THE SOUND OF SILENCE: WOMEN'S VOICES IN MEDICINE AND LAW

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PROLOGUE[1]

Once upon a time, there was a young girl named Angela Stoner. Her friends and family called her Angie. When she was thirteen, she was diagnosed with a rare form of cancer in her left leg and had to undergo radiation and chemotherapy. The treatments made her sick and she lost her hair. The doctors had told her she was going to die; instead she survived. She eventually graduated from high school and took a job as a receptionist.

Angie fell in love with Rick Carder when she was twenty. They moved in together a year later. One day, Angie felt a familiar pain in her left leg. She had a feeling the cancer was back and she was right. This time it was called osteogenic sarcoma and had grown into her hip. The doctors amputated her left leg and half of her pelvis. Angie felt sure that this was finally the end of the cancer. She had beat it.

Angie and Rick married a few years later. They had a special dance they liked to do together: Rick would hop around on the dance floor, spinning her around in her wheelchair. Other people were bothered when they did this in dance clubs, but at their wedding no one seemed to mind and they danced all night. It was the happiest day of Angie's life. She became Angela Carder.

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[1]This story was culled from a variety of sources with somewhat differing versions. *See generally* In re A.C., 573 A.2d 1235 (D.C. App. 1990) (en banc) [hereinafter "A.C. II"]; In re A.C., 533 A.2d 611 (D.C. App. 1987) [hereinafter "A.C. I"]; Brief of Amici Curiae, NOW LDEF *et al.*, in Support of the Appellant, In re A.C. (No. 87-609); Leslie Espinoza, Dissecting Women, Dissecting Law: The Court-Ordering of Caesarean Section Operations and the Failure of Informed Consent to Protect Women of Color, 13 Nat'l Black L.J. 211 (1994); Jennifer Beulah Lew, Comment, Terminally Ill and Pregnant: State Denial of a Woman's Rights to Refuse a Cesarean Section, 38 Buff. L. Rev. 619 (1990); David Remnick, Whose Life is it, Anyway?, Wash. Post, Feb. 21, 1988 (Magazine), at W14.

Soon after they married, Angie and Rick decided they wanted to start a family. Angie's doctor said it would be okay, as long as she received regular prenatal care and entered the high-risk pregnancy clinic at George Washington University Medical Center (GWUMC). Angie got pregnant; she and Rick were thrilled. But their happiness did not last long.

Angie began to have trouble breathing when she was about twenty-five weeks pregnant. Her oncologists thought it was just some fluid on her lung, but Angie knew better. She told her mother, Nettie, that it was the same old familiar ache. "I've had it before, and I know what it is." Sure enough, two days later, the doctors realized the ache in her lungs was not caused by fluid but by a tumor. Angie was not surprised when they suggested she check into the hospital. As usual, she followed their recommendations.

The doctors were shocked when they realized how large the tumor was. Her long-time oncologist from the National Institutes of Health, Dr. Jeffrey Moscow, recommended that Angie receive experimental chemotherapy or "a really big blast" of radiation. He and his colleagues thought this treatment would ease her pain and pose less threat to Angie's fetus than if the tumor were left untreated. Moreover, if Angie could live until her fetus had gestated twenty-eight weeks, a cesarean could be performed to deliver it with a better chance of survival. Her own chances of survival at that point were declining.

Dr. Moscow discussed his treatment proposal with Angie's obstetrician-gynecologists at GWUMC so that they could begin administering the treatment as soon as possible. He did not have admitting privileges at GWUMC, so he depended upon her doctors there to discuss procedures and begin treatment. Four days later, Dr. Moscow learned that the GWUMC physicians had not begun treatment and that the tumor had grown. Angie's options were growing more and more limited, but Dr. Moscow still recommended the chemotherapy and radiation. When the proposal was finally presented to Angie, she agreed to it, even though she knew the treatment itself might harm her fetus. Angie also stressed, as she always did, that her comfort and care should be of the highest importance. She didn't want to be in pain. Neither Dr. Moscow nor Angie's doctors at GWUMC mentioned to Angie the possibility of a cesarean section to remove her fetus at this point, when it was only twenty-six weeks old.

The next day, Angie's condition grew worse. The staff at GWUMC made a decision not to start the treatment as planned as they figured she would die within a matter of days. Instead, the hospital's legal counsel decided to ask a court what it should do to save Angie's fetus. The hospital's lawyer thought a cesarean should be performed, despite the fact that it had not been discussed with Angie and the hospital's obstetric's department would not agree to perform the procedure. Dr. Moscow was not consulted about the reversal of his treatment plan, nor was he informed of, or invited to, the hastily assembled "court" hearing held at the hospital later that day. The hearing was a blur: questions, tears, testimony, angry voices...and finally a court order to perform the cesarean. When the doctors went to tell Angie of the court's decision, at first she agreed. One half-hour later, however, she revoked her consent, stating, "I don't want it done. I don't want it done." The surgery was performed anyway.

Angie's baby girl weighed 1.7 pounds and had fingers the size of matchsticks. Her lungs were so underdeveloped the doctors could not even ventilate them artificially. Lindsay Marie Carder died in her father's arms less than three hours after being forcibly extracted from her mother's womb, against her mother's will. Angie cried when they told her. She died two days later, and mother and daughter were buried in the same casket. Angela Carder, a spirited, vibrant, loving woman, suddenly became immortalized simply as "A.C."

I. INTRODUCTION

This story is not the same one you are likely to hear from the judges, the doctors, or the lawyers involved in the Angela Carder case. It might be close to the one Nettie Stoner tells, but it probably is not the one Rick Carder would tell. Dan Stoner, Angie's father, would simply tell you a story about how a judge killed his daughter. The two opinions issued by the D.C. Court of Appeals tell a story that tries to avoid criticizing the trial judge's conduct in the hospital hearing. Why are there so many versions of Angela Carder's story? Perhaps because she never got to tell her side of it.

This article aims to provide Angela Carder's missing voice. Throughout the extended proceedings in this case, the trial and appeals court judges insisted that they could not determine exactly what Angie would have wanted had she been able to decide for herself.[2] They took the easy way out. If they had really listened, they would have heard a dying woman begging to be allowed to die with her baby. They would have seen that she was able to make the decision, and the decision was to refuse the surgery. Like so many judges faced with the question whether to force a pregnant woman to undergo medical treatment to which she has not

[2] A.C. II, 573 A.2d at 1239-40, 1243, 1247; A.C. I, 533 A.2d at 612.

consented, the judges in Angie's case selectively listened to the many voices advocating varying viewpoints. In the end, they heard only those voices which pointed away from allowing Angie to die peacefully and take her under-developed fetus with her. In the end, they ignored the only voice that should have mattered.

The two opinions issued by the D.C. Court of Appeals could not appear more different on their faces. In A.C. I, the three judge panel affirmed trial judge Emmet Sullivan's order that Angela Carder undergo a cesarean.[3] The court, in a footnote, dismissed the fact that the death rate of healthy women giving birth by cesarean is significantly higher than that of women giving birth vaginally, and stated that the effect of cesarean surgery on "otherwise normal patients" would be temporary.[4]

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[3]A.C. I, 533 A.2d at 617.

