47 (2016): 56-64.

23. The focus of this article is on unwanted cesareans performed by clinicians. But often it is the state that interferes with reproductive liberty. See Goodwin, "Fetal Protection Law," note 18 above. For example, Utah prosecutors charged Melissa Ann Rowland with murder for failing to permit a timely cesarean section that could have saved one of her two babies from death. H. Minkoff and L.M. Paltrow, "Melissa Rowland and the Rights of Pregnant Women," *Obstetrics & Gynecology* 104, no. 6 (2004): 1234-6.

24. R.P. D'Gregorio, "Obstetric Violence: A New Legal Term Introduced in Venezuela," *International Journal of Gynecology and Obstetrics* 111, no. 3 (2010): 201-2; Diaz-Tello, "Invisible Wounds," see note 22 above.

25. J.D. Cantor, "Court-Ordered Care—A Complication of Pregnancy to Avoid," *New England Journal of Medicine* 366, no. 24 (2012): 2237-40; Diaz-Tello, "Invisible Wounds," see note 22 above.

26. V.E. Kolder et al., "Court-ordered Obstetrical Interventions," *New England Journal of Medicine* 316, no. 19 (1987): 1192-6; S. Irwin and B. Jordan, "Knowledge, Practice, and Power: Court-Ordered Cesarean Sections," *Medical Anthropology Quarterly* 1, no. 3 (1987): 319-34. E.g. *Raleigh Fitkin Paul Morgan Memorial Hospital v. Anderson,* 201 A.2d 537 (N.J. 1964) (transfusion); *Application of President and Directors of Georgetown College,* 331 F.2d 1000 (D.C. Cir. 1964) (transfusion); *Jefferson v. Griffith Spalding County Hospital,* 274 S.E.2d 457 (Ga. 1981); *In re Baby Jeffries,* No. 14004 (Mich. P. Ct. 24 May1982); *In re Jamaica Hospital,* 491 N.Y.S.2d 848 (N.Y. Supreme Court Queens 1985) (transfusion); *In re Madyun Fetus,* 114 Daily Wash. L. Rep. 2233 (D.C. Superior Court 26 July 1986). Numerous cases are collected and reviewed in L.M. Paltrow and J. Flavin, "Arrests of a Forced Intervention on Pregnant Women in the United States 1973-2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics Policy and Law* 38, no. 2 (2013): 299-343; R. Roth, *Making Women Pay: The Hidden Costs of Fetal Rights* (Ithaca, N.Y.: Cornell University Press 2000). Some earlier cases denied requested orders. E.g. *Taft v. Taft,* 446 N.E.2d 395 (Mass. 1983).

27. W.J. Curran, "Court-Ordered Cesareans Receive Legal Defeat," *New England Journal of Medicine* 323, no. 7 (1990): 489-92.

28. N.A. Deshpande and C.M. Oxford, "Management of Pregnant Patients when Performing Medically Indicated Cesarean Delivery," *Reviews in Obstetrics and Gynecology* 5, no. 314 (2012): e144-e150.

29. WHO, "The Prevalence and Elimination of Disrespect and Abuse during Facility Based Childbirth," *WHO/RHR/14.23,* 2014, *http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf.* See Diaz-Tello, "Invisible Wounds," note 22 above (describing other international human rights developments); A.U. Lokugamage and S.D.C. Pathberiya, "Human rights in childbirth, narratives and restorative justice: A review," *Reproductive Health* 14 (2017): 17.

30. American College of Obstetricians and Gynecologists Committee on Ethics, "Refusal of Medically Recommended Treatment during Pregnancy," Opinion No. 664, June 2016. Notably, ACOG has maintained this position for 30 years, making similar points in other opinions, particularly opinions 55, 321, 439, and 664. ACOG, "Committee Opinions," *http://www.acog.org/Resources-And-Publications/Committee-Opinions-List.*

31. Ibid.

32. See AMA Board of Trustees, "Legal Interventions during Pregnancy," note 18 above, p. 2666.

33. L.C. Fentiman, "The New Fetal Protection: The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children," *Denver University Law Review* 84, no. 2 (2006): 537-99, 568.

34. P. Laufer-Ukelesd, "Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy," *American Journal of Law & Medicine* 37, no. 4 (2011): 567-623, 602.

35. *In re A.C.,* 573 A.2d 1235 (D.C. 1990) (en banc).

36. *In re A.C.,* 533 A.2d 611 (D.C. App. 1987).

