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# MOTHERS AND DOCTORS' ORDERS: UNMASKING THE DOCTOR'S FIDUCIARY ROLE IN MATERNAL-FETAL CONFLICTS

Michelle Oberman\*

## I. INTRODUCTION

Conflicts between pregnant women and their doctors may arise at any time during prenatal care, from the counseling given to women prior to conception to the treatment of women during labor and delivery. Doctors and their pregnant patients may disagree over when and whether to utilize prenatal, and even preconception, testing.<sup>1</sup> They may differ over maternal lifestyle issues such as smoking, drinking alcohol, substance abuse, exercise and work.<sup>2</sup> They may disagree about the wisdom of pursuing innovative therapies designed to ameliorate a fetus's potentially disabling condition.<sup>3</sup> Finally, they may conflict at the point of labor and delivery, as happens when patients reject invasive medical technology and procedures utilized to monitor, expedite or otherwise intervene in the birth process.<sup>4</sup>

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<sup>1</sup> For example, a doctor may advocate, and a patient resist, testing for genetic markers linked to disability, such as fragile-X syndrome or Tay-Sachs disease. See, e.g., Renee C. Esfandiary, *The Changing World of Genetics and Abortion: Why the Women's Movement Should Advocate for Limitations on the Right To Choose in the Area of Genetic Technology*, 4 WM. & MARY J. WOMEN & L. 499 (1998).

<sup>2</sup> See *infra* notes 127-45 and accompanying text (discussing doctors' responses to substance abuse by pregnant women).

<sup>3</sup> See Katherine A. Knopoff, Comment, *Can a Pregnant Woman Morally Refuse Fetal Surgery?*, 79 CAL. L. REV. 499, 502 (1991).

<sup>4</sup> The literature discussing this issue is voluminous. See, e.g., Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 51-53 (1987); Susan Markens et al., *Feeding the Fetus: On Interrogating the Notion of Maternal-Fetal Conflict*, 23 FEMINIST STUD. 351 (1997); Lawrence J. Nelson, *Legal Dimensions of Maternal-Fetal Conflict*, 35 CLINICAL OBSTETRICS & GYNECOLOGY 738 (1992); Rayna Rapp, *Constructing Amniocentesis: Maternal and Medical Discourses*, in UNCERTAIN TERMS: NEGOTIATING GENDER IN AMERICAN CULTURE 28, 33 (Faye Ginsburg & Anna Lowenhaupt Tsing eds., 1990); Matthew C. Reid & Grant Gillett, *The Case*

Although the specific facts surrounding each conflict vary, these dilemmas all arise out of the same paradigm. A physician perceives an ideal course of treatment, predicated upon the well-being of the pregnant woman, the fetus, or both. He advises the woman of his concerns, and recommends a particular course of action.<sup>5</sup> Rather than acquiescing, the pregnant woman resists the physician's advice, causing the doctor grave anxiety over the potentially negative consequence to his patient or her fetus. He therefore enlists outside help in the hopes of persuading the woman to change her mind. This help may come in the form of counselors or allied health professionals; it may also entail veiled or explicit threats of legal intervention if the woman is unwilling to follow medical orders. Depending upon the context, continued resistance on the woman's part may lead the doctor to seek a court's permission to compel the woman to adhere to medical advice.<sup>6</sup>

Over the course of the past fifteen years, these conflicts have been termed "maternal-fetal" conflicts, and they have generated a veritable cottage industry for scholars in legal, medical, ethical, religious and philosophical circles.<sup>7</sup> At the center of the maternal-fetal conflict debate is the question of when and whether it is appropriate for the law to dictate a pregnant woman's behavior in an effort to benefit her unborn fetus. The medi-

*of Medea—A View of Fetal-Maternal Conflict*, 23 J. MED. ETHICS 19-25 (1997); Bonnie Steinbock, *Maternal-Fetal Conflict and In Utero Fetal Therapy*, 57 ALB. L. REV. 781 (1994). Indeed, the writings on this topic have been prolific enough to warrant a bibliography, *Maternal-Fetal Conflict: Legal and Ethical Issues* (Bibliography), in NATIONAL REFERENCE CENTER FOR BIOETHICS LITERATURE, KENNEDY INSTITUTE OF ETHICS, GEORGETOWN UNIVERSITY, WASHINGTON, D.C. (1990).

<sup>5</sup> Historically, at least in the United States, male physicians have dominated the practice of obstetrics. As such, this Article occasionally uses the male pronoun when referring to doctors in hypothetical scenarios.

<sup>6</sup> Several authors have documented the problems associated with such judicial intervention, not the least of which arises from the circumstances under which the judges render their decisions. In many cases, for example, judges conduct hearings from the hospital, or even the bedside, with attorneys and expert witnesses in attendance. See Watson A. Bowes & Brad Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTETRICS & GYNECOLOGY 209 (1981). Further complicating these makeshift "adjudicative proceedings" is the fact that the pregnant woman is close to delivery and experiencing pain. The doctor, whom the woman should be able to trust, suddenly is cast as her adversary. The presence and involvement of the lawyers and judges is daunting in any situation, let alone at the bedside of a birthing. Often, the woman does not even speak sufficient English to understand what is transpiring. More commonly, the woman does not have a representative at the proceeding and thus the judge hears only the physician's view. In addition, as time is of the essence, the lawyers and the judges are often ill-informed and unprepared to deal with the exigency at hand. The only survey of actual judicial interventions to date found that in 88% of the cases, orders were obtained in less than six hours, and in 19%, in less than one hour, once by telephone. See Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987). See also Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927, n.84 (1994).

<sup>7</sup> See DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 40 (1997) (positing slave owners' dual interest in both slave mothers and children as the prototypical "maternal-fetal conflict"); see also Kolder, *supra* note 6. See, e.g., articles cited *supra* note 4 (addressing maternal-fetal conflicts from a variety of perspectives).

cal, ethical and legal literature on "maternal-fetal conflict" is rich in analysis of the competing rights of mother and fetus. Yet, for all their depth and diversity, the overwhelming majority of articles reach an identical conclusion: in all but the most extreme circumstances, it is impermissible to infringe upon the pregnant woman's autonomy rights.<sup>8</sup>

In spite of this powerful consensus, "maternal-fetal" conflict has not dissipated. Indeed, over the course of the past decade, frenzied, lawyers, doctors, ethicists and the general public have engaged in a frenzied effort to analyze and resolve a burgeoning series of new "conflicts."<sup>9</sup> Legal and academic debates over the clashing "rights" of mothers and fetuses have emerged in various contexts, including substance abuse by pregnant women, homebirths, mandatory HIV screening in prenatal care, and a pregnant woman's rights to utilize a living will.<sup>10</sup> These deliberations over the appropriate course of action in the newest incarnations of maternal-fetal conflict again focus on whether and to what extent women should be permitted to make decisions that their doctors believe to be disadvantageous to their fetuses. And, as in the past, there is a near universal consensus that it is impermissible to infringe upon pregnant women's autonomy rights.<sup>11</sup>

The question that remains, then, is why these debates persist.<sup>12</sup> This Article will argue that it is primarily because the underlying paradigm of

<sup>8</sup> See, e.g., Gallagher, *supra* note 4, at 56-58; Markens et al., *supra* note 4, at 352 (calling court-ordered cesareans "disturbing"), Nelson, *supra* note 4, at 745 (noting the consensus). There are, of course, several exceptions. See, e.g., Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239, 274-78 (1991); Jeffrey A. Parness, *Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life*, 22 HARV. J. ON LEGIS. 97, 171-172 (1985); John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 410-11 (1983).

<sup>9</sup> A current example of this "cottage industry" is seen in the growing literature discussing a pregnant woman's right to refuse intra-uterine therapies designed to remedy a variety of potentially disabling conditions in the fetus. Ironically, although such conflicts plainly are foreseeable, to date, neither legal nor media sources have reported a single incident of such a conflict. See, e.g., Knopoff, *supra* note 3; Krista L. Newkirk, *State-Compelled Fetal Surgery: The Viability Test Is Not Viable*, 4 WM. & MARY J. WOMEN & L. 467 (1998); Ouellette, *supra* note 6; David C. Blickenstaff, Comment, *Defining the Boundaries of Personal Privacy: Is There a Paternal Interest in Compelling Therapeutic Fetal Surgery?*, 88 NW. U. L. REV. 1157 (1994); Scott R. DeBonis, Comment, *The Fetal Maternal-Conflict: Judicial Resolution Based upon Constitutional Rights*, 22 OHIO N.U. L. REV. 479 (1995); Kathleen Rauscher, Comment, *Fetal Surgery: A Developing Legal Dilemma*, 31 ST. LOUIS U. L. J. 775 (1987).

<sup>10</sup> See, e.g., Sam S. Balisy, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 S. CAL. L. REV. 1209 (1985); Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813 (1994); Michelle Oberman, *Test Wars: Mandatory HIV Testing, Women, and Their Children*, 3 U. CHI. L. SCH. ROUNDTABLE 615 (1996); Molly C. Dyke, Note, *A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes*, 70 B.U. L. REV. 867 (1990).

<sup>11</sup> See articles cited *supra* note 4; see also Ouellette, *supra* note 6. Indeed, the virtually unanimous affirmation of the pregnant woman's autonomy rights is seen even in discussions of conflicts that, to date, remain entirely hypothetical. See Gallagher, *supra* note 4 (regarding the potential "problem" of maternal refusal of intra-uterine therapies). But see Finer, *supra* note 8; Parness, *supra* note 8; Robertson, *supra* note 8.

<sup>12</sup> One obvious answer might be that they serve as a fertile source of fodder for the tenure gods.

“maternal-fetal” conflict is fundamentally flawed and incomplete. Under the present framework, each new conflict is presented as an isolated and extraordinary case in which fetal well-being is threatened by the uncaring behavior of pregnant women. One of the primary parties to these conflicts—the doctor—is entirely missing. This omission is critical, as these conflicts originate in the context of the relationship between the doctor and the pregnant woman. Specifically, they result from doctors’ seemingly well-motivated efforts to promote maternal or fetal well-being by imposing their perception of appropriate medical care on their pregnant patients. Hence, these are not maternal-fetal conflicts at all, but rather maternal-doctor conflicts.<sup>13</sup>

The construction of these conflicts as “maternal-fetal,” or arising between pregnant women and their fetuses, begins when doctors project their own estimations of the optimal course of action onto their pregnant patients. When a pregnant woman resists medical advice, the doctor often invests the fetus with interests and rights that directly coincide with his own personal treatment preferences. The pregnant woman’s interests are then rendered in direct opposition to those attributed by the doctor to her fetus. Hence, the “maternal-fetal conflict.” Finally, the doctor steps in as a seemingly neutral arbitrator who is well situated to settle this “conflict.” But, as it is the doctor who identifies the course of action deemed to be “in the fetus’s best interests,” the doctor is, by definition, not neutral. Rather than balancing the competing rights of mother and fetus, the doctor becomes just another party to these conflicts—one who always tips the balance 2:1 against the pregnant woman.<sup>14</sup>

The result of structuring these conflicts as involving dueling claims on behalf of maternal autonomy and fetal well-being is that each issue is analyzed anew, and each generates the same increasingly tiresome discussion of these rights. This reactive analysis ignores the context in which these conflicts arise: they involve doctors and patients who meet in a private relationship in the health care setting.<sup>15</sup> And yet, because the maternal-fetal

<sup>13</sup> I am indebted to Professor Timothy F. Murphy for coining the phrase “maternal-doctor” conflict, and generally, for his rich insight into the manner in which pregnant patients are “exceptionalized” to their grave detriment. It is important to acknowledge that the term *maternal* in “maternal-fetal” conflicts is both misrepresentative and reductionist. It reduces the pregnant woman to what is, at most, one facet of her identity—and should the conflict arise in the course of her first pregnancy, one that may not yet be part of her identity at all. Moreover, because “mother” carries with it connotations of loving altruism, the notion of a conflict between mother and fetus implies that, by refusing to follow medical advice, the mother has cruelly betrayed the sacred trust between mother and child. However, because the entire genesis of these conflicts emanates from the fact that the *doctor* sees the patient *only* as a mother, the name “maternal-doctor conflicts” best describes these situations.

<sup>14</sup> I am indebted to Professor Katherine Baker for her assistance in elucidating this point.

<sup>15</sup> Although beyond the scope of this Article, it is important to note that the contemporary maternal-fetal analysis is ahistorical and uninformed by the history of the medical profession’s efforts to cast pregnancy as a medical condition, to be treated by medical professionals, with the use of a dynamic array of popular medical treatments and technology. Several sources detail this history: BARBARA EHRENREICH & DEIRDRE ENGLISH, *FOR HER OWN GOOD: 150 YEARS OF THE EXPERT’S ADVICE TO*

analysis eclipses the doctor's role in generating these conflicts, one scarcely notices that each instance of such conflict represents a dramatic violation of the legal and ethical norms that govern doctor-patient relationships.

This Article offers a new analysis of maternal-doctor conflicts—one that makes visible the role of the doctor in generating these conflicts. Part II begins with a description of the fiduciary aspects of the traditional doctor-patient relationship, setting an analytical foundation and framework for the legal and ethical analysis of these scenarios. Part III reviews a series of commonplace maternal-doctor conflicts, demonstrating several ways in which doctors violate their fiduciary duty to their pregnant patients. Finally, having resituated these conflicts to accurately reflect the instrumental role played by doctors, Part IV articulates a set of legal strategies designed to prevent, or at least remedy, the harms caused when doctors attempt to impose their will upon their pregnant patients.

## II. FIDUCIARY DUTY IN THE CONTEXT OF THE DOCTOR-PATIENT RELATIONSHIP

Over the course of centuries, the common law notion of a fiduciary relationship has moved far beyond its original mooring in the law of trust and agency, and now encompasses a variety of forms and constituents.<sup>16</sup> In her landmark article on fiduciary law, Professor Tamar Frankel demonstrates that the twentieth century has “witness[ed] an unprecedented expansion and development of the fiduciary law,” such that the category of fiduciary now includes “agents, partners, directors and officers, trustees, executors and administrators, receivers, bailees, and guardians . . . .”<sup>17</sup> In the course of this expansion, the fiduciary model was applied to the doctor-patient relationship, and doctors and commentators, and later judges, came to refer to doctors as fiduciaries.

Widespread adoption of fiduciary terminology in reference to doctors and patients began in the 1980s. Leslie Miller's landmark articles on informed consent declared that the doctrine of informed consent is an outgrowth of the Anglo-American concept of the fiduciary relationship.<sup>18</sup> Physicians' increasing comfort with the fiduciary terminology is seen by official statements of the two principal associations for American physicians, the American Medical Association and the American College of Physicians,

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WOMEN (2d ed. 1989); David A. Grimes, *Technology Follies: The Uncritical Acceptance of Medical Innovation*, 269 JAMA 3030 (1993); Michelle Oberman, *Women, Fetuses, Physicians, and the State: Pregnancy and Medical Ethics in the 21st Century*, in HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY 67, 68-75 (John F. Monagle & David C. Thomasma eds., 1998).

<sup>16</sup> The law governing trusts and agency broadly defines fiduciary as one who is “entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct.” Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 243 (1995).

<sup>17</sup> Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 795-96 (1983).

<sup>18</sup> See Leslie J. Miller, *Informed Consent: I*, 244 JAMA 2100, 2100 (1980).

which utilize the fiduciary model when describing the relationship between physicians and patients.<sup>19</sup>

For several decades, federal and state courts alike have acknowledged the fiduciary nature of the physician-patient relationship. Indeed, courts have termed the physician-patient relationship a "fiduciary" one since at least the mid-1960s.<sup>20</sup> By the 1990s, judges frequently employed the fiduciary law construct when assessing doctors' obligations to their patients. For example, in *Herdrich v. Pegram*, the Seventh Circuit Court of Appeals found that "the fiduciary trust between plan participants and plan fiduciaries no longer exists[,] . . . where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."<sup>21</sup> State courts have been even more explicit in applying the fiduciary model to the doctor-patient relationship.<sup>22</sup>

As a result of the foregoing, it is utterly commonplace to refer to doctors as fiduciaries for their patients.<sup>23</sup> In reality, however, although the fiduciary model accurately describes the doctor-patient relationship, doctors have eschewed the legal regulations that are associated with fiduciary relationships.<sup>24</sup> Absent the enforcement mechanism provided by such legal regulations, there is little means for patients to hold doctors to the fiduciary standards they profess to have embraced.

<sup>19</sup> For example, an American Medical Association report on managed care concluded that conflicts between the physician and the patient "must be resolved to the patient's benefit . . ." due to the "physician's role as a fiduciary, *i.e.*, a person who, by his undertaking, has a duty to act primarily for another's benefit . . ." The Council on Ethical and Judicial Affairs of the American Medical Association, Report 6, at 3, Dec. 1986. See also the American College of Physicians' ethical code, which declares that the physician is "the advocate and the champion of his patient, upholding the patient's interests above all others." AD HOC COMM. ON MED. ETHICS, AM. C. OF PHYSICIANS, AM. C. OF PHYSICIANS ETHICS MANUAL, Part 1, *cited at* 101 ANNALS OF INTERNAL MED. 129, 134 (1984) [hereinafter COUNCIL ON ETHICAL AND JUD. AFF.]

<sup>20</sup> See *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 799 (N.D. Ohio 1965). "We are of the opinion that members of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients . . ." *Id.* at 799, quoting *Alexander v. Knight*, 177 A.2d 142, 146 (Pa. 1962).

<sup>21</sup> *Herdrich v. Pegram*, 154 F.3d 362, 373 (7th Cir. 1998), *cert. granted*, 68 U.S.L.W. 3177 (U.S. Sept. 28, 1999).

<sup>22</sup> See, e.g., *Hammonds*, 243 F. Supp. 793; *Neade v. Portes*, 710 N.E.2d (Ill. App. Ct. 1999), citing *Petrillo v. Syntex Lab., Inc.*, 499 N.E.2d 952, 961 (Ill. App. Ct. 1981) ("Illinois courts have recognized that a fiduciary relationship exists between a physician and his patient."); *Shadrick v. Coker*, 963 S.W.2d 726, 736 (Tenn. 1998) ("Dr. Coker and Shadrick had a confidential or fiduciary relationship by virtue of having a doctor-patient relationship . . ."); *Branom v. Washington*, 974 P.2d 335, 342 (Ct. App. 1999) ("Washington recognizes that the physician-patient relationship is a fiduciary one."). *But see* *Wadsworth v. ABC Ins.*, 732 So. 2d 56 (La. Ct. App. 1998); *D.A.B. et al. v. Brown*, 570 N.W.2d 168, 171-72 (Minn. Ct. App. 1997) (rejecting claims for breach of fiduciary duty which would have had the effect of either extending a tolled medical malpractice statute of limitations, or of allowing a second recovery under the same set of facts).

<sup>23</sup> "The idea that physicians are or should be fiduciaries for their patients . . . is a dominant metaphor in medical ethics and law today and is presumed by much of the legal and ethical analysis of physicians' conflicts of interest." Rodwin, *supra* note 16, at 242.