[4]A.C. I., 533 A.2d at 617, 617 n.5. In fact, maternal morbidity is anywhere from three to thirty times greater for cesarean births than for vaginal deliveries. Espinoza, *supra* note 1 at 223; Janet Gallagher, Prenatal Invasions and Interventions: What's Wrong with Fetal Rights, 10 Harv. Women's L.J. 9, 50 n.211 (1987). Furthermore, women who have had cesarean sections describe deep and long-lasting emotional and physical effects. *Id.* Michelle Harrison describes the surgery as follows:

> The surgeon takes a scalpel from the nurse and with one strong and definite motion creates a crescent-shaped incision along the woman's pubic hairline. As the skin is cut, the subcutaneous tissue bulges upward as though it had been straining to get through all the time. Within moments this fatty tissue, interconnected by thin transparent fibers, becomes dotted and then covered with blood that oozes out of tiny vessels. With scalpel and forceps—delicate tweezers—the surgeon cuts deeper beneath the subcutaneous tissue, to a thick layer of fibrous tissue that holds the abdominal organs and muscles of the abdominal wall in place. Once reached, this fibrous layer is incised and cut along the lines of the original surface incision while the muscles adhering to this tissue are scraped off and pushed out of the way. The uterus is now visible under the peritoneum, a layer of thin tissue, looking like Saran Wrap, which covers most of the internal organs and which, when inflamed, produces peritonitis. The peritoneum is lifted away from the uterus and an incision is made in it, leaving the uterus and bladder easily accessible. The bladder is peeled away from the uterus, for the baby will be taken out through an incision in the uterus underneath where the bladder usually lies...
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> The uterus of the pregnant woman is large, smooth and glistening. Shaped like a huge pear, the top and sides are thick and muscular, the lower end thin and flexible...
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> The obstetrician extends the initial cut either by putting two index fingers into the small incisions and ripping the uterus open or by using blunt-ended scissors and cutting in two directions away from the initial incision. If the membranes are still intact, they are now punctured by toothed forceps, and the fluid spills out onto the table. In the normal position, the baby's head is down and under the incision, so the obstetrician places one hand inside the uterus, under the baby's head, and with the other hand exerts pressure on the upper end of the uterus to

The court also acknowledged that its decision may very well have hastened Angie's death.[5] Despite well-settled legal principles protecting a person's right to bodily integrity, including the right to refuse medical treatment, the court weighed Angie's interest in refusing major invasive surgery which could cause her death against the potential life of her arguably viable fetus.[6] It found that Angie's interest was not significant because she was going to die anyway, and therefore the fetus should be

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> push the baby through the abdominal incision. The assistant also uses force now to help push the baby out...
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> The rest of the surgery is more difficult for the woman. There is more pain and women often vomit and complain of difficult breathing as we handle their organs and repair the damage...
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> The placenta separates from or is peeled off the inside of the uterus. Then, since the uterine attachments are all at the lower end, near the cervix, the body of the uterus can be brought out of the abdominal cavity and rested on the outside of the woman's abdomen, thus adding both visibility and room in which to work.
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> With large circular needles and thick thread a combination of running and individual stitches is used to sew closed the hole in the uterus. A drug called pitocin is added to the woman's IV to help the uterus contract and to decrease the bleeding. Small sutures are used to tie and retie bleeding blood vessels. The "gutters," spaces in the abdominal cavity, are cleared of blood and fluid. The uterus is then placed back in the abdominal cavity. The bladder is sewn back onto the surface of the uterus, and then finally the peritoneum is closed. Now sponges are counted to be sure none have been left inside the abdominal cavity, and then the closure of the abdominal wall begins.
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> Muscles overlying the peritoneum are pushed back in place, and are sometimes sewn with loose stitches. Fascia, the thick fibrous layer, is the most important one, since it holds all the abdominal organs inside and keeps them from coming through the incision, especially if the woman coughs or sneezes. Therefore the layer is closed with heavy thread and many individual stitches so that, even if a thread breaks, the stitches won't all come out. The subcutaneous tissue, most of which is fat, is closed in loose stitches that mainly close any air spaces which might become sites for infection. Skin, the final layer, is closed with either silk or nylon thread or metal staples...
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> A dry bandage is placed over the woman's incision and then taped to her skin. The drapes are removed. A baby has been born.

Gallagher, *supra* note 4, at 36 n.137 (quoting Michelle Harrison, A Woman In Residence 81-84 (1982)). It is thus difficult to understand how the A.C. I court could conclude that the effects of a cesarean are "temporary."

[5] A.C. I, 533 A.2d at 613-14.

[6] *Id.* at 615-17.

given the chance to survive.[7] In effect, as Nettie Stoner says, a trade was made: Angie's life for the life of her fetus.[8]

When the full appeals court heard the case again the next year, this time with the benefit of briefs and oral arguments, it came to a radically different conclusion.[9] While the court did not overturn any of Judge Sullivan's findings of fact as clearly erroneous, it held that he and the appeals court were wrong to use a balancing test.[10] The court questioned whether a fetus could even have rights superior to those of someone who was already born.[11] In language that has been lauded by activists for reproductive rights and feminists generally, the court held that

> it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section...[i]ndeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will.[12]

Though too late for Angela Carder, the D.C. Appeals Court appeared to vindicate the future right of pregnant women to determine the course of their own medical treatment, even if that includes refusing treatment recommended for the benefit of their fetus.[13]

Both Court of Appeals opinions generated a flurry of law review articles and continue to receive attention from authors, academics, doctors, and journalists.[14] Feminists condemn A.C. I and applaud A.C. II.[15] An

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[7] *Id.* at 617.

[8] Cynthia Gorney, Whose Body is It, Anyway? The Legal Maelstrom that Rages When the Rights of Mother and Fetus Collide, Wash. Post, Dec. 13, 1988, at D1.

[9] A.C. II, 573 A.2d at 1237.

[10] *Id.* at 1247.

[11] *Id.* at 1244.

[12] *Id.* at 1252.

[13] *Id.*

[14] *See, e.g.*, Marcia Mobilia Boumil, Law, Ethics And Reproductive Choice (1994); Janna C. Merrick, Caring for the Fetus to Protect the Born Child? Ethical and Legal Dilemmas in Coerced Obstetrical Intervention, in Janna C. Merrick & Robert H. Blank, eds., The Politics Of Pregnancy: Policy Dilemmas In The Maternal-Fetal Relationship 63-81 (1993); George J. Annas, She's Going to Die: The Case of Angela C., 18 Hastings Ctr. Rep. 23 (1988); Espinoza, *supra* note 1; Rebekah R. Arch, Comment, The Maternal-Fetal Rights Dilemma: Honoring a Woman's Choice of Medical Care During Pregnancy, 12 J. Contemp. Health L. & Pol'y 637 (1996); Lew, *supra* note 1; Douglas B. Snyder,

appeals court in Illinois relied heavily on A.C. II in upholding a pregnant woman's refusal to consent to a cesarean section delivery.[16] Almost universally, A.C. II is viewed as a giant step forward in the fight to protect women's rights to reproductive freedom and to refuse unwanted invasive medical procedures.[17] In addition, after the court's A.C. II opinion was released, GWUMC settled a three million dollar medical malpractice lawsuit filed by Angie's parents.[18] The hospital paid the Stoners an undisclosed amount of money and established guidelines for dealing with similar situations in the future.[19] These guidelines, written with the help of the American Civil Liberties Union, state that a pregnant woman has the right to refuse medical treatment for herself and her fetus and may appoint someone else to make decisions on her behalf in the event she is unable to do so.[20] The general consensus appears to be that the D.C. Appeals Court got it right on the second try.