37. Similarly, courts refuse to limit the liberty of women for the sake of living children. E.g. *In re Farrell,* 529 A.2d 404 (N.J. 1987); *Wons v. Public Health Trust of Dade County,* 500 So. 2d 679 (Fla. App. 1987); *Norwood Hospital v. Munoz,* 564 N.E.2d 1017 (Mass. 1991).

38. *Stoners v. George Washington University Hospital,* No. 88-CA-05433 (D.C. Superior Court 2 August 1988).

39. L. Greenhouse, "Hospital Sets Policy on Pregnant Patients' Rights," *New York Times,* 29 November 1990.

40. *In Re Baby Boy Doe,* 632 N.E.2d 326 (Ill. App. 1994). In another case from Illinois at about the same time, a trial court issued an order authorizing clinicians to transfuse a Jehovah's Witness to save her life and her fetus. The court of appeals reversed, holding that a capacitated pregnant woman's right to refuse medical treatment overrides the state's substantial interest in the welfare of a viable fetus. *In re Fetus Brown,* 689 N.E.2d 397 (Ill. App. 1997).

41. NAPW, "Laura Pemberton," *https://vimeo.com/4895023.*

42. *Pemberton v. Tallahassee Memorial Regional Cen-*

ter, 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

43. The court also held that *Roe v. Wade* was not applicable, because bearing an unwanted child is a greater intrusion on the mother's constitutional interests than undergoing a cesarean section to deliver a child that the mother affirmatively desires to deliver.

44. In Pennsylvania, Amber Marlowe checked out of Wilkes-Barre General Hospital when clinicians insisted on a cesarean. The hospital obtained a court order giving it permission to become guardian of the fetus and perform the cesarean if Marlowe returned to the hospital. She delivered vaginally at another facility, and the order was never enforced. D. Weiss, "Court Delivers Controversy Mom Rejects C-Sections; Gives Birth on Own Terms," *Los Angeles Times,* 16 January 2004.

45. *In re Unborn Child of Samantha Burton,* No. 2009-CA-1167, 2009 WL 8628562 (Fla. Cir. Ct. 27 March 2009).

46. *Burton v. Florida,* 49 So. 3d 263 (Fla. App. 2010).

47. *Adarand Constructors Inc. v. Adarand,* 515 U.S. 200, 237(1995).

48. See Fisch, "Signed Off," note 1 above; E.K. Duncan, "The United States Maternal Care Crisis: A Human Rights Solution," *Oregon Law Review* 93, no. 2 (2014): 403-450, 429; C.C. Obade, *Patient Care Decision Making: A Legal Guide for Providers,* § 8:21 (New York: Clark Boardman Callaghan, 2016) ("the clear trend both legal and medical is away from judicial intervention"). On the other hand, some note that physicians and health lawyers still strongly support judicial intervention. T.A. Samuels et al., "Obstetricians, Health Attorneys and Court-Ordered Cesarean Sections," *Women's Health Issues* 17, no. 2 (2007): 107-14.

49. ACOG Opinion 664, see note 14 above.

50. A. Kotaska, "Informed Consent and Refusal in Obstetrics: A Practical Guide," *Birth* (2017).

51. L.J. Nelson and N. Milliken, "Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict," *Journal of the American Medical Association* 259, no. 7 (1988): 1060-66, 1061.

52. Many facilities have an outright ban on VBAC. But this may be less offensive to a patient's autonomy if the facility is transparent about what procedures it will and will not offer.

53. R.C. Rabin, "Let Me Tell You about My Big Baby," *New York Times,* 21 January 2016)(describing women pressured, bullied, and threatened to have cesareans because of the estimated size of their baby). L. Stein, "11-Pound Baby Born to Mother Threatened by USF Obstetrician," *Tampa Bay Times,* 8 March 2013 (USF clinicians threatened to call the police if Lisa Epsteen did not report for a cesarean, but they backed down after Epsteen's lawyers intervened); Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 23 December 2014). More examples are collected at *vbacfacts.com.*

54. See Nelson and Milliken, "Compelled Medical Treatment," note 51 above.

55. ACOG Opinion 664, see note 14 above. Similar recommendations are in ACOG Opinions 55, 321, and 439. ACOG, "Committee Opinions," *http://www.acog.org/Resources-And-Publications/Committee-Opinions-List.*

56. J. Jacobson, "Florida Hospital Demands Woman Undergo Forced C-Section," Rewire, 25 July 2014, *https://rewire.news/article/2014/07/25/florida-hospital-demands-woman-undergo-forced-c-section/.*

57. *Goodall v. Comprehensive Women's Health Center Bayfront Medical Health Group,* No. 2:14-CV-399-FtM-38-CM (M.D. Fla. 25 July 2014) (Amended Complaint ¶ 19).