<sup>24</sup> See *infra* notes 30-34 and accompanying text.

In the following sections, I will describe the limited version of fiduciary duty applicable to doctors, and the various ways in which this model generates negative consequences for patients. As later sections will demonstrate, the harm that results from this hollow fiduciary construct is not restricted to pregnant patients, but nowhere is the betrayal of fiduciary duty more blatant and extreme than in the context of prenatal care.

#### A. *The Limited Fiduciary Nature of the Doctor-Patient Relationship*

The law recognizes three primary structures of legal relationships: status, contract, and fiduciary.<sup>25</sup> The status relationship is one in which one party has no choice about the terms of the relationship, or even about entrance into or exit from the relationship. The classic model for this type of relationship is the medieval interaction between lord and vassal.<sup>26</sup> Although the interaction between doctor and patient may be unbalanced in terms of choice—because the doctor is sought out by the patient, of the patient's own volition, and because the patient can terminate the relationship at any time—it is nonetheless clear that the relationship is not one of status.<sup>27</sup>

The classic contract relationship is one in which both parties are presumed to be motivated by self-interest, and because they are therefore potentially in conflict, each must protect herself from the other's self-interested behavior. The law's main role in governing these relationships is "to prohibit the use of force and monopoly, and to enforce the rules [that] the parties freely set for themselves."<sup>28</sup> The fact that patients contract with doctors for services may give their interaction the aura of a contract relationship, yet this aura is belied by the situational reality of the "contracting" parties. Clearly, the defensive, antagonistic posture inherent between parties in the contracting relationship contrasts sharply with the traditional caretaking notions that inform the doctor-patient relationship.

In a fiduciary relationship, one party is dependent upon the other, but not nearly to the extent of a status relationship. The "entrustor" (as Frankel refers to the dependent party in the fiduciary relationship) relies upon a fiduciary to provide her with a specific service, but she selects the fiduciary, and the relationship exists only to further her own needs. This relation therefore is also distinct from contract relations, in which both parties seek to have their needs met.<sup>29</sup> Fiduciary relations require the entrustor to dele-

<sup>25</sup> See Frankel, *supra* note 17. For a fascinating discussion of the vitality of these categories in a modern capitalist economy, see Freidrich Kessler's classic article, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629 (1943).

<sup>26</sup> See Frankel, *supra* note 17, at 801-02.

<sup>27</sup> Frankel defines the status relationship as one in which "one party, (the Power Bearer) usually has a partial or full monopoly over the means for satisfying the needs of the other party (the Dependent). The Power Bearer can coerce the Dependent into service and obedience by manipulating, increasing, or decreasing the satisfaction of the Dependent's needs." *Id.* at 798.

<sup>28</sup> *Id.* at 800.

<sup>29</sup> *Id.* at 800-01.

gate power to the fiduciary in order that the fiduciary may act on her behalf. Professor Marc A. Rodwin describes the manner in which doctor-patient relationships resemble "classic fiduciary relationships":

Physicians have specialized knowledge and expertise. They also control the use of medical resources needed by patients: only they can admit patients to hospitals, order diagnostic tests, and prescribe drugs. Patients are often ill or anxious about their health, which increases their dependence. The patient-physician relationship presupposes patients entrusting physicians to act on their behalf and physicians remaining loyal to their patients.<sup>30</sup>

Physicians themselves have embraced the fiduciary model as descriptive of the doctor-patient relationship, frequently incorporating it into their professional codes.<sup>31</sup>

Because fiduciary relations originate when the "entrustor" delegates power to the fiduciary to act on her behalf, all fiduciary relations raise the potential for abuse of that power.<sup>32</sup> In considering this potential for abuse, Frankel argues that, "the purpose of fiduciary law should be to solve this problem, and that the differences in the rules applicable to various fiduciary relations stem from differences in the extent of the problem."<sup>33</sup> Professor Rodwin summarizes the various legal mechanisms for promoting fiduciary accountability:

[The law] reduces fiduciary discretion or prohibits suspect transactions; it regulates or supervises fiduciaries; it imposes penalties when fiduciaries breach their trust and provides remedies for those harmed . . . . Often there are adequate remedies for misbehavior. In cases where monetary damages would be inadequate, however, courts often supervise fiduciaries directly. But when supervision would be too costly or would reduce the value of fiduciary work, the law prohibits certain transactions as a preventive measure.<sup>34</sup>

Thus, to the extent that physicians are their patients' fiduciaries, one would expect to find carefully tailored rules that limit doctors' ability to inappropriately exploit the power they have over their patients. Ironically, although doctors possess much of the power over their patients that comes with fiduciary status, doctors have been virtually exempt from the regulation and scrutiny by outsiders that marks traditional fiduciary relationships.<sup>35</sup> As Professor Rodwin con-

<sup>30</sup> Rodwin, *supra* note 16, at 245-46.

<sup>31</sup> See *supra* note 19 (listing several examples).

<sup>32</sup> Frankel, *supra* note 17, at 804.

<sup>33</sup> *Id.* at 807-08.

<sup>34</sup> Rodwin, *supra* note 16, at 247.

<sup>35</sup> Professor Marc Rodwin's corpus of work on doctors and fiduciary duty is premised on the fact that "the laws holds doctors accountable as fiduciaries only in restricted situations." *Id.* at 242. See also MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* (1993).

cludes in his thorough study of the field, fiduciary law principles have been applied to physicians in only a narrow set of circumstances.<sup>36</sup> In short, "Courts and legislatures have not developed comprehensive fiduciary obligations for physicians and do not consistently hold them accountable as such."<sup>37</sup>

There is no rich body of case law articulating broad fiduciary standards for physicians, the violation of which would constitute a distinct form of malpractice. Despite the fact that doctors are considered fiduciaries, there is no line of cases in which doctors have been found liable for acting in ways that ignore or undermine a patient's best interests. Indeed, although the issue of fiduciary duty occasionally arises in the context of medical negligence actions, it is used only as a vehicle for evaluating the physician's technical clinical competence, generally as it relates to the duty to obtain an informed consent.<sup>38</sup> Thus, the only physicians likely to be accused of breaching fiduciary duty under the present regime are those who have acted in a manner also recognized as violating the medical standard of care (for example, by performing an inappropriate medical procedure). This leaves unremedied a host of abuses of physician authority—abuses that should be classified as breaches of fiduciary duty.<sup>39</sup>

As a result of the law's limited application of fiduciary principles to physicians who abuse their positions of power over patients, maternal-doctor conflict is not seen for the breach of fiduciary duty that it represents. Instead, doctors' actions are judged through the lens of existing medical malpractice law and, as is the case with other instances in which physicians breach their fiduciary duty to their patients, only those doctors whose actions deviate from an articulated standard of care are held accountable for violating their patients' trust. In other words, doctors are held accountable for the breach of fiduciary duty only insofar as the breach also constitutes medical malpractice. In order to expose the inadequacy of this approach to the breach of fiduciary duty, Subpart B discusses the specific challenges to fiduciary duty that arise in the health-care setting.

### B. Challenges to Fiduciary Duty in the Health Care Setting

The current structure of the U.S. health care system generates at least three types of challenges to physicians' loyalty to patients: conflicts arising

*But see infra* notes 41-44 and accompanying text (regarding federal regulations against physician self-dealing).

<sup>36</sup> "These include requiring that physicians not abandon patients, keep information that they learn confidential, obtain patients' informed consent to treatment, and in one case, disclose to patients any financial interest in clinical research." Rodwin, *supra* note 16, at 247-48.

<sup>37</sup> *Id.* at 248.

<sup>38</sup> See *Cobbs v. Grant*, 502 P.2d 1, 7-8 (Cal. 1972); *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974), *aff'd* 530 P.2d 334 (1975); *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967); Rodwin, *supra* note 16, at 247, citing *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

<sup>39</sup> See *infra* notes 40-47, 55, 89 and accompanying text for a description of such unregulated abuses.

out of the physician's role as gatekeeper, conflicts relating to the duty of confidentiality, and conflicts resulting from the patient's right to autonomy. Maternal-doctor conflicts fall under this last category, and I will therefore discuss it at greatest length. First, however, I will describe the fiduciary challenges arising out of doctors' duties as gatekeepers and their obligations to maintain patient confidentiality.

1. *Divided Loyalties and the Physician as Gatekeeper.* The most frequently cited issue in the contemporary literature on a doctor's divided loyalties is the set of problems relating to the physician's role as the "gatekeeper" who controls access to, and information concerning, medical care. Contemporary mechanisms for health care delivery and finance have generated a host of potential conflicts for physicians. These conflicts range from issues such as self-dealing (in which physicians make referrals for care to entities in which they have a financial stake) to the broader issue of how physicians ration resources on behalf of health care organizations (which may stand to lose money on a given patient), health care payors (which may resist covering the cost of medical care), health care plans (which may employ the physician), or society at large (as the ultimate health-care payor).<sup>40</sup> These new conflicts join a list of similar, longstanding conflicts, such as those facing government physicians who evaluate patients in the context of eligibility for disability income, military service, or fitness to stand trial.<sup>41</sup>

Recently, lawmakers have endeavored to limit some forms of divided loyalties. Beginning in 1994, Congress passed a series of federal fraud and abuse regulations that sanction physicians who engage in self-referrals.<sup>42</sup> Additionally, both federal and state legislators are struggling to draft laws

<sup>40</sup> For a detailed discussion of physician conflicts of interest stemming from financial and other structural interests, see Rodwin, *supra* note 16. For additional consideration of the challenges to regulating physicians' financial conflicts of interest under managed care, see Mark Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 514 (1997); Michael D. Reagan, *Health Care Rationing: What Does it Mean?*, 317 NEW ENG. J. MED. 1149, 1151 (1988).

<sup>41</sup> Arlene K. Daniels, *Military Psychiatry: The Emergence of a Subspecialty*, in MEDICAL MEN AND THEIR WORK 145, 145-46 (Eliot Freidson & Judith Lorber eds., 1972); Edmund G. Howe, *Ethical Issues Regarding Mixed Agency of Military Physicians*, 23 SOC. SCI. & MED. 803, 803 (1986); Michael D. Reagan, *Physicians as Gatekeepers: A Complex Challenge*, 317 NEW ENG. J. MED. 1731, 1731-32 (1987); Anne R. Somers, *And Who Shall Be the Gatekeeper? The Role of the Primary Physician in the Health Care Delivery System*, 20 INQUIRY 301, 310-11 (1983); Deborah A. Stone, *Physicians as Gatekeepers: Illness Certification as a Rationing Device*, 27 PUB. POL'Y 227, 227-29 (1979).

<sup>42</sup> The Ethics in Patient Referral Act (Stark I), 42 U.S.C. § 1395nn (1994) (effective Jan. 1, 1992) (prohibiting physician self-referrals for laboratory services); Comprehensive Patient Ownership and Referral Act (Stark II), 42 U.S.C. § 1359nn (1994) (effective Jan. 1, 1995) (prohibiting physician self-referrals for designated services). For an in-depth analysis of this legislation, see Marc A. Rodwin, *The Organized American Medical Profession's Response to Financial Conflicts of Interest: 1980-1992*, MILLBANK Q. 703, 731-32 (1992). In a recent Eighth Circuit case, the court held: "When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties." *Shea v. Eesensten*, 107 F.3d 625, 629 (8th Cir. 1997).

that would bar managed care entities from including "gag clauses" in their contracts with physicians.<sup>43</sup> These clauses may limit a physician's ability to discuss health care treatment options that are not covered by a patient's health care plan, to refer patients to specialists who are outside of the patient's plan, or to disclose the method by which he or she is compensated.<sup>44</sup> To date, these efforts to craft viable legislation have failed, leaving patients with no more recourse than to wait and see if they are harmed as a result of the physician's failure to disclose additional treatment options. If that occurs, patients then have the option of bringing a traditional negligence lawsuit against the physician, arguing that they were injured by the doctor's failure to inform them of all of their options and that such failure constituted a breach of duty for which they must be compensated.<sup>45</sup>

Notwithstanding ongoing legislative efforts, gatekeeper instances of divided loyalties are viewed as unavoidable conflicts, similar to those that arise for attorneys in their capacity as officers of the court as well as advocates for their clients. Malpractice law has yet to hold physicians liable for actions motivated by financial conflicts of interest.<sup>46</sup> Although state medical licensing boards establish competency standards and have the power to sanction physicians, their standards typically proscribe only the most egregiously fraudulent conduct. To date, none have issued conflict of interest guidelines.<sup>47</sup>

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<sup>43</sup> As of June 1999, the 106th Congress was considering nine comprehensive managed care reform bills. Although the bills' features varied markedly, all would prohibit gag clauses. See *Healthcare Reform*, HEALTH LAW DIGEST, June 1999, at 35. In 1996, the Healthcare Financing Administration banned gag clauses in contracts with Medicare HMO physicians. See CNN Interactive, *U.S. Bans 'Gag Orders' on Advice for HMO Medicare Patients*, (posted Dec. 7, 1996) <<http://cgi.cnn.com/US/9612/07/hmo.report/index.html>>. Additionally, 46 states currently have laws that set some limits on gag clauses. See Families USA, *The Variability of State Managed Care Consumer Protection Laws* (visited June 21, 1999) <<http://www.familiesusa.org/managedcare+u/TABLE.HTM>>.

<sup>44</sup> See Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 441-42 (1996); Jennifer L. D'Isidori, *Stop Gagging Physicians!*, 7 HEALTH MATRIX 187, 194 (1997).

<sup>45</sup> Doctors complain of being caught between a rock and a hard place in this context. Undoubtedly, they are. However, they fail to recognize that these dilemmas are at least partly of their own making: doctors could not be forced into such choices if they had professional standards requiring disclosure as a part of their fiduciary duty. Thus, the remedy lies not in tort reform (which limits the patient's right to compensation for an injury that results from the lack of information), but rather, in articulating clear professional standards favoring full disclosure.

<sup>46</sup> Rodwin, *supra* note 16, at 249. For example, despite evidence that physicians have prescribed and been compensated for unnecessary tests and surgeries, no malpractice litigation arises out of these practices unless the patients can demonstrate that such practices violated the standard of care and caused them harm. The fact that the physician advocated a course of action because it maximized his or her personal wealth is not, in and of itself, viewed as a violation of fiduciary duty. (My sincere gratitude to Professor Sallyanne Payton for her insights on this topic.)

<sup>47</sup> Rodwin, *supra* note 16, at 249 (noting that "[s]ome boards sanction physicians for 'character unbecoming of a physician,' but only where there is fraud, criminal conviction or other egregious conduct").

2. *Divided Loyalties and the Duty of Confidentiality.* Ancient medical principles require doctors to maintain in strictest confidence information obtained from a patient in the course of rendering treatment.<sup>48</sup> The common law imposes a duty of confidentiality upon physicians, forcing those who disclose information inappropriately to pay damages.<sup>49</sup> The promise of confidentiality is tacitly understood by patients, who rely upon it when they disclose highly personal information to their physicians. The physician acts as fiduciary, using the confidential information in order to treat the patient, and safeguarding the secrets from others.

On occasion, however, the physician may be inclined, or even required, to share the patient's information with others. There are several well-established exceptions to the duty of confidentiality—circumstances under which the law mandates that the physician divulge confidential information to a third party.<sup>50</sup> Mandatory reporting laws explicitly exempt the disclosing physicians from liability, thereby exonerating them from accusations of having breached fiduciary duty.<sup>51</sup> It is critical to note, how-

<sup>48</sup> The Hippocratic oath states: "Whatever in connection with my professional practice or not in connection with it I see or hear in the life of men which ought not to be spoken abroad I will not divulge as recommending that all such should be kept secret." The AMA similarly values physician confidentiality. The AMA principles state,

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

AM. MED. ASS'N, PRINCIPLES OF MED. ETHICS § 9 (1957). "The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest." AMA Council on Ethical and Judicial Aff., *Fundamental Elements of the Patient-Physician Relationship*, in CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS, xliii (1996).

<sup>49</sup> See *Horne v. Patton*, 287 So. 2d 824 (Ala. 1974) (physician liable for breach of confidentiality based on the theory of breach of implied contract); *Martin v. Baehler*, No. Civ. A. No. 91C-11-008, 1993 WL 258843 (Del. Super. Ct. 1993) (physician liable for breach of confidentiality when physician's employee disclosed patient's pregnancy to her grandmother, mother, and step-father); *MacDonald v. Clinger*, 446 N.Y.S.2d 801 (N.Y. App. Div. 1982) (psychiatrist liable for breach of confidentiality when he disclosed intimate details about his patient, discovered in therapy sessions, to his patient's wife).

<sup>50</sup> See, e.g., COLO. REV. STAT. ANN. § 12-36-135 (West 1998) (physicians must report to the police or sheriff gunshot wounds, powder burns, injury caused by a knife, or any other injury which the physician believes was intentionally inflicted); N.J. STAT. ANN. § 26:4-15 (West 1996) (physician must report a patient with a communicable disease to the State Department of Health within 12 hours). See also Illinois' Elder Abuse Demonstration Project Act, 320 ILL. COMP. STAT. ANN. 15/3-4 (West 1996).

<sup>51</sup> See, e.g., DEL. CODE ANN. tit. 24, § 1762 (1975-1996):

Reports of treatment of certain wounds, injuries, poisonings, or other conditions.

(a) Every physician attending or treating a stab wound, poisoning by other than accidental means, or a case of bullet wounds, gunshot wounds, powder burns or other injury arising from or caused by the discharge of a gun, pistol or other firearm or whenever such case is treated in a hospital, sanitarium or other institution, the manager, superintendent or other person in charge shall report such case as soon as possible to the appropriate police authorities where such physician, hospital, sanitarium, or institution is located. This section shall not apply to such wounds, burns, poisonings or injuries received by a member of the armed forces of the United States or the State while engaged in the actual performance of duty. Whoever fails to make such report shall be fined no less than \$25.

ever, that the law's explicit grant of immunity reflects the fact that, but for the law's intervention, these disclosures would be impermissible violations of the physician's duty of loyalty to his or her patient.

The issue of fiduciary obligation becomes murkier in cases in which the disclosure is not mandated, but rather discretionary. The most common example of this occurs when the physician perceives a "duty to warn" a third party, whose well being appears to be threatened by his or her patient. Beginning with the *Tarasoff* case in 1968, which held a psychotherapist liable for failing to warn a known third party that his patient had threatened to harm her, doctors have struggled for guidance on how to balance these competing obligations. Indeed, there is a rich literature discussing the ethical and legal ramifications of a duty to warn.<sup>52</sup> To date, however, there is little consensus on the criteria for determining, in the absence of mandatory reporting laws, what circumstances justify a physician's disclosure of a patient's confidential medical information to a third party.<sup>53</sup> In such cases, disclosure may bring with it a valid accusation of breach of fiduciary duty, and the best legal advice to the physician may well be to "pick your lawsuit": a breach-of-confidentiality action brought by the patient, or a failure-to-warn action brought by the subsequently injured third party.<sup>54</sup>

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(b) Any physician or other person who makes a report pursuant to this section shall be immune from an award of damages, providing such physician or other person acted in good faith without malice.