While it is true that as a legal precedent A.C. II strongly supports a pregnant woman's right to refuse unwanted medical treatment, I suggest that the opinion itself is not as progressive as it appears at first glance. Despite their vastly different results, the two appeals court opinions share one significant similarity: both conclude that it was not possible to determine Angela Carder's intent from the trial record.[21] Its general respect for a woman's decision aside, the A.C. II opinion gives no more credence to Angela Carder's voice than did the trial judge or the first appeals court opinion. Through the structure of its analysis, the court avoided facing

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Note, Mother v. Fetus—the Case of "Do or Die": In re A.C., 5 J. Contemp. Health l. & Pol'y 319 (1989). *See also* Amy Goldstein, When Cancer and Pregnancy Coincide, Ethical Dilemmas Arise, Wash. Post, March 14, 1995, at B1; The Right to Say No, St. Louis Post-Dispatch, Feb. 16, 1991, at 2B.

[15]*See, e.g.*, Susan Faludi, Backlash: The Undeclared War Against American Women 432-37 (1990).

[16]In re Baby Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994).

[17]*See* sources cited *supra* note 14.

[18]Karen Goldberg, GWU Hospital Settlement Seen Helping Pregnant Women's Rights, Wash. Times, Nov. 29, 1990, at B3.

[19]*Id.*

[20]*Id.* However, the guidelines do leave open the possibility that in certain circumstances, the hospital may still seek a court order to force a woman to receive treatment. It is not clear whether these circumstances would have to be of the truly extraordinary and compelling nature the A.C. II court discussed in its opinion. *See* Espinoza, *supra* note 1 at 229.

[21]A.C. II, 573 A.2d at 1247; A.C. I, 533 A.2d at 613.

what the record shows to be true: Angie was competent to make a decision and she did not consent to a cesarean section.[22]

Part II of this article argues that women's voices often are not heard or are ignored by the medical profession. This fact becomes particularly important when a woman makes a medical treatment decision contrary to her doctor's recommendation, and the doctor then seeks a court order to override her wishes. Because judges typically give more weight to the doctor's opinion than the woman's, her decision is dismissed. Part II concludes that stereotypes about women, both as patients and in general, pervade the medical profession and the courts, and lead to the devaluation and suppression of women's voices in these arenas.

Part III explores the suppression of Angela Carder's voice by the court in its second opinion. It argues that the court gave effect only to testimony which supported the trial court's findings, and overlooked testimony which would require it to find that the trial judge's findings of fact regarding what Angie wanted were clearly erroneous. Part III concludes that based on the record before it, the court could have found Angie competent to make her own decision, and should have based its reversal on the fact that the trial judge's findings regarding her wishes were clearly erroneous. Failure to do so suggests that despite its legal vindication of women's rights, the court's opinion perpetuates the suppression of women's voices in medicine and law.

II. WOMEN'S VOICES IN MEDICINE AND LAW

Women's voices are heard in medicine and law as long as they say what society wants to hear.[23] That is, the woman is heard as long as her voice indicates her intent to get pregnant, carry the pregnancy to term, give birth, and nurture her child.[24] The woman's voice must also manifest her willingness to submit to authority, follow doctors' orders, and, if necessary, sacrifice her health for that of her fetus.[25] If the voice begins to waiver, to suggest that the woman would rather avoid invasive and potentially

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[22] A.C. II, 573 A.2d at 1240-41.

[23] *See* Lisa C. Ikemoto, Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women, 59 Tenn. L. Rev. 487, 495 (1992) [hereinafter Furthering the Inquiry].

[24] *See* Reva Siegel, Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection, 44 Stan. L. Rev. 261, 293 (1992).

[25] Ikemoto, Furthering the Inquiry, *supra* note 23 at 511.

dangerous medical procedures recommended to benefit her fetus, it is devalued and silenced—first by doctors, and then by a judge.[26]

A. Court-Ordered Obstetrical Interventions

The story of Angela Carder is not, unfortunately, an unusual one. The forced treatment of pregnant women was documented in a 1987 study conducted by Veronika E.B. Kolder, M.D., Janet Gallagher, J.D., and Michael T. Parsons, M.D.[27] The study surveyed obstetricians at hospitals in 45 states to obtain information about court-ordered obstetrical interventions when pregnant women refused to consent to treatment deemed necessary for their fetuses.[28] The results published in the New England Journal of Medicine revealed the following disturbing statistics: hospitals in 18 states reported 36 attempts to override a pregnant woman's refusal during the prior five years.[29] Hospitals in six other states noted that they knew of other hospitals which had successfully overridden a woman's decision.[30] Fifteen of these court orders were sought to compel the woman to undergo a cesarean section.[31] In all but one state, the order was granted.[32]

Even more troubling than the mere fact of these court orders is the disproportionate impact on poor women and women of color.[33] Of the 15 cases where an order was sought to compel a woman to have a cesarean section, 80% involved women of color: 47% involved black Americans, 33% involved African or Asian, and only 3% involved white Americans.[34] Twenty-seven percent did not speak English as their primary language.[35]

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[26] *Id.* at 514.

[27] Veronika E.B. Kolder, Janet Gallagher, & Michael T. Parsons, Court-Ordered Obstetrical Interventions, 316 New Eng. J. Med. 1192 (1987).

[28] *Id.* at 1192.

[29] *Id.*

[30] *Id.*

[31] *Id.* at 1193.

[32] *Id.* at 1192-93.

[33] *Id.* at 1195.

[34] *Id.* at 1193.

[35] *Id.*

All 15 of these women received treatment at teaching-hospital clinics or were receiving public assistance.[36]

Kolder and her colleagues also asked obstetricians for their opinions about forcing non-consenting women to receive treatment considered necessary for their fetuses.[37] Forty-six percent believe that women who refuse recommended treatment, thereby endangering the lives of their fetuses, should be detained in the hospital to ensure compliance.[38] Forty-seven percent believe that legal precedent ordering women to undergo cesareans should be extended to other forms of treatment necessary for fetal health, such as intrauterine transfusions and other medically standard procedures.[39] Twenty-six percent believe that women should be under surveillance by the state during the third trimester if they do not seek prenatal care in hospitals.[40] From this data and other data they gathered, the researchers concluded that only 24% of the respondents consistently upheld a competent pregnant woman's right to refuse medical advice.[41]

The increase in court-ordered obstetrical interventions has important implications for pregnant women. These cases open the possibility that pregnant women's lives could be increasingly monitored to ensure proper diet, exercise, and sexual activity.[42] The types of work they are allowed to do could be restricted, and they could be required to undergo fetal surgery as it becomes more routine.[43] Gradually, they could become mere

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[36] *Id.* at 1195.

[37] *Id.* at 1193-94.

[38] *Id.* at 1193.

[39] *Id.*

[40] *Id.* at 1193-94.