58. *Goodall v. Comprehensive Women's Health Center Bayfront Medical Health Group,* No. 2:14-CV-399-FtM-38-CM (M.D. Fla. 17 July 2014) (Motion for TRO).

59. *Goodall v. Comprehensive Women's Health Center Bayfront Medical Health Group,* No. 2:14-CV-399-FtM-38-CM (M.D. Fla. 7 August 2014) (Order approving voluntary dismissal).

60. *Mitchell v. Brooks,* No. CL-1300-1773-00 (Augusta County, Va. 2015).

61. "August County Jury Rules in Favor of Brooks," *News Virginian,* 6 November 2015.

62. *Switzer v. Rezvina,* No. 3697-14 (Superior Court of New Jersey, Atlantic County 2015). Court documents from the case are collected at *http://www.healthymothersmattertoo.com/.*

63. *Murphy v. El Paso Health System,* 511 S.W.3d 602 (Tex. App. 2015).

64. *Murphy v. El Paso Health System,* No. 15-0575, 2017 WL 1534054 (Tex. 28 April 2017).

65. T.M. Pope, "Mandated Reporters and Compulsory Reporting Duties," *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016): 76-83.

66. *Cooper v. Lankenau Hospital,* 51 A.3d 183 (Pa. 2012). In one case, clinicians were able to rely upon the emergency exception to the consent requirement. *Waring v. Matalon,* No. 11-10248 (Suffolk County Superior Court 27 September 2016). This case is unusual. Normally, the emergency exception will be unavailable, because the clinicians will be aware of the patient's objections.

67. Affidavit of James Ducey, *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 1 December 2014); Affidavit of James Ducey, *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 14 July 2015).

68. *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County).

69. *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 12 May 2015) (Order); *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 29 October 2015) (Order).

70. *Dray v. Staten Island University Hospital,* No. 2016-05859 (N.Y. Supreme Court Appellate Division, 2d Department 15 May 2017) (Reply Brief).

71. *Dray v. Staten Island University Hospital,* 016 NY Slip Op 93011(U) (1 December 2016) (denying motion for stay pending appeal).

72. *Malatesta v. Brookwood Medical Center* (Jefferson County, Ala. August 2016); K. Faulk, "Jury Awards Mountain Brook Couple $16 Million in Case against Brookwood

Medical Center," *Birmingham News,* 6 August 2016; "Bait and Switch Advertising Brings $16 Million Verdict," *Healthcare Risk Management,* 1 October 2016; A.N. Nathman "Another Nurse Held My Baby's Head into My Vagina to Prevent Him from Being Delivered," *Cosmopolitan,* 10 August 2016.

73. *https://www.youtube.com/watch?v=lCfXxtoAN-I.*

74. *Turbin v. Abassi,* No. BC58006 (Los Angeles Superior Court 27 April 2015).

75. *Turbin v. Abassi,* No. BC58006 (Los Angeles Superior Court 10 June 2016).

76. *Skol v. Pierce,* No. 08L-13805 (Cook County, Ill. 1 March 2012).

77. *In re Pierce,* No. 2008-00-5891 (Illinois Department of Financial and Professional Regulation 20 July 2009). Similarly, Abbassi surrendered his medical license at about the same time, apparently because of the lawsuit by Turbin.

78. T.M. Pope, "Counting the Dragon's Teeth and Claws: The Definition of Hard Paternalism," *Georgia State University Law Review* 20, no. 3 (2004): 659-722.

79. N.E. Matevosyan, "Court-Visited Obstetrics and Fertility Procedures," *Archives of Gynecology and Obstetrics* 285, no. 5 (2012): 1195-1203.

80. *In re AA,* [2012] EWCOP 4378**.**

81. *In re AA,* [2014] EWHC 132; *In re AA,* [2014] EWHC 166.

82. "Judge Orders Caesarean if Needed for Mentally Ill Mother-to-Be," *Guardian,* 10 February 2016.

83. Press Association, "Woman with Learning Disability Should Have Caesarean, Judge Rules," *Guardian,* 16 November 2016. There were also several cases involving incapacitated patients in Ireland. E.g. M. Carolan, "Mentally Ill Woman Can Be Given Caesarean, Court Rules," *Irish Times,* 13 March 2017; *Health Service Executive v. B,* 2016 IEHC 605, 2 November 2016. In a third case, an Irish hospital sought a court order, but the patient consented before the court issued a ruling. R.M. Cormaic, "Woman Agrees to Caesarean after Hospital Goes to Court," *Irish Times,* 9 March 2013.