<sup>52</sup> See, e.g., Bernard Friedland, *HIV Confidentiality and the Right to Warn—The Health Care Provider's Dilemma*, 80 MASS. L. REV. 3 (1995); Timothy E. Gammon & John K. Hulston, *The Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749 (1995); Christine E. Stenger, *Taking Tarasoff Where No One Has Gone Before: Looking at 'Duty to Warn' Under the AIDS Crisis*, 15 ST. LOUIS U. PUB. L. REV. 471 (1996); Jake Taylor, *Sex Lies, and Lawsuits: A New Mexico Physician's Duty to Warn Third Parties Who Unknowingly May Be at Risk of Contracting HIV from a Patient*, 26 N.M. L. REV. 481, 481-83 (1996).

<sup>53</sup> For example, it remains uncertain whether a doctor legally can warn the spouse of an HIV-infected patient who is unwilling either to advise her of his serostatus or to take precautions not to place her at risk. See Friedland, *supra* note 52. In fact, many states, such as New Mexico, have mandated both a duty to warn third parties at risk and to keep HIV-related information confidential. See Taylor, *supra* note 52, at 481-83. Faced with conflicting statutes, physicians are forced to decide on a case-by-case basis to whom their legal duty lies. See Friedland, *supra* note 52; Taylor, *supra* note 52, at 481-83.

<sup>54</sup> Using the scenario raised in the previous note, the choice of lawsuits may not be terribly difficult. Realistically, the patient who complains that the doctor breached a fiduciary duty by divulging information in an attempt to save his spouse's life is not a particularly attractive plaintiff. (My thanks to Mr. Ed Goldman, University of Michigan Hospital Attorney, for his sage advice regarding a pragmatic approach to this dilemma.) Indeed, although courts have recognized a patient's right to confidentiality in such situations, it is offset by the provider's competing interests in protecting others. For example, in a case involving an HIV-infected surgeon, the court upheld the medical center's policy of immediately suspending privileges and requiring the doctor to divulge his HIV status to all surgical patients. However, the court simultaneously found that the hospital had breached the doctor's right to confidentiality by failing to take "reasonable precautions regarding [his] . . . medical records to prevent [his] . . . AIDS diagnosis from becoming a matter of public knowledge." *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1255 (N.J. Super. Ct. Law Div. 1991). This compromise ruling renders inevitable the widespread disclosure of the patient's HIV status, and ultimately requires only that such disclosure re-

The absence of professional consensus about the extent to which physicians must keep patient information confidential has significant implications for the doctor-patient relationship. As in cases involving a gatekeeper's divided loyalties, patients are not informed about the limited extent to which they can trust their physicians to keep their secrets. To be sure, physicians' decisions to breach confidentiality in order to protect a third party generally carry with them a profound moral justification. Although this makes the breach of the patient's trust more palatable as a matter of justice, it nevertheless remains a breach. And, as in the case of gatekeeper divided loyalties, the absence of fiduciary standards not only dupes patients into believing they can trust their doctors, but also limits their ability to bring a claim against their doctors when a betrayal of that trust occurs.<sup>55</sup>

3. *Divided Loyalties and the Patient's Right to Autonomy.* The patient's right to autonomy is, at least on its face, wholly consistent with the physician's fiduciary duty, in that the physician's sole obligation is to pursue the patient's well-being in accordance with the patient's wishes. In reality, however, the patient's right to provide an informed consent or refusal to any proposed treatment creates conflict for the physician who firmly believes that a particular treatment would be beneficial. In order to understand these conflicts as challenges to fiduciary duty, it is important to review the strength of the patient's right to autonomy as it has evolved over the course of the past hundred years.

a. *The Patient's Right to Autonomy and the Law of Informed Consent.*—The patient's right to control medical access to his or her body evolved gradually through twentieth-century common-law decisions. The first cases to articulate a patient's right to be free of unwanted medical treatment involved physicians who treated patients successfully, but failed to secure the patient's consent prior to treatment. The courts found that

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sult not from inappropriate access to medical records, but rather from explicit notice given by the infected individual, or from indirect "notice" signaled by a sudden suspension of staff privileges.

<sup>55</sup> This may not seem particularly heart-rending in the case of the secretly HIV-infected spouse. However, the balance shifts if we imagine a doctor who elects to inform an unwitting husband of his wife's extramarital affair, or to tell a teenage patient's parents of her sexual activity. Recent case law governing breach of confidentiality demonstrates some limits on the law's tolerance of the release of medical information in the name of "protecting" third parties. For example, a family physician was found liable for releasing information regarding his patient's mental health to her ex-husband, with whom the patient was involved in a child custody dispute. See *McCormick v. England*, 494 S.E.2d 431, 432 (S.C. Ct. App. 1997). In another case, a plastic surgeon was found liable after displaying a cosmetic surgery patient's "before" and "after" photographs in a department store presentation and on television. *Vassiliades v. Garfinckel's*, 492 A.2d 580 (D.C. 1985). For two interesting discussions of this line of cases, see Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291 (1994), and Alan B. Vickery, Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982).

such treatment constituted battery and permitted the patients to recover damages against the physicians despite the successful outcomes.<sup>56</sup>

The notion that treatment without consent constituted battery was a critical step in establishing patients' unequivocal right to control access to their bodies. Initially, however, it had only a limited impact on patients' experiences of autonomy in their routine encounters with doctors. In order to avoid battery charges, physicians needed only to obtain a patient's written consent prior to rendering treatment. Thus, doctors developed generic consent forms, which served to eliminate claims of battery, but failed to provide the patient with an opportunity to give a meaningful consent to treatment. Indeed, the consent form became a "take it or leave it" proposition, so that a patient who wanted treatment had no alternative but to sign away her autonomy rights.

As a result of this limitation, the law attempted to fill the hollow autonomy right by requiring doctors to provide patients with sufficient information about any proposed medical treatment prior to obtaining consent. This effort is reflected in the series of decisions giving rise to the patient's right to make an informed consent to treatment. Beginning in the 1950s, courts found that treating patients without first informing them of the risks, benefits, and alternatives to treatment constituted negligence.<sup>57</sup> As with the earlier battery cases, patients' actual experiences of informed consent vary.<sup>58</sup> Nevertheless, the right to make an informed consent establishes with utter certainty the principle that doctors may not impose medical treatment upon their patients, even if they believe such treatment to be in the patient's best interests, unless and until the patient permits the doctor to do so.<sup>59</sup>

<sup>56</sup> See *Pratt v. Davis*, 118 Ill. App. 161 (Ill. App. Ct. 1905) (awarding punitive damages for removal of patient's vital organs without consent), *aff'd*, 79 N.E. 562 (Ill. 1906); *Schloendorf v. Society of N. Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (recognizing the right to bodily integrity).

<sup>57</sup> See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (permitting claims by plaintiffs who argued that, had they understood the risk of this particular bad outcome, they never would have consented to treatment); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960). See generally PAUL S. APPELBAUM, *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* (1987); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

<sup>58</sup> Physicians often see informed consent as a technicality, a task to be taken care of after they have decided what to do. This is reflected in a phrase the chief of medical ethics at the University of Utah School of Medicine often hears in the hallways: "I'm going to go in and get consent." Flora Johnson Skelly, *The Payoff of Informed Consent*, AM. MED. NEWS, Aug. 1, 1994, at 13. See also KATZ, *supra* note 57; Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69 (1994) (arguing that emphasis on disclosure will enhance patient decision-making autonomy, which historically has been neglected); Daniel P. Sulmasy et al., *Patients' Perception of the Quality of Informed Consent for Common Medical Procedures*, 5 J. CLINICAL ETHICS 189 (1994) (discussions between doctors and patients when consent is obtained are more formal than substantive); Peter H. Shuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 917 (1994) (state disclosure laws vary). For an analysis of the particularly problematic nature of informed consent in the obstetric realm, see Nancy K. Rhoden, *Informed Consent in Obstetrics: Some Special Problems*, 9 W. NEW ENG. L. REV. 67 (1987).

<sup>59</sup> Note that this right has a basis in constitutional law as well as in common law. Indeed the entire line of decisions invoking a right to die by the withdrawal of life support is predicated upon a Fourteenth

The central element of informed consent is the physician's duty to disclose relevant information to the patient. Because the information regarding diagnosis and course of action is otherwise inaccessible to the patient, the patient must rely upon the physician as fiduciary to convey the relevant information in an accessible manner. Informed consent thus represents one of the few areas in which physicians' fiduciary obligations are relatively well articulated.

At least at the aspirational level, physicians have embraced the notion of an autonomy right for patients. The American Medical Association's ethical and policy guidelines advocate unambiguous support for the right to refuse treatment, even in cases in which refusal means that the patient likely will die for want of a simple medical procedure such as a transfusion.<sup>60</sup> Nevertheless, because physicians are trained to diagnose, treat, and whenever possible, cure human ailments, the recognition of a patient's right to refuse medical treatment inherently poses an ethical challenge.<sup>61</sup> By definition, physicians trained in the art and science of healing cannot be entirely comfortable with patients' autonomous decisions to reject medical advice. The best evidence of this discomfort is the long line of cases arising out of doctors' efforts to compel their patients to accept medical treatment. One way to evaluate the role of fiduciary duty in this context is to examine what happens when doctors' ethical injunctions to heal meet with conflicting patient assertions of a right to be free of unwanted medical treatment.

*b. The Patient's Right to Refuse Treatment Intended for Own Benefit.*—As recently as 1972, courts permitted doctors to impose unwanted treatment upon competent adult patients when such treatment was necessary to save the patient's life. For example, in the case of Dolores Heston, the New Jersey Supreme Court found that a relatively simple treatment of blood transfusions would return the otherwise dying patient to complete health, and the court therefore rejected the notion that the patient had a right to refuse treatment.<sup>62</sup> Central to the court's holding was its concern about the impact on physicians of a patient's refusal of treatment:

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Amendment right to liberty or privacy. See *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

<sup>60</sup> COUNCIL ON ETHICAL AND JUDICIAL AFF., AM. MED. ASS'N CODE OF MEDICAL ETHICS—CURRENT OPINIONS WITH ANNOTATIONS, § 8.08, at 134-35 (1998-1999 ed. 1998) [hereinafter CODE OF ETHICS]. Courts have cited this rule in upholding a patient's right to refuse life-saving treatment. See *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *In re Brooks Estate*, 205 N.E.2d 435 (Ill. 1965); *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997).

<sup>61</sup> The physician's training, experience, and technological capability all militate against respecting the patient's wishes. In the physician's eyes, particularly in the case of relatively minor treatment, allowing the curable to go uncured is unjustifiable, and engenders feelings of helplessness and frustration. Jeffrey P. Phelan, *Symposium on Biomedical Technology and Health Care: Social and Conceptual Transformations: Technical Article: The Maternal Abdominal Wall: A Fortress Against Fetal Health Care?*, 65 S. CAL. L. REV. 461, 471 (1991).

<sup>62</sup> *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670 (N.J. 1971).

A surgeon should not be asked to operate under the strain of knowing that a transfusion may not be administered even though medically required to save his patient . . . Miss Heston's family made no effort to take her elsewhere . . . . When the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards.<sup>63</sup>

Cases decided over the course of the past several decades have rendered that position almost completely obsolete. Beginning with the *Quinlan* case, the same court predicated an incompetent patient's right to die upon the claim that competent patients had a constitutional privacy right that empowered them to refuse unwanted treatment.<sup>64</sup> Years later, the U.S. Supreme Court echoed this position, citing in dicta a liberty interest in being free from unwanted medical care.<sup>65</sup> So powerful is this right that several cases have extended it to minor patients.<sup>66</sup> So extensive is the support for this right that my research does not reveal a single case after 1972 in which a competent patient was forced to undergo medical treatment intended strictly for her own benefit.

*c. The Patient's Right to Refuse Treatment Intended to Benefit Another.*—It is clear that the doctor's fiduciary duty requires him to honor his patient's refusal of treatment, even though so doing conflicts with his medical training and his ethical obligation to save life. This outcome remains essentially unchanged in the related autonomy conflict that arises when patients refuse treatment that the physician believes would be beneficial for a third party.

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<sup>63</sup> *Id.* at 673.

<sup>64</sup> *Quinlan*, 355 A.2d at 663.

<sup>65</sup> *Cruzan*, 497 U.S. at 278. The Court narrowly defined the issue as whether the State of Missouri, in keeping with the Due Process Clause of the Fourteenth Amendment, could ignore one's liberty interest in every case except those in which the patient had left clear and convincing evidence of her desire to have life-prolonging treatment withdrawn. *Id.* at 280-81. However, the Court assumed, for purposes of its decision, that an individual has a "liberty interest" in having life-prolonging treatment withdrawn. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278.

<sup>66</sup> See *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989). The court stated:

If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment.

*Id.* See also *Cardwell v. Brechter*, 724 S.W.2d 739 (Tenn. 1987) (adopting mature minor exception to common-law rule requiring parental consent); *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990) (holding that there is much merit to the "mature minor" doctrine and that the New York legislature should address the issue). For a critique of the extension of the right to refuse treatment to minors, see Michelle Oberman, *Minor Rights and Wrongs*, 24 J.L. MED. & ETHICS 127-38 (1996).

The effort to impose treatment on a patient in order to benefit another represents an instance of divided loyalties similar to that raised when doctors consider breaching confidentiality in order to benefit a third party. For the most part, these conflicts arise infrequently, litigation is scarce, and, outside of the context of pregnancy, the law simply will not countenance such actions. The law's intolerance of such a request is illustrated by the powerful dicta in the one frequently cited case on this topic, *McFall v. Shimp*.<sup>67</sup> This case involved a man dying of aplastic anemia who sued his cousin. The cousin agreed to undergo preliminary testing for bone marrow compatibility, but, after the test indicated that he was a suitable bone marrow donor, he declined further testing or donation. In upholding the cousin's right to refuse donation, the court invoked "the sanctity of the individual" and emphasized that to force the cousin to donate would "change every concept and principle upon which our society is founded."<sup>68</sup>

Doctors' responses to situations in which treatment of one patient might yield a benefit for another are limited not so much by fear of the law as by ethical injunctions against perpetrating intentional medical harm. Two areas in which conflicts between multiple patients arise include live-donor tissue transplantation and nontherapeutic research.<sup>69</sup> The stakes are high in these situations. For instance, the physician's failure to intervene with a patient's family members in an effort to help the patient find a kidney transplant may well lead to the worsening of the patient's condition. Nonetheless, if the physician does coerce a family member into becoming a donor, the donor will suffer harm "directly and exclusively from medical intervention."<sup>70</sup>

Standard medical practice in these cases prohibits such intervention. As Professor Susan Mattingly explains, the policy against physician intervention reflects the Hippocratic tradition, which presumes that the only justification for physician-caused harm to a patient is therapeutic intent for *that* patient. Indeed, "a professional ethics that allowed treatment recommendations to be based on . . . therapeutic intent for others . . . would erode the fiduciary character of the physician-patient relationship, undermining the basis for patients' trust."<sup>71</sup> Just beneath the surface of these cases is evidence of the cognitive dissonance that physicians experience in relation to issues of patient autonomy. Although they might embrace the norm of patient autonomy and feel legally and ethically bound to effectuate it, it is nonetheless true that doctors experience conflicting ethical impulses when

<sup>67</sup> *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (Allegheny County Ct. 1978).

<sup>68</sup> *Id.* at 91.

<sup>69</sup> See, e.g., EXPERIMENTATION WITH HUMAN SUBJECTS (Paul A. Freund ed., 1970); LAW & ETHICS OF TRANSPLANTATION (Gordon Wolstenholme & Maeve O'Connor eds., 1966); ROBERT J. LEVINE, ETHICS AND REGULATION OF CLINICAL RESEARCH (1981); ROBERTA G. SIMMONS et. al., GIFT OF LIFE: THE SOCIAL AND PSYCHOLOGICAL IMPACT OF ORGAN TRANSPLANTATION (1977).

<sup>70</sup> Susan Mattingly, *The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model*, 22 HASTINGS CENTER REP. 13, 15 (1992).

<sup>71</sup> *Id.*

their patients refuse treatment. It is also true that physicians' will to preserve and promote health can clash with their obligation to honor their patients' autonomy.<sup>72</sup> Given the deeply felt nature of this conflict, it is actually quite remarkable that there are not myriad contexts in which physicians attempt to impose treatment on unconsenting patients. And yet, no matter how vigorously they may oppose the patient's decision, in virtually every context but one, doctors no longer assert a right to force care upon a conscious, competent patient who has refused to consent to treatment.<sup>73</sup>

It is only in the context of pregnancy that doctors assert the right to compel their patients to heed medical advice. Doctors' responses to their pregnant patients therefore emerge as a startling exception to the nearly universal consensus that patients, not doctors, should control determinations about whether and when to undergo medical treatment. Because doctors assert the right, if not the duty, to intervene when pregnant women reject medical advice, maternal-doctor conflict cases represent the critical test of the meaning, and the true limits, of doctors' fiduciary duty to their patients. Part III provides a detailed discussion of maternal-doctor conflicts, paying special attention to the doctors' role in generating these conflicts.

### III. MATERNAL-DOCTOR CONFLICT AS BREACH OF FIDUCIARY DUTY: THE RATIONALIZATION AND TWO CASE STUDIES

Doctors do not deny that they employ a different standard when treating pregnant women. On the contrary, they readily acknowledge it, contending that pregnant patients must be viewed differently from other patients because there are "two lives involved."<sup>74</sup> The argument that pregnancy is *sui generis*, and therefore should be governed by distinct legal and ethical principles, is neither new nor unique to medicine. Indeed, feminists

<sup>72</sup> See Phelan, *supra* note 61, at 472 (describing the difficulty physicians experience when patients ask them to allow the curable to go uncured).

<sup>73</sup> For example, Edward H. Winters, an Ohio man, filed suit, claiming negligence and battery, against a hospital for resuscitating him in spite of his "do not resuscitate" order. *Patient Suing Hospital for Saving His Life*, 31 MED. WORLD NEWS 8 (Apr. 23, 1990). Although Winters was in good health following the successful resuscitation effort, he argued that the hospital overrode his explicit wishes regarding the most fundamental decision of all: whether to live or die. See *id.* In *Bartling v. Glendale Adventist Medical Center*, 229 Cal. Rptr. 360 (Cal. Ct. App. 1986), a man tried to remove his ventilator tubes (after his repeated requests for their removal were ignored). *Id.* at 361. The hospital used soft restraints and close supervision to restrain him. *Id.* at 363. Although the court held that a "competent non-terminally ill adult patient has a right to reject and/or terminate medical treatment," it simultaneously exonerated the hospital by emphasizing their "good faith." *Id.* at 366. This slippage reflects the court's deference to the hospital's "good efforts" and disregard of the patient's autonomy rights. For a probing and provocative analysis of the issue of forced treatment from a variety of perspectives and scholarly fields, see DAX'S CASE: ESSAYS IN MEDICAL ETHICS AND HUMAN MEANING (Lonnie Kliever ed., 1989).