[41] *Id.* at 1194. Kolder and her colleagues point out that in no case was the woman found to be incompetent by a psychiatrist. An investigation of competency was made in just three of the 20 cases they reported; all three women were found to be competent. *Id.* at 1195.

[42] *See* Robert H. Blank, Reproductive Technology: Pregnant Women, the Fetus, and the Courts, in Merrick & Blank, *supra* note 14, at 12; George J. Annas, Pregnant Women as Fetal Containers, 16 Hastings Ctr. Rep. 13, 14 (1986) [hereinafter Fetal Containers]; Gallagher, *supra* note 4, at 44- 46; Dawn E. Johnsen, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 Yale L.J. 599, 608 (1986).

[43] *See* Rachel Roth, At Women's Expense: The Costs of Fetal Rights, in Merrick & Blank, *supra* note 14 at 119; Gallagher, *supra* note 4, at 42.

containers for the potential lives inside of them.[44] An increase in court intervention could also deter some pregnant women from seeking prenatal care, because they may fear that their decisions will not be honored.[45] The doctor-patient relationship could be compromised: will doctors be required to violate confidentiality codes to report maternal refusals of treatment? In their attempts to ensure healthy births, doctors and courts have laid the foundation for further restriction on the rights of women and for more women to avoid prenatal care. The Kolder study is a statistical representation of a greater problem for women: the devaluation and suppression of their voices by the medical profession and the courts.

There would be no need for debate over the forced treatment of pregnant women if those in the medical and legal profession simply respected a pregnant woman's decision to refuse medical treatment the same way they would respect a similar decision by a non-pregnant individual. There is no longer any question whether competent adults have the right to refuse unwanted medical treatment, even if it is necessary to save their lives.[46] Courts consistently uphold such decisions, even those that may appear to be medically irrational, reasoning that constitutional and common law rights to bodily integrity, privacy, and self-determination may not be overridden absent a compelling state interest.[47] Moreover, the American Medical Association and the American College of Obstetricians and Gynecologists have stated that respecting patient autonomy is one of the most important principles of medical ethics, and that a physician rarely would be justified in seeking a court order to override a pregnant woman's decision to refuse treatment.[48] Lastly, even the bodily integrity and privacy rights of cadavers are protected: organs may not be harvested from a dead

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[44]*See* Cynthia R. Daniels, At Women's Expense: State Power And The Politics Of Fetal Rights 28 (1993); Wendy Chavkin, Woman and Fetus: The Social Construction of Conflict, in Merrick & Blank, *supra* note 14, at 199; Annas, Fetal Containers, *supra* note 42, at 14.

[45]*See* Merrick, in Merrick & Blank, *supra* note 14, at 72; Gallagher, *supra* note 4, at 45.

[46]*See, e.g.*, Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 278-79 (1989); Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 633-34 (Mass. 1986); Matter of Conroy, 486 A.2d 1209, 1222 (N.J. 1985); Lane v. Candura, 376 N.E.2d 1232, 1236 (Mass. App. Ct. 1978); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 425-26 (Mass. 1977); In re Quinlan, 355 A.2d 647, 663 (N.J. 1976).

[47]Courts consider four potentially compelling state interests in medical treatment refusal cases: the preservation of life, the prevention of suicide, the protection of innocent third parties, and maintaining the ethical integrity of the medical profession. *See, e.g.*, Saikewicz, 370 N.E.2d at 425; In re Baby Boy Doe, 632 N.E.2d 326, 334-35 (1994); A.C. II, 573 A.2d 1235, 1246-47 (D.C. App. 1990).

[48]*See* Boumil, *supra* note 14, at 65; Daniels, *supra* note 44, at 50-52.

body unless the deceased consented during his or her lifetime.[49] Yet, with few exceptions, when a pregnant woman makes a decision that appears medically irrational, *i.e.*, refuses treatment deemed necessary for her fetus, doctors have been quick to seek court intervention and courts have been equally quick to order treatment.[50]

B. Assumptions and Presumptions

Two assumptions are implicit in these cases.[51] The first is that if a pregnant woman refuses to consent to treatment necessary for her fetus, she is either irrational or incompetent because a "normal" woman would subordinate her own interests to those of her fetus.[52] The second is that doctors, as highly educated and experienced professionals, are presumptively rational and know what is best.[53] Unfortunately, most of the court-ordered obstetrical intervention cases are unreported. However, through accounts of unreported cases and the language courts have used in the few published opinions, it is possible to highlight how these assumptions result in the suppression of women's voices by the medical profession and, in turn, by the law.[54]

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[49] *See* Daniels, *supra* note 44, at 33; Deborah Mathieu, Preventing Prenatal Harm: Should The State Intervene? 90 (1996); Roth, in Merrick & Blank, *supra* note 14, at 120.

[50] *See generally* Merrick and Blank, *supra* note 14; Arch, *supra* note 14; Gallagher, *supra* note 4; Ikemoto, Furthering the Inquiry, *supra* note 23; Kolder *et al.*, *supra* note 27; Lawrence J. Nelson, Brian P. Buggy & Carol J. Weil, Forced Medical Treatment of Pregnant Women: Compelling Each to Live as Seems Good to the Rest, 37 Hastings L.J. 703 (1986).

[51] *See* Espinoza, *supra* note 1, at 220; Lisa C. Ikemoto, The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law, 53 Ohio St. L.J. 1205, 1245 (1992) [hereinafter Code of Perfect Pregnancy]; Ikemoto, Furthering the Inquiry, *supra* note 23, at 502.

[52] *See* Espinoza, *supra* note 1, at 224; Ikemoto, Furthering the Inquiry, *supra* note 23, at 502; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1245.

[53] *See* Ikemoto, Furthering the Inquiry, *supra* note 23, at 502; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1245.

[54] *See* In re Jamaica Hosp., 491 N.Y.S.2d 898 (1985) (ordering blood transfusion to be administered to pregnant woman against her will); Jefferson v. Griffin Spalding County Hosp., 274 S.E.2d 457 (Ga. 1981) (ordering pregnant woman to undergo cesarean section surgery); Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) (ordering blood transfusion to be administered to pregnant woman against her will); In re Madyun, 573 A.2d 1235, 1259 (D.C. App. 1990) (ordering cesarean performed on non-consenting pregnant woman). *But see* In re Baby Boy Doe, 632 N.E.2d 326 (1994) (refusing to order woman to have cesarean without her consent). *See also* Ikemoto, Furthering the Inquiry, *supra* note 23, at 509-14 (describing unreported forced treatment cases); Gallagher, *supra* note 4, at 9, 32-34, 48-49 (same).

A pregnant woman may refuse medical treatment deemed necessary for her fetus for any number of reasons: religion, fear of surgery, or simply a belief that her doctor has misdiagnosed the situation.[55] Doctors are likely to view these reasons as irrational, emotional, or selfish even though the woman is competent.[56] By characterizing women this way, doctors can rationalize dismissing patient autonomy and turning to the courts to override the women's decisions. Underlying this rationalization is the belief that a "good" woman would subordinate her interests to those of her fetus, even when doing so increases the risk to her own health or life.[57] A woman who fails to do so becomes less human, and ignoring her decision becomes easy and justified. This argument finds its support in the way in which doctors have described pregnant women who refuse to consent to medical treatment advised for the health of their fetuses.[58] The women are considered to be "angry and uncooperative" or "stubbornly refus[ing] to submit to surgery."[59] Medical staffs have described their "devastating sense of helplessness" at not being able to treat the woman's fetus, and their frustrations at what they view as the woman's "unreasonable sensitivity to the welfare of her infant."[60] What is not described is the woman's equal frustration and sense of helplessness at being forced to receive invasive treatment she does not want.[61] Her voice is completely silenced in the mad rush to help her fetus.