84. *In re MB,* [1997] EWCA Civ 3093.

85. M. Esmaeilzadeh et al., "One Life Ends, Another Begins: Management of a Brain Dead Pregnant Mother: A Systematic Review," *BMC Medicine* 8 (2014): 74; E.A. Epstein, "It's a Miracle," *Daily Mail,* 21 April 2012 (Christine Bolden); R. Willing and W. Koch, "Devastating Loss," *USA Today,* 13 September 2005 (Susan Torres); "Joy and Heartbreak," *Daily Mail,* 11 February 2014 (Robyn Benson).

86. "Ruling by a Court Keeps Fetus Alive," *New York Times,* 26 July 1986; M.C. Coutts, "Maternal-Fetal Conflict: Legal and Ethical Issues," *Scope Note* 14, August 1990, *https://repository.library.georgetown.edu/bitstream/handle/10822/556868/sn14.pdf;sequence=1.*

87. An Act Relating to the Determination of Death, 2017 Nev. Acts ch. 315 (A.B. 424) (effective 1 October 2017), to be codified at Nev. Rev. Stat. § 449.5701.

88. For example, in a similar case in Houston, a Texas court ordered a hospital to continue treatment for a comatose Tammy Martin, who was then 15 weeks pregnant. But the court reversed the order, a few weeks later, once Martin had been declared dead. R. Nissimov, "Comatose Woman's Fetus Focus of Battle," *Houston Chronicle,* 28 July 1999.

89. Tex. Health & Safety Code § 671.001(b).

90. Tex. Health & Safety Code § 166.049.

91. Tex. Health & Safety Code § 166.002(10).

92. Tex. H.B. 3542 (2017) (Cain).

93. A.L. Caplan and T.M. Pope, "Pregnant and Dead in Texas: A Bad Law, Badly Interpreted," *Los Angeles Times,* 16 January 2014; T.W. Mayo, "Brain Dead and Pregnant in Texas," *American Journal of Bioethics* 14, no. 8 (2014): 15-18.

94. *Munoz v. John Peter Smith Hospital,* No. 096-270080-14 (Tarrant County District Court, Tex. 14 January 2014) (Plaintiff's Original Petition for Declaratory Judgment and Application for Unopposed Expedited Relief).

95. *Munoz v. John Peter Smith Hospital,* No. 096-270080-14 (Tarrant County District Court, Tex. 26 January 2014) (Judgment).

96. M. Fernandez, "Texas Woman Is Taken Off Life Support after Order," *New York Times,* 26 January 2014.

97. D. Sperling, "Maternal Brain Death," *American Journal of Law and Medicine* 30, no. 4 (2004); D. Sperling, *Management of Post Mortem Pregnancy* (London: Ashgate 2006); *Dinino v. Washington,* 684 P.2d 1297 (Wash. 1984); *Gabrynowicz v. Heitkamp,* 904 F. Supp. 1061 (D.N.D. 1995); *University Health Services v. Piazzi,* No. CV86-RCCV-464 (Richmond Cty., Ga. 4 August 1986).

98. The claims depended upon contingent facts and future events that might not occur. Therefore, the courts would not rule on them. The basic rationale of the ripeness doctrine is to prevent courts from entangling themselves in abstract disagreements and to protect parties from judicial interference until the effects of the law are felt in a concrete way.

99. Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island University Hospital,* No. 500510/14 (N.Y. Supreme Court, Kings County 23 December 2014), 16; ibid., 2. ("A vicious cycle ensues: because no one expects women's rights to be legally enforced, they become in fact unenforceable.")

100. Ibid., 16.

101. C. McCartney, "The Patient Protection and Affordable Care Act and Choice in Childbirth: How the ACA's Nondiscrimination Provisions May Change the Legal Landscape of Childbirth," *American University Journal of Gender Social Policy and the Law* 24, no. 3 (2016): 337, 364-65.

102. See Diaz-Tello, "Invisible Wounds," note 22 above; D. Fox, "Reproductive Negligence," *Columbia Law Review* 117, no. 1 (2017): 149-240, 157. ("Existing causes of action lack the narratives required to appreciate the richness of reproductive interests as well as the vocabulary with which to articulate the magnitude of reproductive injuries.")