<sup>74</sup> J. PRITCHARD & P. MACDONALD, WILLIAMS OBSTETRICS VII (16th ed. 1980) ("Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient."); Fernand Daffos, *Access to the Other Patient*, 13 SEMINARS IN PERINATOLOGY 252 (1989); Finer, *supra* note 8, at 283-84. For a critique of the construction of the two-patient model, see Mattingly, *supra* note 70.

and others have raised this argument in contexts ranging from the employment setting,<sup>75</sup> to efforts to secure women's rights to abortion.<sup>76</sup> This argument takes place against the broader backdrop of the debate over formal versus substantive equality. Proponents of formal equality argue that the road to women's equality lies in treating women the same as men, while proponents of substantive equality argue that doing so eclipses key realities of women's lives, thereby perpetuating women's subordinate social status.<sup>77</sup>

In the context of pregnancy, this debate is framed as a struggle over the extent to which the fact of a pregnancy might legitimate subjecting pregnant women to a distinct set of rules, rights, and privileges. In legal terms, this devolves into a debate over the extent to which pregnancy should be viewed as a disabling condition. To the extent that the latter view prevails, pregnant women will be afforded greater deference and accommodation under the law.<sup>78</sup>

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<sup>75</sup> For example, the U.S. Supreme Court's decisions on pregnancy-based discrimination began with *Geduldig v. Aiello*, 417 U.S. 484 (1974) (holding that a company's failure to pay disability benefits for pregnancy was not discrimination on the basis of sex), and continued through *International Union, UAW v. Johnson Controls*, 499 U.S. 187 (1991) (holding that Title VII forbids sex-specific fetal protections). For a thorough, yet concise summary of this line of cases prior to *Johnson Controls*, the Congressional response to the issue, and the difficulty pregnancy poses to advocates of formal equality, see Mary E. Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219 (1986).

<sup>76</sup> See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992).

Abortion is a unique act . . . . Though abortion is conduct, it does not follow that the State is entitled to proscribe it in all instances. That is because the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. . . . Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture.

*Id.*

<sup>77</sup> See generally MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW 41-43 (1990) (the law's official neutrality treats women like men but leaves women to shoulder the burdens created by differences); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1007-13 (1984) (arguing that laws governing reproductive biology be scrutinized by courts to ensure they do not perpetuate gender stereotypes or the oppression of women). Regarding abortion, see Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 357-58 (1992), who writes:

A legislature's purpose in enacting restrictions on abortion is to pressure or compel women to carry a pregnancy to term which they would otherwise terminate . . . . Motherhood is the role upon which this society has traditionally predicated "gross, stereotyped distinctions between the sexes." Thus, the objective of abortion-restrictive regulation is to force women to assume the role and perform the work that has traditionally defined their secondary social status.

*Id.* Regarding equality in the workplace, see Mary Joe Frug, *Securing Job Equality for Women: Labor Market Hostility to Working Mothers*, 59 B.U. L. REV. 55, 58 (1979) ("As long as the labor market is hostile to parents, and as long as roles in the American family continue to be allocated on the basis of gender, the labor market gap between the sexes will continue.").

<sup>78</sup> This debate was central to the Supreme Court's decision in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), in which the court held that the exclusion of pregnancy from an insurance plan was not a pretext for discrimination against women, but rather, was a reflection of the fact that, unlike other covered illnesses, pregnancy was not a disease. *Id.* at 136. Two years later, the United States Congress rejected this view by passing the Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (1994), which amended Title VII specifically to forbid discrimination on the basis of "pregnancy, childbirth or

There is a critical distinction, however, between these ongoing debates about pregnancy's uniqueness and the debates generated by physicians seeking to justify imposing treatment on pregnant women. Unlike the debates over whether, in the name of equality, pregnant women should be treated the same as their male (and nonpregnant female) counterparts or instead have *more* rights than their male counterparts, doctors are proposing that, in the name of pregnancy, women should have *fewer* rights than do their male counterparts. This argument represents a legally and ethically obsolete premise, reminiscent of the sex-specific protectionist policies of the latter half of the nineteenth century and the early decades of this century.<sup>79</sup> It is an approach that, over the course of the past forty years, has been overwhelmingly rejected as an impermissible violation of women's legal rights.<sup>80</sup>

The claim that pregnant patients must be accorded fewer rights than other patients because there are two lives involved is wholly unpersuasive as a justification for abandoning the fundamental principles of patient autonomy and doctors' fiduciary obligations to their patients. And yet, as will be seen in this Part's exploration of two examples of maternal-doctor conflict, doctors' rationalization that the fetus is their "second patient" constitutes their sole justification for subordinating the interests of their pregnant patients to their own vision of the fetus's best interests.

#### A. *The Rationalization: The Fetus as a "Second Patient"*

At first blush, it seems rather logical to reason that, because of the fetus's presence, pregnant women are different from other patients, and that, as a result, doctors might treat their pregnant patients differently from other patients. It is self-evident that only pregnant patients have fetuses inside of them and that doctors must recognize that any treatment they render potentially affects both the pregnant woman and her fetus. Yet there is little logic justifying the leap from acknowledging the fetus's presence to severely curtailing the autonomy rights of pregnant women.

In large part, the leap from acknowledging the fetus's presence to limiting the pregnant woman's autonomy is a reflection of the medical com-

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related medical conditions . . ." and to require that "women affected by pregnancy [or] childbirth" be treated "the same for all employment-related purposes . . . as other persons not so affected . . ." A more recent incarnation of this debate takes place in the context of the Americans with Disabilities Act, which has been interpreted to exclude pregnancy from coverage. See Colette G. Matzzie, Note, *Substantive Equality and Antidiscrimination: Accommodating Pregnancy Under the Americans with Disabilities Act*, 82 GEO. L.J. 193 (1993). But see *Bragdon v. Abbott*, 118 S. Ct. 2196, 2207 (1998) (holding that reproduction is a "major life activity.").

<sup>79</sup> See Becker, *supra* note 75, at 1221-24 (noting that ostensibly protectionist legislation tended to view all women "only in terms of the biologic and domestic responsibilities associated with motherhood").

<sup>80</sup> The beginning of the end of sex-specific subordination of women's rights came with the passage of Title VII of the Civil Rights Act, in 1964. For a summary of the twentieth century's history of the legal challenges and reforms in the arena of sexual discrimination, see CYNTHIA HARRISON, *ON ACCOUNT OF SEX* (1988); JOAN HOFF, *LAW, GENDER, AND INJUSTICE* (1991).

munity's response to technological advances such as ultrasound, which permits obstetricians to visualize the fetus within the mother's uterus. Many authors have noted how this technology has altered medical practice, substituting doctors' traditional reliance on the mother for information with the power "to see, examine and invade the fetus and its environment" directly.<sup>81</sup> The result, as one widely cited medical text concludes, is that "[t]he fetus is no longer dealt with as a maternal appendage ultimately to be shed, but has achieved the status of a second patient who faces greater risks of serious morbidity and mortality than does the mother."<sup>82</sup>

It is imperative to note, however, that the mere fact that a fetus can be visualized provides neither a legal nor an ethical foundation for the notion that the fetus is the obstetrician's "second patient," still less one whose interests trump those of the "first patient," the pregnant woman. Like all doctor-patient relationships, relationships between pregnant patients and their doctors are established when a woman seeks treatment from a doctor. Patients, or their guardians, initiate relationships with doctors. Absent a patient or guardian's consent, a doctor has no power to adopt an individual as a patient.

This applies with equal force to adults and to minors, as relationships between children and their doctors are predicated upon the child's parent or guardian consenting to such treatment.<sup>83</sup> As a result, even if a doctor suspects that a minor is in need of medical care, the doctor cannot initiate a health care relationship with the minor, but rather must report the child to a state agency charged with investigating possible instances of medical neglect.<sup>84</sup> The doctor's act of filing such a report in no way creates a doctor-patient relationship between himself and the child.

<sup>81</sup> F.A. Manning, *Reflections on Future Directions of Perinatal Medicine*, 13 SEMINARS IN PERINATOLOGY 342, 343 (1989).

<sup>82</sup> F. GARY CUNNINGHAM, M.D. ET AL., WILLIAMS OBSTETRICS 1031 (19th ed. 1993). There is a rich literature discussing and critiquing the construction of the fetus as second patient. See, e.g., LAURENCE B. McCULLOUGH & FRANK A. CHERVENAK, ETHICS IN OBSTETRICS AND GYNECOLOGY (2d ed. 1996); Frank A. Chervenak & Laurence B. McCullough, *Ethical Issues in Recommending and Offering Fetal Therapy*, 159 W.J. MED. 396 (Sept. 1993); Mattingly, *supra* note 71; Joan C. Callahan, *First Steps in Preventative Ethics*, HASTINGS CENTER REPT., Mar.-Apr. 1996, at 45 (reviewing LAURENCE B. McCULLOUGH, ETHICS IN OBSTETRICS AND GYNECOLOGY (1994)).

<sup>83</sup> The common-law position regarding health care treatment for minors was that, until reaching the age of majority, minors lacked the legal authority to consent to their own care. Thus, any treatment rendered to a minor absent parental consent could subject the health care provider to an action by the parents for assault and battery. ANGELA RODDY HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 124-25 (1985); Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOOD HALL L.J. 115 (1973). In recent decades, mature minor laws have provided several exceptions to this rule, permitting minors to consent to their own health care in certain narrowly defined circumstances. For a brief discussion of these laws, see Michelle Oberman, *Turning Girls into Women: Re-Evaluating Modern Statutory Rape Law*, 85 J. CRIM. L. & CRIMINOLOGY 15, 46-53 (1994). See also *supra* note 65.

<sup>84</sup> See, e.g., CAL. PENAL CODE § 11166 (West 1998):

(a) Except as provided in subdivision (b), any child care custodian, health practitioner, employee of a child protective agency, child visitation monitor, firefighter, animal control officer, or humane society officer who has knowledge of or observes a child, in his or her professional capac-

Therefore, *absent the pregnant woman's consent*, her doctor has no more right to adopt the fetus as his "second" patient than he does to make any of her other living children, or even her husband, his patient. Indeed, because the fetus lacks legal status, the doctor arguably has *less* right to initiate a doctor-patient relationship with the fetus than he would with these other family members.<sup>85</sup>

In spite of this, beginning in the mid-twentieth century, the medical profession rapidly adopted the vision of the fetus as a medically vulnerable second patient, trapped within its mother's womb.<sup>86</sup> The practical consequence of this has been the advent of "conflicts" that are deemed to exist whenever the pregnant woman resists or rejects medical advice.<sup>87</sup> A 1987 study documents the medical community's widespread support for the doctor's right to identify these conflicts and to impose the "appropriate" treatment on the recalcitrant pregnant woman.<sup>88</sup> This study surveyed seventy-six current heads of fellowship programs and found that forty-six percent of the respondents thought mothers who endangered their fetuses' lives by refusing to comply with medical advice should be detained in a hospital until compliance.<sup>89</sup> Forty-seven percent thought that the legal precedent permitting emergency cesarean sections when the fetus was endangered should also include other procedures that may be lifesaving for the fetus.<sup>90</sup>

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ity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse, shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

<sup>85</sup> This is because of a relatively long line of recent cases holding that fetuses are not covered under child abuse statutes. See *Reyes v. Superior Court*, 75 Cal. App. 3d 214, 219 (1977); *In re Valerie D.*, 613 A.2d 748, 760 (Conn. 1992) (court found the statutory definition of "child" is limited to a person who has been born); *State v. Gray*, 584 N.E.2d 710 (Ohio 1992) (holding that the state child abuse statute does not apply when a mother abuses drugs during her pregnancy); *Wisconsin ex rel. Angela M. W. v. Kruzicki*, 561 N.W.2d 729, 740 (Wis. 1997) (holding that the definition of child under the child protection statute does not include a viable fetus). See also *Johnson v. State*, 602 So. 2d 1288 (Fla. 1992) (holding that women who use drugs during their pregnancy cannot be prosecuted under criminal statutes prohibiting the delivery of a controlled substance to a child). *But see Whitner v. South Carolina*, 492 S.E.2d 777, 779 (S.C. 1997) (finding that a fetus is a person holding certain rights and privileges under South Carolina law).

<sup>86</sup> See CUNNINGHAM, *supra* note 82. See also Mattingly, *supra* note 70.

<sup>87</sup> Another practical consequence has been the revised nomenclature surrounding obstetric practice. Originally, doctors interested in treating pregnancy specialized in obstetrics and gynecology, a field that involved the treatment of female patients for reproductive health care over the course of their lifetimes. They served on hospital staffs, within departments of obstetrics and gynecology. In the last decades of the twentieth century, these departments, and the doctors who work within them, began changing their names. Now it is common to refer pregnant women to departments of "maternal-fetal medicine," in which they might be treated by "maternal-fetal experts," or perhaps even by a "fetal medicine specialist."

<sup>88</sup> Kolder, *supra* note 6.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* at 1193.

Finally, only twenty-four percent believed the decision of a competent pregnant patient to refuse treatment should be upheld.<sup>91</sup>

In order to understand the startlingly anomalous nature of these doctor-generated conflicts, imagine that an internist is treating a patient for a heart condition. Over the course of time, the doctor comes to believe that the patient, who is a middle-aged, overweight, married father of two minor children, is abusing alcohol. The doctor is familiar not only with the medical literature demonstrating the potentially fatal impact of excess alcohol consumption on obese patients with heart conditions, but also with the considerable literature documenting the devastating consequences of parental alcoholism on families. Now imagine the doctor taking any of the actions that have become commonplace in the treatment of pregnant women. Can you imagine the doctor obtaining a court order requiring that the patient be confined in an alcohol detoxification center? Can you imagine the doctor reporting the patient to the criminal justice authorities? Can you imagine the doctor deeming the patient's children his "second patients" and petitioning a court to appoint a guardian to consent to their removal from the family's home? Can you even imagine the doctor testing the patient for the presence of alcohol without his express consent?<sup>92</sup>

There are at best two plausible legal justifications for curtailing autonomy rights in cases involving pregnant women and fetuses in ways that would be impermissible in cases involving the parents of living children. The first stems from a belief that the state has an overriding interest in safeguarding fetal well-being. Proponents of this view argue that the line of Supreme Court decisions governing abortion establish a state interest in protecting the viable fetus.

For example, a recent law review article attempting to justify the compulsory treatment of pregnant women begins with the attribution of legal rights to viable fetuses in certain circumstances, including the abortion context.<sup>93</sup> The author concedes that these cases do not address the issue of whether fetuses have legal rights as against their mothers in general, but claims that, "because a cesarean involves a verge-of-birth fetus, one can reasonably argue that this fetus should have the rights of a born person."<sup>94</sup> The author's only justification for eliding the line between fetus and human being, a line etched brightly into law, medicine, and simple human experience, is his unsupported claim that "[t]he medical profession places no greater emphasis on the health of a newborn than it does on the healthy

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<sup>91</sup> *Id.* Thirty-seven percent actually answered this question in the affirmative; however, seven of the twenty respondents who advocated this also supported state surveillance of third trimester pregnant women who refuse to stay in the hospital when medically advised.

<sup>92</sup> I am indebted to Dr. Michael Newdow for his assistance with this hypothetical dilemma.

<sup>93</sup> Finer, *supra* note 8, at 247-50.

<sup>94</sup> *Id.* at 270.

birth of a fetus."<sup>95</sup> The author then appends a handful of supporting arguments, ranging from a border-line absurd claim that, because cesarean sections are commonplace, they need not be considered invasive, to the wholly unfounded assertion that, once the time for a lawful abortion has passed, the mother implicitly undertakes an obligation to "bring [the fetus] to life in as healthy a condition as she can . . ."<sup>96</sup>

The author himself acknowledges the weaknesses of each of his claims, noting that "the argument [in favor of compulsory cesareans] is admittedly somewhat less than compelling."<sup>97</sup> Then, in a stunning display of irrationality, he concludes that, in spite of the fact that "each component of my argument may be 'distinguishable,' the whole is greater than the sum of its parts." In short, his claim is that, by weighing all of his losing arguments together, one can muster enough support to justify the compulsory treatment of pregnant women!<sup>98</sup>

The logical flaw in the arguments justifying the curtailment of pregnant women's autonomy rights lies in reading an expansive affirmative duty into the abortion cases, which limit third trimester abortions to cases of medical necessity. *Roe* and its progeny, however, stand *only* for the proposition that, at the point of viability, the State's interest in fetal life becomes sufficiently compelling to permit a state to prohibit all abortions, save those necessary to preserve the pregnant woman's life and health.<sup>99</sup> In no way do

<sup>95</sup> *Id.* at 256.

<sup>96</sup> *Id.* at 259. Contrary to Finer's belief, a cesarean section is major abdominal surgery regardless of the commonality of the procedure. For a vivid description of a cesarean section, see MICHELLE HARRISON, *A WOMAN IN RESIDENCE* 81-84 (1982), quoted in Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 35-36 (1987). In addition, the notion that a woman implicitly undertakes an obligation to "bring [the fetus] to life in as healthy a condition as she can . . ." is completely unsupported. Indeed, even a cursory analysis of this issue must recognize that because the individual's rights to autonomy and liberty are *fundamental*, they cannot be "implicitly" waived. For a more detailed critique of the "implicit waiver" proposition, see Michelle Oberman, *Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs*, 43 HASTINGS L.J. 505 (1992) (contending that, in order to be even marginally plausible, a pregnant woman's waiver of her autonomy rights would need to be secured early in the pregnancy. This could be accomplished by advising the woman that, should she elect to continue the pregnancy, her autonomy rights would be limited to those which her doctor deemed permissible).

<sup>97</sup> Finer, *supra* note 8, at 271.

<sup>98</sup> See Finer, *supra* note 8. Among Finer's self-proclaimed "less than compelling" arguments are some of the following: the increased likelihood that *Roe v. Wade* will be altered; the treatment of late-stage fetuses as patients by the medical profession; and the close analogy of the blood transfusion cases in light of the relatively low risks involved in an ordinary cesarean section.

<sup>99</sup> See *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992):

It must be stated at the outset and with clarity that *Roe's* essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State . . . . Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.

these cases imply that women who choose to carry their pregnancies to term have somehow waived their fundamental constitutional rights. Nor do they posit a broad-based interest in the viable fetus sufficient to usurp pregnant women's right to remain free from unwanted medical treatment in all contexts.