The failure to hear women's voices also reflects society's belief that doctors are presumptively rational, and women are inherently irrational.[62] Society does not question doctors' authority and infallibility, even though in several cases, women who were ordered to have cesareans gave birth to

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[55]*See* Arch, *supra* note 14, at 642; Nelson *et al.*, *supra* note 50, at 714.

[56]*See* Espinoza, *supra* note 1, at 221; Ikemoto, Furthering the Inquiry, *supra* note 23, at 502; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1241, 1245.

[57]*See* Boumil, *supra* note 14, at 69; Daniels, *supra* note 44, at 42; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1245.

[58]*See* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1241; Ikemoto, Furthering the Inquiry, *supra* note 23, at 502.

[59]Ikemoto, Furthering the Inquiry, *supra* note 23, at 502; *See also* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1241.

[60]Ikemoto, Furthering the Inquiry, *supra* note 23, at 502.

[61]*See* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1208.

[62]*See* Daniels, *supra* note 44, at 42; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1239; Ikemoto, Furthering the Inquiry, *supra* note 23, at 501.

healthy babies naturally.[63] One way in which courts manifest this belief is through the amount of space judges devote to the doctor's diagnosis in their opinions on the forced treatment cases.[64] In Jefferson, for example, the opinion contains four full paragraphs describing Mrs. Jefferson's medical condition.[65] The court states that she has a complete placenta previa (the afterbirth is blocking the birth canal) and the evidence shows that there is a "99% certainty that the child cannot survive natural childbirth (vaginal delivery)."[66] The court states in three brief sentences that Mrs. Jefferson has refused the cesarean because she and her husband believe that "the Lord has healed her body and that whatever happens to the child will be the Lord's will."[67] Without a single word about an adult's right to bodily integrity or religious freedom, the court ordered the cesarean.[68] The opinion does not reveal that after the court proceedings, the placenta previa corrected itself and Mrs. Jefferson gave birth to a healthy baby naturally.[69] Both the doctors and the judges in this and other cases ignored the women's instinctive or religious belief that their babies would be okay without the surgery, thus devaluing and silencing voices which, in the end, proved correct.

C. Continuing Stereotypes

The fact that women have been forced to forfeit certain fundamental rights to ensure the health of their fetuses would not be true but for society's view of women generally.[70] Despite the gains of various women's movements, there persists the belief that women's primary role is reproductive.[71] Historically, society and the courts were overt about attempting to place restrictions on women who stepped outside this role.[72]

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[63]*See* Arch, *supra* note 14 at 653; Gallagher, *supra* note 4, at 47.

[64]*See* Ikemoto, Furthering the Inquiry, *supra* note 23, at 500-501.

[65]*See id.* at 501.

[66]Jefferson v. Griffin Spalding County Hospital, 274 S.E.2d 457, 458 (1981).

[67]*Id.* at 459.

[68]*See id.* at 460.

[69]*See* Ikemoto, Furthering the Inquiry, *supra* note 23, at 501.

[70]*See* Siegel, *supra* note 24, at 324.

[71]*See id.*

[72]*Id.*

However, with the advent of formal equality under the law, the pressure for women to conform to traditional feminine molds has become more subtle.[73] The movement towards fetal rights is one such subtle pressure.[74] Though couched in terms of protecting potential life, restrictions on women in the name of their fetuses obscure what is really an attempt to preserve women's roles as child-bearers.[75] These restrictions also punish women who refuse to conform to society's ideal of the "good mother."[76]

The "good mother/bad mother" dichotomy is deeply rooted in our culture.[77] Because women have the biological means to become pregnant and give birth, they are also expected to be the primary caretakers and nurturers.[78] Good mothers assume this role with pride and enthusiasm.[79] They are nurturing, fearless, and compliant.[80] They do everything they can to protect the health of their fetuses, including sacrifice themselves if necessary to benefit their fetuses.[81] Historically, because white middle- and upper-class women had the option of staying home while their husbands worked outside the home, they came to define what a "good mother" should be.[82] All women, regardless of race and class, were expected to meet this heavily race- and class-based motherhood ideal.[83]

Out of this ideal emerged the bad mother stereotype: she is opposite in every way.[84] She probably is not married and has to work to support

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[73]*Id.*

[74]*Id.* at 328.

[75]*See* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1208; Ikemoto, Furthering th Inquiry, *supra* note 23, at 495; Siegel, *supra* note 24, at 265.

[76]*Cf.* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1215; Ikemoto, Furthering th Inquiry, *supra* note 23, at 495; Siegel, *supra* note 24, at 265.

[77]Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1210-11 (describing nineteenth centu social and cultural norms regarding motherhood and womanhood).

[78]*Id.*

[79]*Id.*

[80]Espinoza, *supra* note 1, at 224; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1210-1

[81]Boumil, *supra* note 14, at 69; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1219

[82]Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1210-11.

[83]*Cf.* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1219; Ikemoto, Furthering t Inquiry, *supra* note 23, at 511.

[84]*See* Espinoza, *supra* note 1, at 228; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, 1219; Ikemoto, Furthering the Inquiry, *supra* note 23, at 511.

herself.[85] She is likely to be uneducated, unsophisticated, easily influenced by simple religious dogma, and hostile to authority.[86] Because similar stereotypes have also been attached to women of color, the two have become almost inseparable.[87] The quintessential characteristic of a bad mother, however, is her failure to sacrifice herself for the sake of her fetus.[88] Race and class aside, the woman who refuses medical treatment deemed necessary for her fetus is a bad mother automatically, even if she is wealthy and white.[89]

The evolution of fetal rights, then, is better viewed as a modern attempt to preserve what society continues to view as a woman's proper role.[90] When women assert their individual rights, society sees them stepping outside this role.[91] "Something must be wrong with them," society says, or else they would not even think to subordinate their fetus' health to their own.[92] That this is true is evident in the fact that when a woman makes a medical decision putting her own health at risk for the benefit of her fetus, doctors respect the decision and never seek court intervention.[93] Therefore, women's voices are heard only as long as they conform to the good mother ideal. As soon as society hears the voice say something about putting the woman's interest above the fetus', doctors, lawyers, and judges step in to "encourage" her to make the right decision. Without the continuing hold these stereotypes have on society, it probably would not be possible for doctors and judges to make decisions for pregnant women. The assumption that pregnant women are inherently irrational if they decide to refuse treatment would fall away, and pregnant women's medical decisions would be respected.

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[85] *Id.*

[86] Ikemoto, Furthering the Inquiry, *supra* note 23, at 511.

[87] *See* Espinoza, *supra* note 1, at 228; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1219; Ikemoto, Furthering the Inquiry, *supra* note 23, at 511.

[88] Daniels, *supra* note 44, at 42; Espinoza, *supra* note 1, at 224.

[89] Daniels, *supra* note 44, at 42; Espinoza, *supra* note 1, at 228; Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1219; Nelson *et al.*, *supra* note 50, at 720.

[90] Siegel, *supra* note 51, at 324.

[91] *Id.*

[92] Espinoza, *supra* note 1, at 224.

[93] *Id.*; *see* Ikemoto, Code of Perfect Pregnancy, *supra* note 51, at 1238.

III. THE MISSING VOICE

The story told at the beginning of this article suggested that Angela Carder knew what was going on and did not consent to the cesarean section that killed her. The appeals courts' two opinions both state that Angie had two responses when she was told about the judge's order. First, as her sedation was wearing off, she agreed to the surgery.[94] A half-hour later, when two doctors sought to confirm her consent, they found her lucid.[95] This time, she twice clearly mouthed the words: "I don't want it done."[96] The trial judge and the court of appeals in A.C. I believed this meant Angie's intent was not clear.[97] The court in A.C. II, while holding that a hospital should virtually never seek a court order to compel a pregnant woman to have a cesarean, nonetheless agreed that it was impossible to determine Angie's intent.[98]

The courts' refusal to hear Angela Carder's voice at her most lucid moment is the most troubling aspect of this tragic story. The A.C. II court silenced her voice at the same time it emphasized a pregnant woman's right to decide what medical treatment to accept or refuse. This section argues that the same societal forces and stereotypes about women which have suppressed their voices in other forced-cesarean cases were operating in A.C. II. In reversing A.C. I on the grounds it did, the court avoided acknowledging that what Angela Carder really wanted was to die with her baby. Thus, the court could "do the right thing" and emerge as the protector of women's rights without having to amplify the voice of a "bad mother."

The A.C. II opinion contains many rationalizations and apologies. Throughout its discussion, the court makes a great effort to avoid criticizing the trial judge, Emmet Sullivan. After the court acknowledges that it had the benefit of time to decide, briefs, and oral argument, it commends Judge Sullivan for the "painstaking and conscientious manner in which he performed the task before him."[99] In the very next paragraph, the court sets out the scene of the original hearing: "After a hearing lasting approximately

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[94]A.C. II, 573 A.2d at 1240; A.C. I, 533 A.2d at 613.

[95]*Id.*

[96]*Id.*

[97]A.C. I, 533 A.2d at 612.

[98]A.C. II, 573 A.2d at 1247.

[99]*Id.* at 1237 n.2.

three hours, which was held at the hospital (though not in Angela Carder's room), the court ordered that a caesarean section be performed on A.C. to deliver the fetus."[100] Although later in its opinion the court stresses the importance of the judge speaking to the patient directly, at no time does it highlight Judge Sullivan's glaring failure to speak with Angela Carder himself, even though he was invited to do so.[101] The court's use of parentheses around the words "though not in A.C.'s room" foreshadows the relative lack of weight it will accord Angie's voice throughout its consideration of the facts.[102]

The court goes on to describe Angie's childhood cancer, though it does not mention the amputation of her left leg and hip several years earlier.[103] It does, however, find it important to point out that Angie was "excited about her pregnancy and very much wanted the child."[104] The court also notes that she sought prenatal care on a regular schedule at the high-risk pregnancy clinic.[105] By omitting certain facts and highlighting others, the court was setting Angie up as a "good mother." The fact that Angela Carder went to a high-risk pregnancy clinic was included to show that, although she knew there was a chance her cancer could return if she became pregnant, she subordinated her interest in remaining cancer-free to fulfill her womanly role as a mother and ensure the safe development of her fetus.

The first instance in which the court suppresses Angie's voice occurs in its description of the facts leading up to the hospital hearing. In describing the discovery and discussion of Angie's tumor and prognosis, the court fails to mention that Angie had agreed to an aggressive treatment plan formulated by her long-time oncologist, Dr. Moscow.[106] The plan was designed to ease some of her pain and extend her life for a couple of weeks, so she could deliver her fetus by cesarean at 28 weeks' gestation, giving it a better chance for survival.[107]

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[100] *Id.* at 1238.

[101] *Id.* at 1247 n.15.

[102] *Id.* at 1238.

[103] *Id.*

[104] *Id.*

[105] *Id.*

[106] *Id.* at 1238-39; Lew, *supra* note 1, at 624.

[107] *Id.*

The court, however, does not mention the aggressive plan and instead jumps to June 15, when the GWUMC doctors unilaterally decided to administer "palliative treatment designed to extend her life until at least her twenty-eighth week of pregnancy."[108] The court appears to confuse this passive treatment plan with the aggressive plan discussed prior, stating that "A.C." agreed to this treatment knowing it might harm her fetus.[109] In fact, it was the aggressive treatment that posed a threat to her fetus. The treatment eventually provided did nothing more than ease her pain so she could continue breathing comfortably. The court does not explore why the aggressive plan, which Dr. Moscow believed could possibly save Angie, was not administered and ultimately was dismissed. By failing to discuss this fact, the court buries the first medical treatment decision Angie made which was ignored by the GWUMC doctors. It thus perpetuates the suppression of her voice by those doctors when they failed to administer the treatment.

The court rather abruptly moves into a discussion of how the trial court convened a hearing the next morning.[110] It is not at all clear from the opinion why the hospital's legal department petitioned the court in the first place, nor is it evident that there was any dispute to be decided.[111] The court again silenced Angie Carder by implicitly accepting as fact the hospital's assumption that Angie would not consent to a cesarean at that point, despite the fact that prior to the hospital approaching the court, she had neither refused nor consented to it.[112] She simply was not asked, but was presumed to have refused consent even before she actually did.[113] Perhaps the fact that she had consented to treatment that posed increased risks to her fetus had tainted her "good mother" image. Perhaps the hospital assumed she would continue to act as a "bad mother" if choices were presented to her, so it removed the choice before she even had a chance to consider it. The hospital suppressed her voice when it did not seek her consent, and again the court perpetuated the silence by failing to point out that no dispute existed and by accepting the hospital's assumption that she would not consent to the surgery.

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[108]A.C. II, 573 A.2d at 1238.

[109]*Id.* at 1238-39.

[110]*Id.* at 1239.

[111]*Id.* at 1238-39.

[112]*Id.* at 1239.

[113]Lew, *supra* note 1, at 626.

The court goes on to describe the hearing testimony as presented in the record.[114] The testimony consisted of a neonatologist, Dr. Maureen Edwards, who was not treating Angela Carder but testified as an expert; Dr. Alan Weingold, one of Angie's treating obstetricians; Dr. Louis Hamner, another treating obstetrician; Dr. Lawrence Lessin, one of Angie's treating oncologists; and Nettie Stoner, Angie's mother.[115] Dr. Moscow, the one doctor who had been treating Angie for most of her life, was not notified of the hearing and did not testify.[116] Only some of the testimony is reproduced in the opinion, so the court has made a decision about whose voices will be heard. It apparently accords great weight to the doctors' testimony and opinions.[117] In terms of space alone, the court's description of the doctors' testimony fills nearly four columns in the opinion; the testimony of Angie's mother and Angie herself consists of approximately seven lines of text.[118] The fact that Angie's husband was too distraught to testify at all is dispensed with in a footnote.[119] The court demonstrates textually the great reliance it placed on the opinions of doctors and the little significance it attached to the opinions of people who knew Angie well and could testify to what she would want: the people who could provide her voice.