A second seemingly plausible justification for doctors who act to limit pregnant women's autonomy rights might be found in the law governing fiduciary obligation in the context of mergers and acquisitions. Specifically, case law provides that the nature of fiduciary duties may shift in the event of "changed circumstances."<sup>100</sup> For example, in *Revlon, Inc. v. MacAndrews and Forbes Holdings, Inc.*, the court held that, once the sale of the company became inevitable, the board of directors' fiduciary duty to the shareholders required that their goal shift from "the preservation of Revlon as a corporate entity to the maximization of the company's value at a sale for the stockholders' benefit."<sup>101</sup> Reasoning by analogy, a physician might argue that pregnancy constitutes a "changed circumstance," thus justifying a shift in fiduciary duty to encompass the fetus, as well as the pregnant woman.

This analogy is fundamentally flawed. First of all, a doctor who treats pregnant women could scarcely argue that his patient's pregnancy constitutes a "change in circumstances." Both the doctor and the patient knew of the pregnancy at the start of prenatal care, when the fiduciary relationship between the doctor and the pregnant woman began. Instead, the doctor would have to argue that pregnancy as such constitutes the "changed circumstance," and that fiduciary duties owed to pregnant patients always differ from those owed to non-pregnant patients. This is but a new gloss on the old tautological justification that pregnant women merit fewer rights because they are pregnant.<sup>102</sup> Doctors cannot transform the observation that pregnant women are different from other patients into a justification for betraying their patients' trust in them.

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*Id.* The principle, as originally stated in *Roe*, was as follows:

With respect to the State's important and legitimate interest, . . . the "compelling" point . . . is at approximately the end of the first trimester. . . . It follows that, from and after this point, a State may regulate the abortion procedure to the extent that regulation reasonably relates to the preservation and protection of maternal health.

*Roe v. Wade*, 410 U.S. 113, 163-64 (1973).

<sup>100</sup> These changed circumstances may arise from inside or outside of the business entity. See, e.g., *The Mediators, Inc. v. Manney*, No. 83 Civ. 2304 (CSH), 1996 U.S. Dist. LEXIS 14402 (S.D.N.Y. Sept. 25, 1996); *Great W. Producers Coop. v. Great W. United Corp.*, 613 P.2d 873 (Colo. 1980); *Revlon, Inc. v. MacAndrews and Forbes Holdings, Inc.*, 506 A.2d 173, 182 (Del. 1986). For a discussion of the "changed circumstances" doctrine, see Rutherford B. Campbell, Jr., *A Positive Analysis of the Common Law of Corporate Fiduciary Duties*, 84 KY. L.J. 455 (1995/1996). Campbell summarizes the common law of fiduciary duties in recapitalizations, affiliated mergers, lockups and freeze outs as generally requiring corporate managers "to make all moves in which, as a result of the move, at least one stockholder is better off and no stockholder is worse off." *Id.* at 469.

<sup>101</sup> *Revlon*, 506 A.2d at 182.

<sup>102</sup> See *supra* notes 74-79 and accompanying text.

Secondly, even if we accept the premise that doctors bear a fiduciary duty to pregnant patients that is distinct from the fiduciary duty they bear to their non-pregnant patients, it is clear that this in no way authorizes them to ignore, let alone to undermine, their duty of loyalty to their pregnant patients. *Revlon's* lesson is that the essence of fiduciary duty is the obligation to protect the best interests of the dependent party. Thus, we see that, in the event of a bidding war over a corporation, the shareholders' interests, and therefore the fiduciary's duties, no longer lie in preserving the "corporate bastion," but rather entail maximizing the value of the company's shares.<sup>103</sup> When the context involves choosing between the various treatment options available to a pregnant patient, there is no objective criterion like share value to determine what the patient's best interests are.

Likewise, even if pregnancy were viewed as a "changed circumstance," it at most adds additional considerations of fetal well-being to the physician's preexisting fiduciary obligations to the pregnant woman. These considerations should permit, if not require, that the doctor inform the woman about issues of consequence to her fetus's welfare. However, if the doctor attempts to impose treatment on the pregnant woman against her will, he necessarily violates his duty of loyalty to her. The *Revlon* precedent, to the extent that it is relevant at all, does not stand for the proposition that, in the name of changed circumstances, a fiduciary may ignore his obligations to one beneficiary in favor of another.<sup>104</sup>

This close scrutiny demonstrates that the underlying justification for treating pregnant patients differently from non-pregnant patients is not logical, but rather tautological: pregnant patients are different because they are pregnant. This brings us back to where this section began—with the faulty assumption that a doctor is entitled to dictate and impose medical treatment upon a pregnant patient in the name of protecting the fetus. Subparts B and C discuss two examples of this assumption in practice, helping to illustrate its legal, ethical and practical shortcomings. I have selected these examples because they represent the most obvious instances of maternal-doctor con-

<sup>103</sup> *Revlon*, 506 A.2d at 182.

<sup>104</sup> Even under the most extreme construction of this broadened fiduciary duty, in which we assume that the doctor owes duties of loyalty to both the woman and her fetus and that he is capable of determining how best to represent the fetus's best interests, the doctor could not attempt to force treatment upon the woman. To do this would completely undermine his fiduciary obligations to her. At best, the doctor could seek the appointment of a truly neutral third party, who would be charged with advocating on the fetus's behalf. In such event, an additional party likely would be needed to advocate on behalf of the pregnant woman, because the doctor's actions betray a conflict in his ability to act as her fiduciary. This would entail a trip to court to seek an appointed "guardian" for the fetus and a guardian or lawyer for the mother, particularly if she was unable to represent herself effectively due to her stage of pregnancy. And, as we know, when courts look carefully at this issue, the mother virtually always wins these battles. See *supra* notes 3, 4, 6, 8-10; *infra* notes 119, 128, 130 (citing articles that explain and justify women's autonomy in the event of maternal-fetal conflicts). See also *In re A.C.*, 573 A.2d 1235 (D.C. App. 1990); *Johnson v. State*, 602 So. 2d 1288 (Fla. 1992); *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

flict, in that each has been the subject of considerable publicity and widespread academic scrutiny. It is crucial to remember, however, that they reflect not isolated phenomena, but rather variations on the broad theme of conflicts that arise when doctors attempt to impose their treatment preferences upon their pregnant patients.<sup>105</sup>

### B. Court-Ordered Cesarean-Section Deliveries

Perhaps the quintessential example of a maternal-doctor conflict is the controversy generated when a pregnant woman rejects a medically advised cesarean section delivery. Writers from a host of academic and lay backgrounds have been drawn to this high-drama scenario and have generated an abundance of articles that attempt to articulate a just outcome to these situations.<sup>106</sup>

Many have noted that U.S. rates of cesarean section births far exceed rates of other first world nations.<sup>107</sup> Moreover, these rates are not accompanied by higher rates of infant survival.<sup>108</sup> Several commentators have attributed the swollen rates to factors such as U.S. doctors' drive to minimize risk of medical malpractice,<sup>109</sup> increase profits,<sup>110</sup> and maintain conven-

<sup>105</sup> See *supra* notes 1-4 and accompanying text for a discussion of the spectrum of scenarios reflecting "maternal-doctor conflict."

<sup>106</sup> See Kelly F. Bates, *Cesarean Section Epidemic: Defining the Problem—Approaching Solutions*, 4 B.U. PUB. INT. L.J. 389 (1995); Charity Scott, *Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615 (1994); Annette Williams, *In re A.C.: Foreshadowing the Unfortunate Expansion of Court-Ordered Cesarean Sections*, 74 IOWA L. REV. 287 (1988).

<sup>107</sup> See MARY GABAY & SIDNEY WOLFE, M.D., UNNECESSARY CESAREAN SECTIONS: CURING A NATIONAL EPIDEMIC 24 (1994). Gabay and Wolfe present the following comparison:

<u>Country</u>	<u>Cesarean Section Rates per 100 Hospital Deliveries</u>
United States	24.7
Canada	19.5
Italy	19.1
Portugal	15.8
Netherlands	15.0
Finland	13.8
Denmark	13.1
Norway	12.7
New Zealand	11.2
Sweden	11.2
United Kingdom	10.0
Czechoslovakia	7.8

*Id.* at 24.

<sup>108</sup> In fact, the United States has a higher infant mortality rate than virtually any first world country. Myron E. Wegman, *Annual Summary of Vital Statistics—1990*, 88 PEDIATRICS 1081, 1091 (1991). When factoring in racial variations, the infant mortality rate for African-Americans is comparable to that of many third world nations. Consuelo Beck Sague, *Prevention of Prematurity in Black and White*, 111 U.S. DEP'T OF HEALTH & HUMAN SERVS. PUBLIC HEALTH REPS. 114 (Mar. 1996).

<sup>109</sup> See *Finer, supra* note 8; Hilary E. Berkman, Note, *A Discussion of Medical Malpractice and Cesarean Sections*, 70 OR. L. REV. 629 (1991). *But cf.* Margaret M. Donohoe, *Our Epidemic of Unneces-*

ience,<sup>111</sup> as well as to the increased detection of problems made possible by fetal monitoring systems.<sup>112</sup> Numerous authors have decried the interventionist mindset of American medicine that drives cesarean section rates and the resultant high costs to women<sup>113</sup> and the health-care system.<sup>114</sup>

In addition to demonstrating an irrational allocation of scarce health care resources, the cesarean section phenomenon also demonstrates a classic case of breach of fiduciary duty, in which doctors become the self-appointed mediators in conflicts they create between pregnant women and their fetuses. When a woman resists her doctor's recommendation that she submit to a cesarean section delivery, her doctor almost invariably will subject her to a series of informal and formal sanctions designed to induce, if not to coerce her into consenting to the operation.<sup>115</sup> It is herein that the breach of fiduciary duty lies.

*sary Cesarean Sections: The Role of the Law in Creating It, The Role of the Law in Stopping It*, 11 WIS. WOMEN'S L.J. 197, 199 (1996) (finding no convincing evidence of a causal link between malpractice liability and the increase in cesarean sections).

<sup>110</sup> In performing a cesarean section, as opposed to a vaginal delivery, doctors can earn 20-40% more and hospitals can double their revenues. Jane E. Brody, *Personal Health*, N.Y. TIMES, July 27, 1989, at B5.

<sup>111</sup> Cesareans often are performed at 9 a.m., 5:30 p.m., and 10:30 p.m. These opportune times are easily scheduled, coincide with the physician's rounds, and eliminate a 4 a.m. return to the hospital. See Hilary A. Berkman, *supra* note 108, at n.12. See also William Fraser et al., *Temporal Variation in Rates of Cesarean Section for Dystocia: Does "Convenience" Play a Role?*, 156 AM. J. OBSTETRICS & GYNECOLOGY 300 (1987).

<sup>112</sup> Cf. Donohoe, *supra* note 108, at 199 ("Doctors are heavily dependant on technology. They expect abnormal births and respond with technological intervention.").

<sup>113</sup> For myriad reasons, most pregnant women prefer a vaginal birth to a cesarean section delivery. Cesarean sections are more risky to the pregnant woman's health, the recovery time is lengthier and more painful, the scarring is permanent, and many women report an intangible, yet very real, perception that a non-vaginal delivery is somehow "unnatural" and "a failure." For a comprehensive explanation of the emotional differences between women who have vaginal births and those who have a cesarean delivery, see M. SAMUELS, M.D. & N. SAMUELS, *NEW WELL PREGNANCY BOOK* 370-73 (1996). Women who undergo a cesarean section also face additional post-natal complications, such as uterine and urinary tract infections. In addition, they are three times more likely to have postdelivery infertility, must stay an additional 2-3 days in the hospital, and are more likely to have to pay some bills out of their own pockets. See Donohoe, *supra* note 108, at 201-02. For an extensive list of possible complications women may face after a cesarean section see Donohoe, *supra* note 108, at 201-02. Additionally, cesarean section deliveries whether because they involve blood transfusions or for other reasons, violate the religious beliefs of many United States women.

<sup>114</sup> Cesarean sections present high costs to the health care system. In 1991, the estimated cost of unnecessary cesarean sections was \$1.3 billion. See Karen A. Butler, *Health Care Quality Revolution: Legal Landmines for Hospitals and the Rise of the Critical Pathway*, 58 ALB. L. REV. 843, 853 (1995).

<sup>115</sup> As one commentator explains:

What are an obstetrician's alternatives when thrust into [this situation]? . . . An obvious alternative advocated by many is to do nothing and let the fetus die . . . Can you imagine the level of frustration this alternative creates in the medical profession? . . . To override her decision . . . would only lead to further erosion of the trust embodied in the doctor-patient relationship and promote coerced health care . . . [However,] the obstetrician's primary concern is not the erosion of trust or coerced health care, but timely delivery of the fetus.

Phelan, *supra* note 61, at 472.

The urgency of the proposed cesarean section will be impressed upon the pregnant woman by any or all of a number of individuals within the health-care setting—doctors, nurses, social workers, ethicists, pastoral care workers and even hospital attorneys.<sup>116</sup> If time permits, these individuals will approach her in the hospital setting, where they will attempt to isolate and evaluate her reasons for refusing treatment.<sup>117</sup> If her grounds are non-religious, a psychiatric evaluation may be ordered, so that she might be declared an incompetent, and an alternate decisionmaker appointed to consent to the procedure.<sup>118</sup>

Throughout this “persuasion” phase, the woman’s doctor likely will be in contact with the hospital attorney, urging him or her to seek a court order compelling the woman to undergo surgery. Neither doctors nor hospital personnel are obliged to advise the woman that she has a legal right to refuse treatment and that she may wish to hire a lawyer in order to ensure that her interests are protected. Ultimately, many institutions will attempt to compel the woman’s compliance by obtaining a court order.<sup>119</sup> Judges may

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<sup>116</sup> In the context of a dispute over a proposed cesarean section, the patient’s condition makes her particularly vulnerable. Therefore, physicians have an extraordinary amount of control over the course of treatment. This control often permits the doctor to persuade the patient to comply with his recommendation without his having to resort to judicial intervention. See Ouellette, *supra* note 6, at 937.

<sup>117</sup> However, doctors and hospitals frequently escalate these conflicts into legal actions before identifying the woman’s true reasons for refusing the proposed treatment. For example, in the *Bricci* case, an obstetrician who interviewed the couple learned that the basis for their refusal to permit doctors to induce labor stemmed from their belief that labor should not be induced until the pregnancy was at full-term, and that this would not occur until the fortieth week of pregnancy. When the doctor explained that a 38-week pregnancy is full term, the couple was far more amenable to induction, but by then, court proceedings were well underway, and the two sides were polarized. Interview with Susan Wishnick, ACLU attorney and one of Bricci’s lawyers, Chicago, Ill. (July 1998). See also *infra* note 119. In another case, a hospital attorney refused to assent to doctors’ pleas to pursue a court-ordered cesarean section until social workers interviewed the patient. The social workers learned that the woman’s refusal was predicated upon her fear that if the baby was born prematurely it would be mentally retarded, as was the woman’s sister, who had been born prematurely. (This case arose at the University of Michigan hospital in the mid-1980s, when the author of this Article was an employee there.)

<sup>118</sup> In situations where a patient is deemed incompetent to consent to treatment but there is no immediate threat to the patient’s life, the law clearly requires doctors to identify an alternate decisionmaker. See *In re Quinlan*, 355 A.2d 647, 666 (N.J. 1976) (articulating the doctrine of substituted judgment). Although the evidentiary standards guiding surrogate decisionmakers vary from state to state, generally speaking, they are asked to render a decision that reflects the patient’s wishes. In reality, however, the line of cases involving court-ordered cesarean sections reveals that many hospitals skip this step and simply request the court’s permission to order the surgery on behalf of the fetus. See, e.g., *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) (in which the appellate court ruled that once the doctors determined that the patient was incompetent consent for surgery should have been sought from the patient’s husband). A recent British case demonstrates the power consolidated in the hands of mental health professionals in such cases. When a pregnant patient rejected her doctor’s advice that she undergo a cesarean section, a social worker was solicited, the woman was “sectioned” for assessment under the Mental Health Act, and finally she was admitted to a psychiatric hospital. Clare Dyer, *Birth of a Dilemma*, THE GUARDIAN (LONDON), Mar. 11, 1997, at 17.

<sup>119</sup> For decades, court-ordered cesarean sections were granted as a matter of course, and women were forced to undergo surgery to which they did not consent. Kolder, *supra* note 6; Nancy K. Rhoden, *Cesareans and Samaritans*, 15 LAW, MED. & HEALTH CARE 118 (1987). In the 1990s, several well-

enter these orders on an emergency basis, after a brief telephone consultation with a doctor, and without ever hearing the woman's objections.<sup>120</sup> Indeed, in most of the cases that have been litigated on this point, the women were unrepresented at the initial hearing.<sup>121</sup>

Even though several recent decisions have upheld the woman's right to refuse the surgery, there is little reason to believe that this form of maternal-doctor conflict will soon dissipate.<sup>122</sup> First, many jurisdictions around the country have yet to decide this issue, or have old case law supporting the right to compel surgery.<sup>123</sup> Second, even the decisions upholding the woman's right to refuse unwanted surgery leaves some leeway for an alter-

publicized judicial decisions rejected this practice as legally unfounded and upheld the woman's right to refuse treatment. See *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994). The practice of resorting to the law to force women to comply with medical advice emerges as particularly ironic in view of the widespread consensus that cesarean sections are over-utilized in this society. For example, the Public Citizen Health Research Group in Washington, D.C., estimates that nearly half of the one million cesareans performed every year are unnecessary. See *International Cesarean Awareness Network* (visited Aug. 1, 1998) <<http://www.childbirth.org/ICAN/icanavoid.html>>.

Although it is impossible to design a retrospective study evaluating how many of doctor-recommended cesarean sections *actually were* necessary to maternal or fetal well-being, a surprising number of cases in which women refused treatment have ended favorably for mother and baby alike. *Baby Boy Doe* provides a recent example of this. In 1993, Talitha Bricci, a competent, married pregnant woman, was informed by her doctor that, absent a cesarean section, her child's life was in danger, and mental retardation likely would result, should the child survive. When the parents refused the procedure, doctors and hospital officials contacted the state's attorneys' office, which sought custody of the fetus in order to compel the cesarean section. Included in their petition for custody was a medical expert's testimony that the fetus's chances of surviving a natural labor were close to zero. Further, any slim chance of survival would result in severe retardation. Nevertheless, the court denied the state's petition, and reaffirmed the mother's autonomy rights. See, e.g., Theodore Postel, *The Right to Refuse Medical Treatment*, CHI. DAILY L. BULL., Dec. 14, 1994, at 1, 20. Two weeks later, the mother vaginally delivered a healthy baby boy. Maureen O'Donnell, *Anti-Cesarean Parents Celebrate Boy's 1st Birthday*, CHI. SUN TIMES, Dec. 23, 1994, at 3. See *Baby Boy Doe*, 632 N.E.2d at 326. For a list of cases with similar outcomes, see Rhoden, *supra* note 118, at 118-19. See, e.g., *Hasemeier v. Smith*, 361 S.W.2d 697, 697-99 (Mo. 1962) (woman died from anesthetic given during cesarean section to remove baby physician thought was dead but was actually alive and healthy; husband brought wrongful death action).

<sup>120</sup> This certainly was the case as recently as the late 1980s. See interview with Mr. Edward Goldman, University of Michigan Medical Center Attorneys Office (July 1998). Indeed, one Chicago hospital lawyer bemoaned judges' increasing reluctance to grant these orders over the phone and recalled that in the good old days (prior to the 1993 *Bricci* ruling which upheld the woman's right to refuse treatment), they could simply call their favorite judge in the Probate Division, and the order would be issued. See Mr. E. Michael Kelly, Attorney at Hinshaw & Culbertson, Address to DePaul Law School Health Law & Policy class (Sept. 22, 1994). Similarly, Max Brown, an attorney with Rush-Presbyterian Medical Center, was quoted in the CHICAGO TRIBUNE as saying that the hospital had previously dealt with five or six cases similar to the *Bricci* case. However, he lamented, "what's unusual in this one is that the trial judge refused to order the woman to undergo a cesarean." Jan Crawford & Jean Latz Griffin, *Cesarean Poses a Dilemma for Hospitals*, CHI. TRIB., Dec 19, 1993, at C1.

<sup>121</sup> See *Finer*, *supra* note 8; *Scott*, *supra* note 105, at 617.

<sup>122</sup> See *A.C.*, 573 A.2d at 1235; *Baby Boy Doe*, 632 N.E.2d at 326, *Fetus Brown*, 689 N.E.2d 397 (Ill. 1997).

<sup>123</sup> See *Scott*, *supra* note 105, at 624-27 (describing several examples of recent cases where the court compelled women to have treatment to which they would not consent).

native outcome under “more extreme” circumstances.<sup>124</sup> Third, and most important, these conflicts typically arise at or near the time that the woman is beginning labor, when she is unlikely to be in a position to confront her doctor or to hire an advocate to assert her rights for her. In such a situation, even a hollow threat of legal intervention might be sufficient to lead the woman to capitulate to her doctor’s will. Indeed, doctors at Chicago’s Rush-Presbyterian Medical Center, interviewed at the time of the *Bricci* case, admitted that they recently had had five or six similar cases, but that the women had backed down when legal action was threatened.<sup>125</sup>

These high-drama cases illustrate the truly adversarial potential in the contemporary relationship between doctors and their pregnant patients. Yet, in the vast literature generated by this particular type of maternal-doctor conflict, no one has addressed the legitimacy of these doctors’ actions. It is critical to recognize that it is the doctor who identifies the conflict, the doctor who transforms a patient’s assertion of her right to bodily integrity and autonomy into an adversarial confrontation, and the doctor who breaches the patient’s trust and confidentiality by enlisting unrelated third parties to pressure her into submitting to surgery. From the patient’s perspective, the doctor’s shift from ally to adversary comes as a betrayal. Regardless of whether the woman ultimately succeeds in enforcing her right to refuse treatment, the breach of the trusted relationship between doctor and patient remains unaddressed. Doctors pose as fiduciaries to their pregnant patients, but pregnant women are unable to hold them accountable as such.

### *C. Doctors’ Responses to Their Pregnant Patients’ Use of Controlled Substances*

Beginning in the late 1980s, several well-publicized studies called public attention to the problems arising from pregnant women’s use of controlled substances. Specifically, this research demonstrated that the use of

<sup>124</sup> The court in *A.C.* limited the competent woman’s right to reject a cesarean section in “virtually all cases,” therefore leaving room for court intervention in extreme cases. The court also left an opening for possible intervention by future courts stating: “We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient’s wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional.” *A.C.*, 573 A.2d at 1252. Two more recent Illinois decisions upholding the pregnant woman’s right to refuse a cesarean section to “save” a full-term fetus suggest that, at least in Illinois, there may be no such thing as circumstances justifying court intervention. See *Baby Boy Doe*, 632 N.E.2d at 326; *Fetus Brown*, 689 N.E.2d at 405. Note that, after the courts refused to intervene, both of these cases resulted in successful vaginal deliveries of healthy babies.

<sup>125</sup> An obstetrician at one prestigious Chicago medical center proudly explained how he always complied with American College of Obstetricians and Gynecologists (ACOG) guidelines, which require that doctors honor the woman’s refusal of a cesarean section. See *infra* note 175 and accompanying text (regarding ACOG Committee Opinion #55). However, faced with a situation similar to the one in *Bricci*, he would “probably do the same thing that the doctors from St. Joseph Hospital did—exhaust all possible remedies to intervene.” Indeed, he acknowledged having twice brought suits to “persuade” women to have cesareans and both times the women agreed to the surgery when faced with legal action. See Crawford & Griffin, *supra* note 119.

drugs by pregnant women was widespread, and that it was linked to a number of harmful outcomes in their offspring.<sup>126</sup>

The medical community, either individually or through such representative organizations as the American Medical Association, might have responded to this information in any number of ways. They could have treated it in much the same way as they have alcohol consumption by pregnant women—that is, by viewing it as more of a social problem than a health problem, and doing little more than occasionally counseling pregnant patients against using drugs. Given that there is far more damning evidence regarding the long-term negative consequences for the offspring of pregnant women who consume alcohol, as opposed to illicit drugs, such a response would have been entirely reasonable.<sup>127</sup> Alternatively, because they had reason to know of the shortages in drug treatment programs for pregnant women (given that a majority of facilities simply refuse to admit most pregnant addicts), the medical community might have mounted a proactive campaign to demand that pregnant women be given priority access to drug treatment.<sup>128</sup> They might have decided that the outpouring of public con-

<sup>126</sup> See Ira J. Chasnoff et al., *Cocaine Use in Pregnancy*, 313 *NEW ENG. J. MED.* 566 (1985); see also Michelle D. Mills, Comment, *Fetal Abuse Prosecutions: The Triumph of Reaction Over Reason*, 47 *DEPAUL L. REV.* 989 (1998) (summarizing recent studies on substance abuse during pregnancy). Of course, none of this information should have been surprising, because studies from earlier decades documented the harms arising out of heroin use and alcohol by pregnant women. See, e.g., C. A. Abrams, *Cytogenetic Risks to the Offspring of Pregnant Addicts*, 2 *ADDICTIVE DISEASES* 63 (1975); J. F. Connaughton, *Health Care for Pregnant Addicts*, 1 *AUSTRALASIA NURSES J.* 18 (1972); A. F. Ghodse et al., *The Effect of Maternal Narcotic Addiction on the Newborn Infant*, 7 *PSYCHOL. MED.* 667 (1977); K. L. Jones & D. W. Smith, *Fetal Alcohol Syndrome Experience with 41 Patients*, 235 *JAMA* 1458-60 (1976); K. L. Jones & D. W. Smith, *Recognition of the Fetal Alcohol Syndrome in Early Infancy*, 2 *LANCET* 999-1001 (1973).

<sup>127</sup> One group of researchers recently decried the over-emphasis on prenatal cocaine use and consequent de-emphasis on alcohol use. "Public health interventions should aim to forestall alcohol and tobacco use during pregnancy in all racial and ethnic groups. Much popular and political concern has focused on illicit drug use during pregnancy, especially the use of 'crack' cocaine." William Vega et al., *Prevalence and Magnitude of Prenatal Substance Exposures in California*, 329 *NEW ENG. J. MED.* 850-54 (1993). Unlike alcohol, the teratogenicity of which is so clearly established that there is no longer any reasonable debate about its causal relationship to mental retardation, there is considerable academic controversy surrounding the extent to which bad birth outcomes may be attributed to maternal cocaine use. The newest studies on maternal cocaine use indicate that "exposure to cocaine does not, in and of itself, adversely affect childhood development . . . former cocaine babies are demonstrably slow to develop intellectually but that has more to do with their economic disadvantage than any drug use by their mothers." Robin Blummer, *The Myth of the Cocaine Babies*, *ST. PETERSBURG (FLA.) TIMES*, Dec. 7, 1997, at 6D.

<sup>128</sup> See Michelle Oberman, *Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs*, 43 *HASTINGS L.J.* 505, 516 (1992) (detailing various reasons why clinics have excluded pregnant women, the primary reason being fear of liability). See also ROBERTS, *supra* note 7, at 187-94. "Most treatment centers either refuse to treat pregnant women or are effectively closed to them because they are ill-equipped to meet the needs of pregnant addicts." *Id.* at 188. Some groups have protested the exclusion of pregnant women from drug treatment centers as a violation of human rights. For example, in 1993, the New York Court of Appeals declared invalid a hospital policy barring all pregnant women from detoxification programs without a showing of medical necessity. The court found that such a policy violated the New York Human Rights Law. See *Elaine W. v. Joint Dis-*

cern regarding harm to fetuses from drugs signaled the public's readiness to take action on the myriad issues, including drug use, that impair fetal and newborn well-being in this country. Toward this end, doctors might have sought to increase public awareness of the factors underlying the inflated U.S. infant mortality rate, including limited access to prenatal care, poor nutrition and unhealthy environment and living conditions.<sup>129</sup>

To a small extent, doctors' actual responses to the heightened awareness of substance abuse by pregnant women included all of the above.<sup>130</sup> A second type of response, however, constituted a radical departure from the trust that had formerly marked the doctor-patient relationship: some doctors forged an alliance with criminal justice authorities in order to detect and punish their patients who used drugs.

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eases N. Gen. Hosp., 613 N.E.2d 523 (N.Y. 1993). See also *Suit Seeks Drug Treatment for Pregnant Women*, N.Y. TIMES, Dec. 10, 1998, at 62.

<sup>129</sup> The most recent studies on prenatal cocaine use suggest that it is these factors, rather than the drug itself, which combine to indelibly affect the child's cognitive ability. "These findings suggest that the culprit in slowed development is not one single factor such as prenatal exposure to cocaine but all of the deleterious effects associated with poverty." Susan FitzGerald, *Crack Baby's Fears May Have Been Overstated: Children of Cocaine-Abusing Mothers Are No Worse Off than Others in Urban Poverty, Study Says*, WASH. POST, Sept. 16, 1997, at 10. In fact, one of the leading scholars in this field, Dr. Ira Chasnoff, recently reported his latest findings in the *New York Academy Annals of Science*. *Id.* His long-term study, tracking 100 drug exposed children, from birth to the present, challenges the notion that cocaine significantly impairs IQ. He thus refutes the earlier theories posited by scientists (himself included) and concludes that the single best predictor of children's cognitive development was their home environment. See Jeremy Manier, *Addiction Shadows Crack-Exposed Kids*, CHI. TRIB., July 12, 1998, at 12. Note, however, that Chasnoff's study does find that cocaine-exposed children exhibit some behavioral problems. *Id.*

<sup>130</sup> For example, official medical sounding boards, such as the Journal of the American Medical Association and the American Academy of Pediatrics, criticized the punitive approach to the problem of prenatal substance abuse. They noted the deleterious effect that prosecutions would have on public health in general, and the health of substance-abusing women and their offspring, in particular. Such considerations led the American Medical Association Board of Trustees to oppose criminal sanctions for a pregnant woman's harmful behavior towards her fetus and to urge, instead, that pregnant substance abusers be provided with proper rehabilitative treatment attuned to their specific psychological and physiological needs. American Medical Association, Board of Trustees, *Legal Intervention During Pregnancy: Court Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2670 (1990). Similarly the American Academy of Pediatrics warned, "[p]unitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health." American Academy of Pediatrics Committee on Substance Abuse, *Drug-Exposed Infants*, 86 PEDIATRICS 639, 641 (1990). Many state medical associations similarly decried the move towards prosecution. The California Medical Association [CMA], for example, in condemning the arrests of pregnant addicts, found criminal charges to be both discriminatory and inappropriate. The CMA expressed grave concern that such a policy would ultimately cause greater harm to both mother and fetus by discouraging women from seeking prenatal care or from providing health care workers with accurate information. See Jeffrey B. Phelan, *The Maternal Abdominal Wall: A Fortress Against Fetal Health Care?*, 65 S. CAL. L. REV. 461, 475 (1991). Other public experts opposing prosecution include the American Nurses Association, American Public Health Association, American Society of Addiction Medicine, and many others. See Michelle Mills, Comment, *Fetal Abuse Prosecutions*, 47 DEPAUL L. REV. 989, 998 & n.71 (1998).

Over the course of the past decade, there have been numerous prosecutions of pregnant women under laws governing drug use and transmission.<sup>131</sup> Many authors have written about the policy issues raised by the punitive responses to substance abuse by pregnant women.<sup>132</sup> Virtually all of these articles conclude that there is little legitimate legal precedent upholding the punishment of this population, and that policy reasons militate against this punitive response.<sup>133</sup> To date, however, little or no attention has been paid to the role doctors play in identifying these women and offering them up to the criminal justice system.

A brief review of several cases reveals the profound breach of trust afoot in many of these cases. For instance, the case of *Wisconsin ex rel. Angela M.W. v. Kruzicki* involved a pregnant woman whose obstetrician suspected that she was using drugs.<sup>134</sup> Over the course of several months in which Angela scheduled and attended her prenatal appointments, her doctor surreptitiously tested her for drugs. After three months of positive drug tests, her doctor confronted her with the results of the tests and demanded that she seek treatment. A month later, at her next prenatal appointment, her doctor again tested her without her consent. The test was positive, and the doctor again confronted her with the results. When Angela failed to keep her next appointment, the doctor reported his "concerns" to the Waukesha County authorities, who filed a "Motion to Take an Unborn Child into Custody." By order of the Waukesha County Juvenile Court, she was thereafter confined to an inpatient drug facility.<sup>135</sup>

A similar pattern of behavior was demonstrated by the health care workers involved in the case of Jennifer Johnson.<sup>136</sup> In this case, in an effort to obtain help for her addiction, Ms. Johnson confided to her doctor and

<sup>131</sup> Since the early 1980s, more than 200 women in over thirty jurisdictions have been prosecuted for ingesting drugs while pregnant. Lynn Smith, *Punish or Protect?*, L.A. TIMES, Sept. 3, 1996, at E1.

<sup>132</sup> See, e.g., Nancy J. Bennett, *Drug Exposed Newborns: Alternatives to Punitive Sanction of the Mother—A Coordinated Response*, 24 J. HEALTH & HOSP. L. 182 (1991); Stephen R. Kandall & Wendy Chavkin, *Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women*, 43 HASTINGS L.J. 615 (1992); Nancy K. Schiff, Note, *Legislation Punishing Drug Use During Pregnancy: Attack on Women's Rights in the Name of Fetal Protection*, 19 HASTINGS CONST. L.Q. 197 (1991); Derk B.K. VanRaale IV, Note, *Punitive Policies: Constitutional Hazards of Non-Consensual Testing of Women for Prenatal Drug Use*, 5 HEALTH MATRIX 443 (1995).

<sup>133</sup> See, e.g., Bennett, *supra* note 131; Schiff, *supra* note 131. But see Charles Molony Condon, *Clinton's Cocaine Babies, Why Won't the Administration Let Us Save Our Children?*, 72 POL'Y REV. 12 (1995).

<sup>134</sup> 561 N.W.2d 729, 732 (Wis. 1997).

<sup>135</sup> See *id.* at 732-33. Ultimately, the Wisconsin Supreme Court vindicated Angela's rights by holding that the CHIPS statute did not grant the state jurisdiction over fetuses. See *id.* at 740. This decision did not come soon enough to prevent Angela from being detained for the final month of her pregnancy, during which time her baby was born.

<sup>136</sup> This case was the first in the nation to reach a state supreme court. The Florida Supreme Court overturned the lower courts' convictions of Ms. Johnson, noting that the transmission to minors statute never was intended to apply to transfers via the umbilical cord. *Johnson v. State*, 602 So. 2d 1288 (Fla. 1992), *quashing Johnson v. State*, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991).

a series of health care providers that she was addicted to cocaine. In stark contrast to the dictates of doctor-patient confidentiality in the fiduciary relationship, Johnson's doctor elected to file a report with state child protection authorities on behalf of the fetus, and he provided the most damaging evidence against her at trial. Indeed, when Johnson was charged with delivering a controlled substance to a minor, the doctor's testimony regarding blood traveling through the umbilical cord to the fetus in the moments immediately after birth became the centerpiece of the prosecution's drug delivery case.<sup>137</sup> Others who divulged information that Johnson had confided in them included a child-protection investigator and an ambulance driver. In sum, the entire case against Johnson was predicated upon information that she, of her own accord, shared with health care workers in the hope of helping her children.<sup>138</sup>

Perhaps the most notorious example of breach of fiduciary duty in the context of prenatal substance abuse involves the Medical College of South Carolina, where doctors and criminal justice authorities worked together to design a protocol that entailed the surreptitious nonconsensual testing of patients seeking prenatal care, combined with threats of criminal prosecution for those who, after testing positive, failed to comply with a drug treatment protocol. During the first few months of the program, women who tested positively were immediately arrested. Of the resulting forty-two arrests, forty-one involved African-American patients. In some instances, patients were arrested within days, or even hours, of giving birth. Patients were dragged from hospitals and homes in leg shackles and handcuffs, some still bleeding. In one instance, a woman was handcuffed to her bed during the entire course of her delivery.<sup>139</sup>

In a sense, doctors' exasperation with pregnant patients who use drugs is understandable. As is the case with all addicts, they tend to have sporadic and inconsistent behavior, they appear to be irresponsible, and, of course, they are unable to control their cravings for a substance that is threatening not only their own well-being, but also that of their fetus.<sup>140</sup> However, an additional subtext in these cases is that, like society in general,

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<sup>137</sup> According to Professor Dorothy Roberts, assistant state's attorney Jeff Deen built his case of drug delivery through the testimony of the obstetricians who attended the births of Carl and Jessica, Drs. Randy Tompkins and Mitchell Perlstein. "Dr. Tompkins, who delivered Jessica, testified that even after delivery 'maternally altered' blood circulates between the placenta and the baby through the still-attached umbilical cord." ROBERTS, *supra* note 7, at 163. Tompkins added that once Jessica was delivered from the birth canal she was a person and no longer a fetus, even though the umbilical cord was still attached. Perlstein, who delivered Carl, testified to similar facts with respect to Carl's birth. *See id.*

<sup>138</sup> *See* ROBERTS, *supra* note 7, at 162-64.

<sup>139</sup> *See id.* at 166.