The opinion points out that Dr. Edwards testified that Angie's fetus was viable, had a 50 to 60% chance of survival, and less than a 20 percent chance of being born with substantial impairment, if it were delivered promptly.[120] The court reduces to a footnote the fact that Dr. Edwards had not had any direct involvement with Angie or her family.[121] In so doing, it further suppresses Angie's voice because it accepts as fact the testimony of a witness who had not personally spoken to or examined the subject of the testimony. The court includes pieces of the testimony of both Dr. Weingold and Dr. Hamner to the extent that it corroborated Dr. Edwards.[122]

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[114]*Id.* at 1239-41.

[115]*See id.*

[116]Lew, *supra* note 1, at 626.

[117]A.C. II, 573 A.2d at 1240-41.

[118]*Id.* at 1239-41.

[119]*Id.* at 1240 n.4.

[120]*Id.* at 1239.

[121]*Id.* at 1239 n.3.

[122]*Id.* at 1239-41.

However, while Dr. Hamner agreed with Dr. Edwards' opinion that Angie's fetus had a 50 to 60% chance of survival, he also testified that the morbidity factor was increased due to its exposure to many medications, its abnormal electrolyte acid base environment, its probable chronic asphyxiation, and rapid heartbeat.[123] The court excluded this testimony while including Dr. Weingold's statement that "any delay in delivering the child by caesarean section lessened its chances for survival."[124] The court thereby selectively focused on doctors' testimony in the record that tended to support the trial judge's finding that the fetus had a good chance for survival.

In discussing testimony regarding Angie's ability to understand what was happening and respond to questions about her treatment (in other words, whether she was competent to make her own decision), the court devotes a great deal of time to the testimony of Doctors Weingold and Hamner.[125] Both doctors stated that at that point, Angie was heavily sedated, that she probably could not carry on a meaningful conversation, and that reducing her medication to obtain a response could shorten her lifespan.[126] The court in effect admits the possibility of determining Angie's wishes, but does not take this opportunity to reprimand the trial judge for failing to speak to her and determine her ability to communicate himself.[127] Thus, the court implicitly condones the trial judge's great reliance on the testimony and opinion of the doctors regarding Angie's competence.

The court does admit that the testimony showed that there was no agreement about whether Angie would have consented to the surgery at that point.[128] The court acknowledges that Angie's mother opposed the surgery and that one of her treating obstetricians, Dr. Louis Hamner, testified that "he did not think she would have chosen to deliver a child with a substantial degree of impairment."[129] The court also notes that Dr. Hamner and his whole department believed they should abide by the wishes of

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[123]Lew, *supra* note 1, at 626 n.48.

[124]A.C. II, 573 A.2d at 1239.

[125]*Id.* at 1239-41.

[126]*Id.*

[127]*See id.*

[128]*Id.* at 1239.

[129]*Id.*

Angie's family.[130] What is absent from this language is the fact that the whole department had made it known that they were opposed to performing the surgery.[131] The court once again selects the testimony that supports the trial judge's findings of fact and suppresses the testimony that could give effect to Angie's voice.

The most significant suppression of Angie's voice occurs after the trial judge made his findings of fact and issued the order for surgery,[132] when Dr. Hamner relayed the decision to Angie. The court notes that Dr. Hamner told the trial judge that Angie had consented to the surgery.[133] The opinion goes on to quote what happened after Dr. Hamner and Dr. Weingold went back to her room to confirm her consent:[134]

When the hearing reconvened later in the day, Dr. Hamner told the court:

> THE COURT: Will you bring us up to date? Did you have a conversation with [A.C.]?
>
> DR. WEINGOLD: I did not. I observed the conversation between Dr. Hamner and [A.C.]. Dr. Hamner went into the room to attempt to verify his previous discussion with the patient, with the patient's husband at her right hand and her mother at her left hand. He, to my satisfaction, clearly communicated with [A.C.]. She understood.
>
> THE COURT: You could hear what the parties were saying to one another?
>
> DR. WEINGOLD: She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she's saying rather readily. She asked whether she would survive the operation. She asked [Dr.] Hamner if he would perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a few

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[130] *Id.* at 1240.

[131] Lew, *supra* note 1, at 632.

[132] The trial court found that (1) Angie would probably die within 24 to 48 hours; (2) Angie's fetus was viable and had a 50 to 60% chance of survival; (3) given that the fetus was viable, "the state has an important interest in protecting the potentiality of human life;" (4) the cesarean surgery may very well hasten Angie's death, but any delay would increase the risk to the fetus; and (5) the court did not know what Angie's intent was. A.C. II, 573 A.2d at 1240.

[133] *Id.*

[134] *Id.* at 1240-41.

> moments and then very clearly mouthed the words several times, *I don't want it done. I don't want it done.* Quite clear to me.
>
> I would obviously state the obvious and that this is an environment in which, from my perspective as a physician, this would not be an informed consent one way or the other. She's under tremendous stress with the family on both sides, but I'm satisfied that I heard clearly what she said.
>
> THE COURT: Dr. Hamner, did you wish to elaborate?
>
> DR. HAMNER: That's accurate. I noticed she was much more alert than she had been earlier in the day and was responding to the nurses in the room as well as to all the physicians and went through the same sequence Dr. Weingold noted.

Dr. Weingold later qualified his opinion as to A.C.'s ability to give an informed consent, stating that he thought the environment for an informed consent was non-existent because A.C. was in intensive care, flanked by a weeping husband and mother. He added:

> I think she's in contact with reality, clearly understood who Dr. Hamner was. Because of her attachment to him [she] wanted him to perform the surgery. Understood he would not unless she consented and did not consent.
>
> That is, in my mind, very clear evidence that she is responding, understanding, and is capable of making such decisions.

Dr. Hamner stated that the sedation had "worn off enough for her to wake up to this state" and that "the level of drugs in her body is much different from several hours ago." After hearing this new evidence, the court found that it was "still not clear what her intent is" and again ordered that a cesarean section be performed. [emphasis added]

The court does not say that the second conversation took place thirty minutes after the first, which allows one to infer that if Angie was lucid enough to consent at 4:40 p.m., she was even more lucid at 5:10 p.m., when she refused.[135] Even after Dr. Weingold testified that "she is responding, understanding, and is capable of making such decisions," Dr. Hamner testified that "she was much more alert than she had been earlier in the day," and Angie herself had clearly said, "I don't want it done," the appeals court adheres to the finding of the trial court that it was impossible to

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[135]Remnick, *supra* note 1, at W14; Marney Rich, A Question of Rights: Birth and Death Decisions Put Women in the Middle of a Legal Conflict, Chi. Tribune, Sept. 18, 1988, at C1.

determine what her intent was.[136] In fact, the court goes even further than the trial judge, affirmatively dismissing Angie's clear refusal:

> Undoubtedly, during most of the proceedings below, A.C. was incompetent to make a treatment decision; that is, she was unable to give an informed consent based on her assessment of the risks and benefits of the contemplated surgery. The court knew from the evidence that A.C. was sedated and unconscious, and thus it could reasonably have found her incompetent to render an informed consent; however, it made no such finding. On the other hand, there was no clear evidence that A.C. was competent to render an informed consent after the trial court's initial order was communicated to her.[137]

The court suppresses Angie's voice in two ways here. First, the court overlooks the doctors' testimony that Angie was clear-headed and able to make a decision on this matter, instead focusing on the testimony that she was deciding in an emotionally charged environment. The court hones in the phrase "informed consent" in determining that the trial judge could have reasonably found Angie incompetent to give informed consent. [138] The court is obviously relying on Dr. Weingold's testimony that Angie was not able to give informed consent because she was flanked by a weeping husband and mother, ignoring his testimony that she was lucid and aware of the situation. It is certainly possible that Angie considered the reactions of her family when she made her final decision. The problem with the court's dependence on this part of Dr. Weingold's testimony, however, is that the testimony itself contains an unstated assumption that the court takes for granted. His testimony incorporates the stereotypes about women making medical treatment decisions that have often resulted in the suppression of their voices. Implicit in Dr. Weingold's statement is the idea that pregnant women who refuse recommended treatment are inherently irrational. Therefore, even though she is admittedly lucid and understanding, she could not possibly make an informed decision in this emotionally charged environment, so her clear refusal cannot constitute informed consent. Dr. Weingold, in devaluing Angie's ability to make an informed decision because of the environment she was in, laid the foundation for the court of appeals to perpetuate the devaluation. The court of appeals dutifully followed suit, concluding in the face of contradicting

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[136] A.C. II, 573 A.2d at 1247.

[137] *Id.*

[138] *See id.*

evidence that the trial judge could reasonably have found that she was incompetent.

The second way the court silences Angie is by blatantly ignoring Angie's actual voice, communicated through Dr. Hamner, when she told him clearly, "I don't want it done."[139] The testimony is clear that at no time was Angie more lucid than when Dr. Hamner and Dr. Weingold returned to her room to confirm her "consent."[140] This time, Angie said over and over again that she did not want the surgery.[141] In fact, because no one had even asked her what she wanted *before* the hearing began, these two exchanges were the only time Angie had the chance to speak her mind.[142] Rather than view Angie's responses on a continuum of lucidity, the trial judge and court of appeals found her equivocation to represent uncertainty. Further, the court's conclusions manifest hidden assumptions about women's ability to make difficult decisions: irrational, immature, emotional, incompetent. If the court of appeals had been able to overcome its stereotypical notions about women, and chosen to focus on Angie's clarity and decisiveness during the second meeting, it could have found the trial judge's finding that he could not determine her intent clearly erroneous. Instead, the court could have stated that the trial judge should have found that, because Angie's last statement was the clearest and most adamant, she was competent and in fact refused the surgery. Its failure to do so effectively silences Angie's voice and reinforces stereotypes about pregnant women's irrational decision-making.

The court of appeals finally admits that the factual record was flawed because of time constraints, the trial judge's failure to talk to Angela Carder personally, and the absence of Dr. Moscow's testimony.[143] Still, the court refuses to find error in any of Judge Sullivan's findings, and in fact goes out of its way to point out that its opinion should not be construed as a criticism of the judge's acts or omissions.[144] In the end, though, the court

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[139]*Id.* at 1241.

[140]*Id.*

[141]*Id.*

[142]Lew, *supra* note 1, at 631 n.80.

[143]A.C. II, 573 A.2d at 1248. Dr. Moscow filed an affidavit stating that had he been notified about the hearing, he would have been present and would have testified that a cesarean was not medically advisable for either Angela Carder or her fetus. He did not believe Angie was terminal at that point, and feared the surgery would hasten her death. Lew, *supra* note 1, at 626 (citing Appellant's Amended Brief on the Merits at 15 (citing Affidavit of Dr. Jeffrey Moscow at 2, filed Nov. 19, 1987)).

[144]A.C. II, 573 A.2d at 1247 n.15.

reveals a different position. After outlining the extensive case law establishing the right of adults to refuse any and all unwanted medical treatment, the court states that "[t]here are two additional arguments against overriding A.C.'s objections to caesarean surgery."[145] Perhaps the court's use of the word "objections" was inadvertent. Alternatively, it is possible that the word "objections" was a Freudian slip, indicating that the court in fact believed the trial judge could have, and should have, found that Angela Carder was competent and that she had clearly refused the surgery that was forced upon her. Obviously, we will never know what the court of appeals really thought. What is clear is that the court was extremely reluctant to find error in any of the trial judge's findings and instead constructed an elaborate scheme for determining pregnant women's intent in the future. This is not intended to be a criticism of the structure the court established, which in theory appears as though it would successfully enable a pregnant woman to exercise her right to refuse medical treatment. Instead, this argument is meant to suggest that even as it affirmed a woman's right to self-determination, the court of appeals' analysis was influenced by the social status of doctors and the stereotypes about women and motherhood.

IV. CONCLUSION

Despite the D.C. Court of Appeals' A.C. II opinion, which held that a pregnant woman's right to refuse medical treatment should virtually never be overridden, the court suppressed Angela Carder's voice when she failed to make a decision indicating maternal self-sacrifice. Social beliefs persist that women should be self-sacrificing, compliant, and nurturing; those who do not meet this standard are irrational, immature, and ignorant. These stereotypes subtly informed the court's analysis. Even though there was uncontroverted testimony that Angie was lucid and had refused the treatment, the court reasoned that because she had equivocated earlier in the day, under heavy sedation, Judge Sullivan's finding that he could not determine Angie's intent was reasonable. The court should have relied upon all the testimony in the record, and found that Angie's final decision represented her most lucid and understanding communication. Had it truly heard Angie's voice, the court would have found her competent and her

[145] *Id.* at 1248. The arguments the court sets forth are (1) court-ordered caesareans erode the element of trust between a pregnant woman and her doctor and will deter women from seeking prenatal care; and (2) the time constraints of these types of judicial proceedings have serious due process implications. These arguments are not relevant for the purposes of the point to be made regarding the court's introduction of them.

decision clear: let me die with my baby. The irony of the court's second decision is that only after Angela Carder was dead, and could not voice her wishes at all, did the court place its legal stamp of approval on the decision she actually had made. One wonders whether, if she had survived the surgery, the first court of appeals decision would have been reversed at all.

EPILOGUE[146]

The trial judge, Emmet Sullivan, now sits on the federal bench in Washington, D.C. Nettie Stoner continues to talk about what happened to her daughter and though she still is outraged, she believes Angie's experience will help other women in the future. She and her husband appear on news and talk shows, commemorating Angie and her tragic experience. Nettie still weeps. Rick Carder does not see the Stoners much anymore; he met and moved in with another woman just two weeks after Angie's funeral. Nettie was furious. Rick's response: "Everybody said it's too soon, it's too soon. But I guess I'm the one to decide that, aren't I?" Ironically, that type of belief is what started this case in the beginning. Dr. Hamner, who does not usually attend the funerals of his patients, went to Angie's. "It's not the usual thing, but neither was Angie," he says. "She was special to me. Going to the funeral—well, I guess I owed her at least that much."

[146]Remnick, *supra* note 1, at W14.