<sup>140</sup> *See generally*, Oberman, *supra* note 127, at 512-14 (discussing the self-esteem problems of drug addicted women).

doctors tend to associate this problem with poor women of color.<sup>141</sup> That is, despite statistics indicating that prenatal substance abuse occurs at similar rates across racial lines, doctors are far more likely to suspect, test, and report women of color for using illicit drugs during pregnancy.<sup>142</sup> Perhaps race is the factor that accounts for the formerly unimaginable responses of some doctors to these patients in crisis: testing a patient without her consent, threatening her with criminal action if she fails to follow his advice, and ultimately violating her trust by informing criminal justice authorities of her drug use. As Professor Dorothy Roberts has so powerfully demonstrated, the notion of violating the civil rights of a pregnant woman of color comes almost as second nature in a society that long has regarded this population and their offspring as public property.<sup>143</sup>

Obviously, the surreptitious drug testing and reporting of pregnant women represents only a small part of what pregnant women have been subjected to in the name of protecting their fetuses. Given that arrest and incarceration represent a far greater violation of rights than a surreptitious drug test, it is no wonder that the litigation and the academic literature dealing with such incidents focuses far more on the actions of law enforcement authorities than on the actions taken by doctors with regard to their patients. This does not mean that these doctors' actions are permissible. Indeed, under basic tort principles, a doctor who tests a patient without her consent, and then notifies public authorities of the test results, has both committed a battery and violated the duty of confidentiality.<sup>144</sup> It is equally clear that, while holding himself out to the patient as a fiduciary, the doctor has forsaken the trusted nature of the fiduciary relationship and has abandoned his obligations of loyalty to the patient who sought his care.

#### IV. REMEDYING THE BREACH OF FIDUCIARY DUTY

The foregoing illustrations of maternal-doctor conflict each involve doctors who breach the fiduciary duty owed to their pregnant patients. They do so with impunity. Indeed, the entire "two-patient" model of modern obstetrical medical practice tacitly concedes this breach of duty by in-

<sup>141</sup> See ROBERTS, *supra* note 7, at 172; Ira J. Chasnoff et al., *The Prevalence of Illicit—Drug [sic] or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202 (1990).

<sup>142</sup> See Chasnoff et al., *supra* note 141, at 1202.

<sup>143</sup> See ROBERTS, *supra* note 7; Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1480 (1991); Dorothy E. Roberts, *Unshackling Black Motherhood*, 9 MICH. L. REV. 938 (1997).

<sup>144</sup> See *supra* note 49. See also Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990) (physician's unauthorized use of patient's cells to develop commercial cancer treatment gave rise to cause of action for lack of informed consent); Harnish v. Children's Hosp. Med. Ctr., 439 N.E.2d 240 (Mass. 1982) (physician's failure to advise patient of possible complications to cosmetic surgery constituted professional misconduct); Shadrick v. Coker, 963 S.W.2d 726 (Tenn. 1998) (doctor's implantation of experimental screws in spine without patient's consent constituted fraudulent concealment).

sinuating the notion of divided loyalties into the doctor-patient relationship. Current law poses both practical and legal obstacles to a pregnant woman's ability to hold her doctor accountable for the breach of fiduciary duty. This Part describes these obstacles and then suggests two mechanisms designed to secure to pregnant women the same quality of fiduciary loyalty that physicians accord all of their other patients.

*A. The Lawsuit: Pregnant Women's Claims Against Doctors for Breach of Fiduciary Duty*

The first step in articulating a legal claim for the breach of fiduciary duty requires that the plaintiff establish the nature of the doctor's duty toward her. In the context of prenatal care, as in the context of any doctor-patient relationship, the doctor owes the patient a duty of loyalty.<sup>145</sup> As in any tort-based lawsuit, to the extent that the doctor has breached that duty, with resultant harm to the patient, the patient should be permitted to recover damages. As described in the earlier discussion of patient autonomy, the doctor's fiduciary duty to his patients is rooted in, yet broader than, the obligation to abide by a patient's refusal of care. The patient has a right not only to be free from unwanted touching, but also to rely upon her doctor as a fiduciary—as “the advocate and champion of his patient, upholding the patient's interest *above all others*.”<sup>146</sup>

Maternal-doctor conflicts encompass a broad set of actions, some of which plainly are actionable under current medical malpractice doctrine. For example, a patient who was subjected to nonconsensual testing or treatment might sue her doctor for actions such as battery, failure to obtain informed consent, and breach of confidentiality. Yet, many maternal-doctor conflicts never rise to the level of these torts, because doctors succeed, through repeated emotional appeals and threats of legal intervention, in extorting a consent to treatment from the pregnant patient.

Establishing the breach of a fiduciary duty is relatively easy if the patient can demonstrate that the doctor's actions constituted malpractice. Indeed, many malpractice claimants also assert claims for breach of fiduciary duty.<sup>147</sup> Technically speaking, though, in the case of many maternal-doctor

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<sup>145</sup> See *supra* notes 40-47 and accompanying text (regarding duty of loyalty). Recent case law holds that the common law duty of loyalty binds even those who provide health care under the ERISA law, and thus enjoy preemption from state law tort claims. See, e.g., *Shea v. Esensten*, 107 F.3d 625, 628 (8th Cir. 1997) (“ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members.”).

<sup>146</sup> AD HOC COMM. ON MED. ETHICS, *supra* note 19 (emphasis added). See also COUNCIL ON ETHICAL AND JUD. AFF., *supra* note 19 (noting that conflicts between a patient and her physician ought to be resolved to the patient's benefit, owing to the “physician's role as a fiduciary, *i.e.*, a person who, by his undertaking, has a duty to act primarily for another's benefit”).

<sup>147</sup> Research indicates, however, that these claims seldom provide independent grounds of recovery. See Rodwin, *supra* note 16, at 242 (concluding that “the law holds doctors accountable as fiduciaries only in restricted situations”).

conflicts, it may not be "malpractice" for the doctor to have adopted the fetus as a second patient and attempted to coerce the pregnant woman into accepting the doctor's treatment of choice. In fact, such actions on the doctor's part may be standard operating procedure or, at the very least, sufficiently commonplace that a court could not classify them as a violation of the standard of care.

Thus, a central problem for those who would redress the harms perpetrated by doctors who impose their will upon their pregnant patients is that of articulating a remedy in cases that do not also involve medical malpractice. It is clear that there are harms that exist independently of medical malpractice. The pregnant patient sought care from the doctor, placing her health and life in his hands, and relied upon the doctor to honor her, "upholding her interests *above all others*."<sup>148</sup> In generating a conflict between himself and the patient, and attempting to impose a specific course of action on his patient for the ostensible benefit of the fetus, the doctor betrayed the patient's trust. This betrayal is a breach of fiduciary duty, for which the patient should be permitted to recover, regardless of whether it constitutes an independent tort, such as a battery.

There are several obstacles to positing an independent claim for the breach of fiduciary duty. First, the actions constituting breach of fiduciary duty are ill-defined, potentially encompassing behavior ranging from "counseling" to outright threats. Given this lack of clear boundaries, physicians might with reason claim that the threat of liability conflicts with their obligation to counsel patients regarding the preferred course of treatment. This obligation is integral to the practice of medicine and, indeed, legally mandated by the law of informed consent, and doctors might therefore argue that no liability should be imposed.<sup>149</sup> The response to this argument is that, insofar as doctors clearly articulate the range of possible courses of action, noting all of the risks and benefits to the patient as well as to the fetus, the doctor will have honored his fiduciary duty without subjecting himself to any risk of liability for breach. However, the moment the doctor crosses the line into coercion by attempting to persuade the patient to accept an undesired course of action for the benefit of the fetus and threatening her with legal consequences should she refuse, the doctor breaches his fiduciary duty. If the line between counseling and coercion is unclear, it certainly is no more unclear than the line between standard medical practice and negligence. The tort system long has entrusted juries with the difficult task of identifying whether and when a doctor has breached his duty to his patient. There is no reason to believe juries will be any less adept at assessing claims for breach of fiduciary duty than they are at evaluating other tort claims.

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<sup>148</sup> AD HOC COMM. ON MED. ETHICS, *supra* note 19 (emphasis added).

<sup>149</sup> The law of informed consent requires doctors to indicate a preferred course of action, noting potential risks and benefits inherent in that course of action, and listing alternatives. See Miller, *supra* note 18, at 2100-01.

A second, more powerful barrier to recovery in a lawsuit for breach of fiduciary duty following a maternal-doctor conflict grows out of the limited extent to which the law holds doctors accountable as fiduciaries. As noted earlier, although doctors readily embrace the fiduciary label, the law has been slow to hold them accountable as such.<sup>150</sup> Thus, a plaintiff suing her doctor for breach of fiduciary duty likely will face a stiffer evidentiary burden than she would in a nonmedical context.

In nonmedical contexts, plaintiffs suing for breach of fiduciary *need not* show that they were harmed as a result of the breach.<sup>151</sup> Rather, as Rodwin indicates in his careful discussion of fiduciary liability, "When a behavior is questionable, courts require fiduciaries to prove that they have not violated trust," thus facilitating the plaintiff's case by shifting the burden of proof to fiduciaries, who must show that their conduct did not violate *broad fiduciary standards*.<sup>152</sup>

These standards simply do not exist for doctors. Again, Rodwin notes that "[m]alpractice law—which holds physicians responsible for their negligence—only adumbrates fiduciary standards. It focuses on technical clinical competence."<sup>153</sup> Rodwin identifies various groups, such as state licensing boards or hospitals or medical associations, that could establish competency standards for doctors as fiduciaries, but, as he explains, each of these groups has been reluctant to enter this regulatory territory.<sup>154</sup> As a result, the patient's suit against her doctor for breach of fiduciary duty likely will parallel an ordinary tort suit, in which the patient must demonstrate that she was harmed by her doctor's breach of duty.

Establishing harm resulting from breach of fiduciary duty will be challenging because, unlike the typical medical malpractice case, which generally results in tangible, readily quantified injuries, the harm caused by a breach of fiduciary duty is less tangible and more dignitary in nature. This is particularly true if there is no accompanying tort, such as a battery. In such a case, the woman's ability to recover will depend upon her lawyer's success in convincing the jury of the gravity of an intangible harm. This harm occurs when, well into a patient-doctor relationship, a doctor suddenly determines that his opinion of what constitutes the fetus's best interests is not only more important than its mother's opinion, but also more important than his duties toward its mother, his patient.

The success of this complaint may well depend upon the ultimate outcome of the maternal-doctor conflict itself. In other words, recovery is likely in a case like Angela Carder's, in which the doctors sought and obtained judicial permission to perform a cesarean section against the patient's

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<sup>150</sup> See *supra* notes 30, 35-39 and accompanying text.

<sup>151</sup> See Rodwin, *supra* note 16, at 249.

<sup>152</sup> *Id.* at 251.

<sup>153</sup> *Id.* at 249.

<sup>154</sup> See *id.* at 249-51.

wishes, but succeeded only in accelerating the patient's demise and delivering a still-born fetus.<sup>155</sup> Recovery is less likely, however, in cases involving women who used illicit drugs during pregnancy and whose doctors either threatened them, or actually followed through with reporting them to criminal justice authorities. The harms at issue in such cases may be shocking: healthy babies are torn from their mothers and often from their communities. In some cases, mothers who are fully capable of parenting lose custody of their children for months, or even years, as the criminal justice or child protection system slowly processes their cases.<sup>156</sup> Nonetheless, given the stigma of illicit drug use, the disproportional likelihood that the plaintiff will be a poor woman of color, and the racism that shapes society's response to substance abuse by this population, juries are unlikely to be terribly sympathetic to a mother's claim that her doctor violated his duty of loyalty to her.<sup>157</sup> The same is true for the woman who sues following a coerced cesarean section that has produced a healthy baby. Juries likely will be unwilling to second-guess a doctor whose actions, though aggressive, may have salvaged the life of a child and its mother.

This problem hints at a broader set of shortcomings inherent in litigation as a remedy for the breach of fiduciary duty. As is virtually always the case with litigation on behalf of plaintiffs injured in the health care setting, the success of any given case depends upon finding a lawyer willing to take the case on a contingency fee basis. Because of the challenges inherent in demonstrating the harm caused in these cases, prospective plaintiffs are unlikely to find attorneys unless they have injuries that are readily identifiable to juries. Thus, the majority of maternal-doctor conflicts—those that involve divided loyalties, improper coercion, and perhaps a breach of confidentiality, but not necessarily battery or failure to obtain an informed consent, will be unattractive to most plaintiffs' lawyers.

This is all the more true because of the fact that the standard remedy for the breach of fiduciary duty is an injunction, rather than monetary damages.<sup>158</sup> Thus, the plaintiff will have the additional burden of persuading the court that a doctor's breach of his fiduciary duty to his patient is unlike most cases involving the breach of fiduciary duty, and that injunctive relief is inadequate to make this plaintiff whole.

The lack of access to lawyers leads to the final, and perhaps most important shortcoming of litigating a solution to the widespread incidence of maternal-doctor conflict: lawsuits are unlikely to bring about systemic

<sup>155</sup> After Angela's death, the family sued for three million dollars and the hospital settled for an undisclosed amount. *In re A.C.*, 573 A.2d 1235 (D.C. 1990). Cf. Crawford & Griffin, *supra* note 119 (discussing Chicago-area hospital attorney's views on lawsuits to force cesarean sections).

<sup>156</sup> ROBERTS, *supra* note 7, at 159-62.

<sup>157</sup> Many scholars have commented on the racially discriminatory patterns of testing and reporting of pregnant women for substance abuse. See Chasnoff et al., *supra* note 141, at 1202 (finding that black women are disproportionately reported); Oberman, *supra* note 127, at 510.

<sup>158</sup> Cf. Frankel, *supra* note 17, at 823, 828.

change. In the event that the plaintiff has a powerful case for recovery, as was seen in the case of Angela Carder, doctors will settle. This private settlement is unlikely to yield a broad fiduciary standard against which the conduct of other doctors might be measured in the future. It will not cause other doctors practicing in the jurisdiction, let alone doctors around the country, to rethink the manner in which they betray the trust of their pregnant patients by claiming the right to adopt their fetuses as "patients" and to dictate care to the woman.<sup>159</sup>

Addressing the breach of fiduciary duty on a case-by-case basis gives doctors carte blanche to hold themselves out to their pregnant patients as "fiduciaries," without any intention of honoring the obligations that this role carries with it. Women only will realize the costly price of losing their doctor's loyalty when it is too late. By the time this moment arrives, women, pregnant and either demoralized or scrambling to find a lawyer to protect their rights to refuse treatment, are in no position to challenge the doctor for having breached his fiduciary duty to her. Therefore, maternal-doctor conflict must be redressed through alternative mechanisms beyond simply encouraging litigation for the breach of fiduciary duty.

### *B. Professional Guidelines as Regulatory Mechanisms*

Professional societies play an integral role in setting guidelines for optimal professional and ethical medical practice. Although technically non-binding, these guidelines establish a profession's collective vision of appropriate care and thus serve as a tacit indictment of practices that significantly diverge from these standards.<sup>160</sup> These guidelines range from practice standards, which are promulgated and published by professional societies and govern a wide range of clinical situations, to ethical guidelines.<sup>161</sup>

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<sup>159</sup> Indeed, the only scenario under which such settlements are likely to bring about a change in medical practice is if they become sufficiently commonplace and costly that insurance companies begin to balk when forced to make these payments on behalf of the doctors they insure. In this event, insurance companies themselves could begin to pressure doctors to refrain from imposing unwanted treatment upon pregnant women, by practices such as declining to cover liability incurred in this manner, or even inserting into their insurance contracts exclusionary clauses that preclude reimbursement for liability incurred in this manner. Results from utilization review mechanisms created by insurance companies to evaluate cost-effectiveness may also bring about a change in the way doctors impose treatment. See Suzanne Seaman, *Putting the Brakes on Drive-Through Deliveries*, 135 J. CONTEMP. HEALTH L. & POL'Y 497, 500 (1997). Many thanks to Professor Katharine Baker for her insight on this issue.

<sup>160</sup> For a thorough and enlightening discussion of the role of professional guidelines in shaping physician behavior, see David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583 (1994).

<sup>161</sup> For example, the American Academy of Pediatrics has set schedules for childhood vaccinations. See *id.* at 598, citing COMM. ON INFECTIOUS DISEASES, AM. ACAD. OF PEDIATRICS, REPORT OF THE COMM. ON INFECTIOUS DISEASES, 5-60 (21st ed. 1988). The National Institutes of Health also has developed guidelines on numerous practice parameters, including cesarean sections. See Orentlicher, *supra* note 159, at 598, citing Jacqueline Kosecoff et al., *Effects of the National Institutes of Health Consensus Development Program on Physician Practice*, 258 JAMA 2708 (1987).

Perhaps the largest and best known of the professional standard-setting bodies is the AMA's Council on Ethical and Judicial Affairs. The Council is comprised of members who serve single seven-year terms (with the exception of student and resident members, who serve two- and three-year terms, respectively). Council guidelines are promulgated in the AMA's *Code of Ethics*, which addresses issues ranging from appropriate consent prior to HIV testing to financial conflicts of interest.<sup>162</sup> Physicians who violate the AMA's *Code of Ethics* are subject to discipline by the AMA, and by their county and state medical societies.<sup>163</sup> Additionally, some states have expressly incorporated the *Code of Ethics* into their Medical Practice Acts, thus rendering violations of these ethical guidelines grounds for official discipline.<sup>164</sup> Other state licensing boards tend to regard the guidelines as probative evidence of the expected standard of ethical conduct, and they refer to the guidelines when determining whether a physician has committed professional misconduct.<sup>165</sup>

Given the weight attributed to these professional guidelines, it is clear that the promulgation of a policy condemning legal interventions against pregnant women would serve to ratify and perhaps to strengthen the autonomy rights of pregnant women. Although the *Code of Ethics* lacks a specific provision dealing with the compulsory treatment of pregnant women, its provision governing informed consent strongly supports patient autonomy. Rule 8.08 provides:

The patient should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient . . . and to make recommendations for management in accordance with good medical practice . . . . Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.<sup>166</sup>

The rule lists only two narrow exceptions to the obligation to obtain informed consent, neither of which is pertinent to the compulsory treatment of pregnant women.<sup>167</sup>

In addition to the informed consent provision in the *Code of Ethics*, in 1990 the AMA's Board of Trustees issued an official policy statement op-

<sup>162</sup> See Orentlicher, *supra* note 159, at 589 (citing CODE OF ETHICS, *supra* note 60, at § 8.08); Council on Ethical and Jud. Aff., Am. Med. Ass'n, *Gifts to Physicians from Industry*, 265 JAMA 501 (1991).

<sup>163</sup> See Orentlicher, *supra* note 159, at 592.

<sup>164</sup> See *id.* (citing OHIO REV. CODE ANN. § 4731.22(b)(18) (West 1999)).

<sup>165</sup> See *id.* For a detailed discussion of the impact of practice guidelines on judicial determinations of medical standards of care, see John C. West, *The Legal Implications of Medical Practice Guidelines*, 27 J. HEALTH & HOSP. L. 97 (1994).

<sup>166</sup> CODE OF ETHICS, *supra* note 60.

<sup>167</sup> See *id.* The code cites the conventional exceptions of emergency situations, in which the patient is incapable of consenting and harm from non-treatment is imminent, and the doctrine of "therapeutic privilege," wherein risk-disclosure poses so serious a threat as to be medically contraindicated. *Id.*

posing court-ordered medical treatments for pregnant women.<sup>168</sup> The statement declares, "Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus . . . . The physician's duty is to provide appropriate information . . . not to dictate the woman's decision."<sup>169</sup> Furthermore, the policy tacitly condemns interventions against pregnant substance abusers by concluding that criminal and civil sanctions against pregnant substance abusers are "inappropriate," and that such patients should be "provided with rehabilitative treatment appropriate to their specific . . . needs."<sup>170</sup>

This statement reflects official AMA policy; however, because it is not part of the *Code of Ethics*, it does not carry with it an enforcement mechanism. Moreover, the full statement is somewhat equivocal on the subject of the permissibility of legal intervention in the "exceptional circumstance," and it stops short of condemning interventions "[i]n which a medical treatment poses an insignificant or no health risk for the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus . . . ."<sup>171</sup>

By legitimizing interventions in hypothetical "exceptional" cases, the AMA policy loses some of the force that it otherwise might have carried as an official declaration of the impermissibility of compulsory treatment of pregnant women. The optimal professional guideline for protecting pregnant women from coercive medical treatment would be a clear rule banning all such interventions, issued by the AMA's Council on Ethical and Judicial Affairs and promulgated in the *Code of Ethics*. However, as Dr. Stephen Latham, the former head of the Council staff, notes, the current climate with regard to abortion in the AMA House of Delegates is so politically charged that it would be difficult to pass a specific policy governing these interventions.<sup>172</sup> Nonetheless, it is critical to note that the practice of compelling pregnant women to undergo treatment runs so contrary to the broad language of the ethical guidelines on informed consent that a specific provision on pregnancy should be superfluous.<sup>173</sup>

The American College of Obstetricians and Gynecologists (ACOG) has a process for setting professional guidelines that is similar to that of the

<sup>168</sup> House of Delegates, Am. Med. Ass'n, Policy No. H-420.969, *Legal Interventions During Pregnancy* (1998). See *Legal Interventions During Pregnancy*, 264 JAMA 2663 (1990), for a full discussion of this policy.

<sup>169</sup> House of Delegates, Am. Med. Ass'n, Policy No. H-420.969, *Legal Interventions During Pregnancy* (1998).

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> See interview with Steve Latham, former director, Ethics Division, American Medical Association, in Chicago, Ill. (Jan. 12, 1999).

<sup>173</sup> See CODE OF ETHICS, *supra* note 60.

AMA.<sup>174</sup> Although ACOG guidelines lack an enforcement mechanism, they nonetheless may serve as probative evidence of the expected standard of ethical conduct to be utilized in determining whether a physician has committed professional misconduct.<sup>175</sup> In October 1987, the Committee on Ethics promulgated Committee Opinion #55, entitled *Patient Choice: Maternal Fetal Conflict*. The ACOG guideline is, in large part, similar to that of the AMA. After exploring a variety of potential conflicts and explaining that they are rare because "the vast majority of pregnant women are willing to assume significant risk for the welfare of the fetus," the opinion concludes:

Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman. The use of judicial authority to implement treatment regimens in order to protect the fetus violates the pregnant woman's autonomy. Furthermore, inappropriate reliance on judicial authority may lead to undesirable societal consequences, such as the criminalization of noncompliance with medical recommendations.<sup>176</sup>

The ACOG opinion expands upon the AMA guideline in two interesting respects. First, in addition to providing a theoretical justification for deferring to maternal preferences, it offers the more pragmatic explanation of the potential for "undesirable societal consequences." In the opinion's main text, the Committee notes that court orders have a "destructive effect" on the "physician-patient relationship."<sup>177</sup> Secondly, the ACOG opinion suggests an alternative dispute resolution mechanism, namely "[c]onsultation with others, including an institutional ethics committee," as a preferable alternative to recourse to the judicial system.<sup>178</sup> Nonetheless, the ACOG opinion, like that of the AMA, stops short of condemning the use of judicial authority altogether, stating instead that "[t]he use of the courts to resolve these conflicts is *almost never warranted*."<sup>179</sup>

In addition to its position on "maternal-fetal conflict," ACOG and the American Academy of Pediatrics have promulgated guidelines regarding the issue of substance abuse during pregnancy. These guidelines are supportive of pregnant women's autonomy in concluding that "[u]niversal neonatal screening for illicit drugs is not recommended" and stressing the need for counseling and

<sup>174</sup> ACOG issues Committee Opinions, drafted by specialized sub-committees of its membership. These opinions are "intended to provide timely information on controversial issues, ethical concerns, and emerging approaches to clinical management." AM. ACAD. OF PEDIATRICS & AM. C. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE (3d ed.1992).

<sup>175</sup> See Orentlicher, *supra* note 159.

<sup>176</sup> Committee on Ethics, Am. College of Obstetricians and Gynecologists, Comm. Opinion No. 55, *Patient Choice: Maternal-Fetal Conflict* (Oct. 1987).

<sup>177</sup> See *id.*

<sup>178</sup> See *id.*

<sup>179</sup> *Id.* (emphasis added).

support of pregnant addicts.<sup>180</sup> The guidelines do, however, leave open the possibility of periodic, nonconsensual testing for cocaine metabolites, and they omit any mention of the extent to which such test results should remain confidential.<sup>181</sup> As such, they grant tacit approval to the ongoing practices of selective testing and discriminatory treatment of poor women of color, who are disproportionately suspected of drug use by their doctors.<sup>182</sup>

By providing an official condemnation of the practices inherent in generating maternal-doctor conflicts, professional guidelines may be part of a solution to this problem. Yet, even if there were explicit professional guidelines rejecting the compulsory treatment of pregnant women, they only would be effective to the extent that they became incorporated into standard medical practice. As Professor Orentlicher concludes, this does not necessarily happen automatically: "The medical profession's experience with standard-setting suggests [that] . . . professional regulation can have a substantial impact on physician behavior, but professional guidelines alone are generally insufficient to change physician behavior. The guidelines must be combined with other measures to ensure compliance."<sup>183</sup>

Professor Orentlicher notes that ethics and practice guidelines may be more readily adopted by physicians when they provide clear rules with a "credible threat of enforcement from outside of the profession," and when "violations [can] . . . be detected with relative ease."<sup>184</sup> Given the absence of external pressures, coupled with the general reluctance of physicians to police their colleagues' behavior and the poor funding of professional disciplinary boards, the mere issuance of guidelines seldom will suffice to change physician behavior.<sup>185</sup>

There are several additional reasons to fear that maternal-doctor conflicts will continue to proliferate even if professional organizations such as the AMA and ACOG issued specific guidelines mandating deference to the

<sup>180</sup> *Id.* at 225.

<sup>181</sup> *See id.* at 230 ("To reinforce and encourage continued abstinence, periodic urine testing for metabolites of cocaine may be desirable in a pregnant woman admitting to cocaine use prior to or during pregnancy. The requirement for consent may vary from state to state.").

<sup>182</sup> *See supra* notes 139-41 and accompanying text.

<sup>183</sup> Orentlicher, *supra* note 159, at 591. *See also*, Jonathan Lomas et al., *Do Practice Guidelines Guide Practice?*, 321 NEW ENG. J. MED. 1306 (1989) (discussing the gap between reported physician agreement with and actual conformance to guidelines concerning cesarean sections).

<sup>184</sup> Orentlicher, *supra* note 159, at 596, 598. Orentlicher analyzes the AMA's gift-giving guidelines as an example. In the 1980s, the U.S. Senate Labor and Human Resources Committee determined that drug companies' "gifts" to physicians had evolved from pens and coffee mugs to all-expenses-paid resort vacations for physicians and their spouses. In response to the Committee report, the AMA issued guidelines explicitly prohibiting the most egregious gift-giving practices. Major pharmaceutical companies adopted similar guidelines. Bolstered by the widespread industry support, by the fact that physicians understood the rules and could easily observe and report violations, and by a fear of further government intervention if the problem was not checked, the guidelines curtailed the offending practices almost immediately. *See id.* at 592-97.

<sup>185</sup> *See id.* at 604. *See also* Lomas et al., *supra* note 182, at 1310.

autonomous treatment preferences of pregnant patients. First, physicians perceive these conflicts as ethical, rather than clinical, in nature—that is, they perceive them as informed and bounded by personal, subjective prerogatives, rather than by objective, scientific criteria. Doctors are therefore more likely to trust their own judgment in resolving such conflicts than to adopt the suggestions of national experts.<sup>186</sup> Second, these conflicts arise in a private context, and because of the power dynamic between the parties, they seldom escalate to the point of necessitating external, let alone legal, intervention.<sup>187</sup> Thus, physicians who coerce their pregnant patients into following their treatment preferences have little reason to fear detection by their professional colleagues. Finally, even if a physician were exposed as having attempted to pressure a pregnant woman into a given course of action, there is virtually no credible threat of professional censure following from such behavior.

Thus, there is little reason to hope that professional guidelines alone, or even in conjunction with a threat of litigation for the breach of fiduciary duty, will be sufficient to remedy the persistent medical undermining of pregnant women's autonomy rights. As such, it is important to discuss a third mechanism designed to protect pregnant women from doctors seeking to assert the right to impose unwanted treatment upon them.

### *C. Fair Warning to Pregnant Patients: Informed Consent and the Two-Patient Model*

Physicians who claim, in spite of the absence of legal support, that the fetuses carried by their pregnant patients are, in fact, their "second patients," must nonetheless recognize that the pregnant woman has an undeniable right to know that her doctor feels this way.<sup>188</sup> This right is vested in the fiduciary duty that physicians owe to patients, whereby the law requires that "the provider transmit to the patient the information necessary to enable her to maximize her own welfare."<sup>189</sup> Indeed, this duty extends beyond the mere obligation to disclose information, because due to the power dispari-

<sup>186</sup> See Orentlicher, *supra* note 159, at 603.

<sup>187</sup> See *supra* notes 143-57 and accompanying text.

<sup>188</sup> My thanks to Professor Annette Clark for helping to elucidate the application of fiduciary law to this particular scenario.

<sup>189</sup> Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 391 (1990). Mehlman also notes that this duty may be vested in contract law:

A person's non-disclosure of a fact known to him is equivalent to an assertion that the fact does not exist . . . where he knows that disclosure of the fact would correct a mistake of the other party as to a basic assumption on which that party is making the contract and if non-disclosure of the fact amounts to a failure to act in good faith and in accordance with reasonable standards of fair dealing.

*Id.* at 385, n.61, citing the RESTATEMENT (SECOND) OF CONTRACTS § 161 (1981).

ties between the parties, "the patient has the right to expect total candor from the provider."<sup>190</sup>

Ample case law supports the notion that providing a patient with the opportunity for informed consent includes acknowledging the possibility of the patient obtaining care from another provider "when the first provider lacks sufficient skill or expertise to render reasonable care."<sup>191</sup> Clearly, the reasoning underlying this precedent—that the patient should be aware of a choice of doctors if the present doctor is *unable* to perform certain medical duties—would extend to situations in which a doctor is *unwilling* to perform certain medical duties or obligations.<sup>192</sup>

Thus, it is a breach of informed consent, and of fiduciary duty in general, when a physician fails to disclose to his pregnant patient his personal belief, first, that he owes an independent obligation to the fetus and, second, that to the extent that he perceives the fetus to be imperiled by the pregnant woman's conduct, he intends to use all powers available to him to impose upon her whatever course of action he deems appropriate. It is legally and ethically abhorrent that doctors who operate on a "two-patient" model presently neither inform their pregnant patients of their attitudes toward maternal autonomy nor seek the women's permission to treat their fetuses as "patients." This disclosure should be made during the first prenatal visit, as part of the initial informed consent, which generally includes a discussion of the doctor's philosophy regarding the treatment of pregnancy. The doctor should be required to explain the sorts of circumstances in which he would intervene and attempt to override a woman's preferences, and he

<sup>190</sup> *Id.* at 393. See also *id.* at 385, n.61, citing *Emmett v. Eastern Dispensary & Cas. Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967) ("court finds in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know"). See also *Shea v. Esensten*, 107 F.3d, 625, 628 (8th Cir. 1997), citing *Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750 (D.C. Cir. 1990) ("duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA").

<sup>191</sup> *Mehlman*, *supra* note 188, at 383, n.58, citing *Haley v. United States*, 739 F.2d 1502 (10th Cir. 1984) (physician liable for failing to suggest referral to gastroenterologist). See also *Buck v. United States*, 433 F. Supp. 896 (D. Fla. 1977) (physician liable, *inter alia*, for failing to recommend that snake bite victim consult specialist); *Moore v. Preventive Medicine Med. Group, Inc.*, 223 Cal. Rptr. 859 (Ct. App. 1986) (medical group liable for failing to disclose information necessary to allow patient to decide whether to see specialist).

<sup>192</sup> The law governing patient abandonment provides a wealth of useful precedent for this point. Doctors are not obligated to treat, nor need they perform any procedures that violate their personal beliefs, but they may not abandon their patients, and must make a referral to an alternate provider. As one court noted:

Once a physician enters into a professional relationship with a patient, he is not at liberty to terminate that relationship at will. That relationship will continue until it is ended by one of the following circumstances: (1) the patient's lack of need for further care; or (2) the withdrawing physician being replaced by an equally qualified physician. Withdrawal from the case under any other circumstances constitutes a wrongful abandonment of the patient, and if the patient suffers any injury as a proximate result of such wrongful abandonment, the physician is liable for it.

*Ascher v. Gutierrez*, 533 F.2d 1235 (D.C. Cir. 1976) (emphasis omitted).

should advise the woman that she is free to choose other doctors who are more supportive of a pregnant woman's autonomy.

Such a discussion would serve several useful purposes. It would provide advance notice to pregnant patients, so that those who are uncomfortable with a potentially adversarial relationship would have time to discontinue treatment with this doctor and find a doctor who is willing to treat her with the same respect for autonomy accorded by law to all patients. It is critical to note, however, that in today's health-care environment, most women's choices are somewhat constrained. Even well-insured women often have only a short list of providers from whom they may choose, and poor women's options for care are still more limited.<sup>193</sup> Thus, just because her doctor discloses his belief that he has the right to impose his preferred course of treatment upon a pregnant patient, against her will, does not necessarily mean that the pregnant woman will be able to secure care from another doctor.

Even if the woman's choice of provider is constrained and she is unable to switch doctors, there are secondary benefits to forcing doctors to inform their pregnant patients of their positions on "maternal autonomy." First, the pregnant patient is in a much better position to challenge the legitimacy of her doctor's practices if she learns about them early in her pregnancy, prior to the onset of an actual conflict. If she learns about them late in the pregnancy, factors such as being in labor or hesitation about jeopardizing a longstanding doctor-patient relationship may constrain her ability to assert her rights.<sup>194</sup>

Second, this approach cannot help but disabuse pregnant patients (and their doctors) of the notion that their doctor is automatically their ally—their fiduciary. This restructuring of the doctor-patient relationship may, in turn, bring about several changes. It may force doctors to reexamine their values and decide to check their impulses to impose treatment upon pregnant women; it may bring about the recognition that such values and impulses can be the outgrowth of misogynistic notions that pregnant women are somehow less than fully competent. Similarly, by allowing women a chance to "vote with their feet," this fair warning system may help generate a market for women-friendly doctors, thus rewarding those doctors who recognize and abide by their fiduciary obligations.

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<sup>193</sup> See Michelle Oberman & Margie Schaps, *Women's Health and Managed Care*, 65 TENN. L. REV. 555 (1998). Indeed, many poor women have no relationship with a doctor at all during their pregnancy, and see the doctor for the first time when they enter a hospital to deliver their baby. Thus, the solution that I propose would be less feasible for these women, particularly if their labor is very far advanced. However, even for the population of women receiving little or no prenatal care, one could imagine a Miranda-style warning being offered by a doctor who intended to see the fetus as his patient. In response, the woman could either request another doctor, or request to be transferred to another hospital.

<sup>194</sup> For example, if the discussion occurs at their first meeting, she might demand that her insurance plan provide her with another physician, or threaten to report the doctor to a medical society for violating ethical guidelines. See *supra* notes 164-80 and accompanying text for a discussion of the relevant ethical guidelines mandating respect for patient autonomy.

Finally, this approach would help foster open communication from the start of the relationship between doctors and their pregnant patients. One might object to the fair warning requirement on the grounds that doctors may not know that they will feel inclined to override a pregnant woman's will until they are actually faced with a situation where such inclinations come to the fore, at which point they will perceive themselves as acting out of an ethical imperative. Not only is the "ethical imperative" at work in such "crises" unfounded, but these situations arise with sufficient regularity that all obstetricians should be on notice, and should engage, *ex ante*, in the soul-searching process necessary to determine their own preferences. Furthermore, anecdotal evidence suggests that many doctors know full well that they tend to disfavor maternal autonomy. In Chicago, for example, there are a small handful of individual physicians and hospitals who are responsible for the vast majority of recent cases involving attempted court-ordered treatment of pregnant women.<sup>195</sup>

Obviously, there are serious flaws with proposing that maternal-doctor conflicts can be mediated via informed consent. Most important among these is the fact that such an approach suggests to doctors that they can assert a "right" to take actions that I have demonstrated to be ethically and legally indefensible. However, the advantage of this approach is that it is well grounded in current law. In the health-care context, the law of informed consent, unlike the law of fiduciary duty, is well established and breaches are easily remedied. A plaintiff might rather easily show that her doctor had a duty to tell her that he was adopting the fetus as a patient and that, in the event of a disagreement about the course of treatment, the doctor would attempt to force his preferences upon her. She would then argue that, had she known her doctor would behave in such a manner, she never would have continued her relationship with him. Thus, the doctor's failure to inform her of his practice "philosophy" deprived her of her autonomy rights, and as a result she suffered damages. In the short run, it may be easier for pregnant patients to secure the right to this sort of "Miranda-style" warning than it will be for them to vindicate their broader rights to a fiduciary relationship with their physician.

## V. CONCLUSION

This Article has proposed a radical reformulation of conflicts occurring between doctors and pregnant women in the health care setting. Rather than permitting doctors to identify and structure these conflicts as arising between pregnant women and their fetuses, this Article exposes doctors' central role in generating and escalating these conflicts. By viewing the doctors' actions through the lens of fiduciary duty doctrine, this Article also

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<sup>195</sup> See interview with Susan Wishnick, attorney with the ACLU of Illinois Reproductive Freedom Project (July 1998) (noting the extraordinary workload generated for her office, which defends the rights of the women involved in these cases, by one local physician, Dr. James Meserow).

demonstrates that these actions are neither legally nor ethically permissible. Finally, this Article suggests three legal mechanisms by which pregnant women might vindicate their rights to be treated like all other competent patients in the health care setting.

Regardless of whether women begin to bring such lawsuits in large numbers, there is critical progress inherent in the relabeling of what has, to date, mistakenly been called "maternal-fetal" conflict. By insisting that doctors be held accountable for subordinating the autonomy of their pregnant patients, the medical profession as a whole will be forced to account for, and to justify, the fact that certain doctors believe it is appropriate to ignore and undermine the rights of certain pregnant women. At the very least, this will create the conditions necessary for a meaningful discussion of, if not a resolution to, the continual stream of cases involving maternal-doctor conflict.

