Western New England Law Review

Volume 9 9 (1987)
Issue 1

Article 6

1-1-1987

INFORMED CONSENT IN OBSTETRICS: SOME SPECIAL PROBLEMS

Nancy K. Rhoden

INFORMED CONSENT IN OBSTETRICS: SOME SPECIAL PROBLEMS

NANCY K. RHODEN*

INTRODUCTION

As Professor Katz's astute analysis has shown us, the real world of medical decisionmaking bears little resemblance to lofty judicial language about informed consent.[1] Medical authority, professional socialization, doctors' intense yet often unrecognized psychological motivations, and even judges' implicit acceptance of the belief that "doctor knows best," are some of the invisible yet virtually invincible barriers to truly shared decisionmaking. In analyzing the consent process for the first heart transplant, Professor Katz also illustrates why certain areas of medicine, such as catastrophic illness, may raise particular difficulties in achieving informed consent. In this essay I will suggest that obstetrics is another area in which the consent process is peculiarly problematic.

For the last year, I have had the opportunity to observe decisionmaking in obstetrics at several hospitals. My primary interest has been maternal-fetal conflicts—cases where, for example, a Cesarean is necessary for the fetus' life or health but the woman refuses surgery, often on religious grounds. Increasingly, these extreme conflicts are resolved by courts, rather than by patients or physicians. But in the course of observing obstetrical decisionmaking, I have noticed disturbing patterns in some of the far more common cases where there is little or no apparent conflict. The problems here are subtler, I believe, but no less real. The problems stem in part from physicians' traditional and strongly ingrained responses to situations of uncertainty.

Part I of this article describes two paradigmatic decision strategies in obstetrics, one which permeates routine obstetrical care, the

---

* Associate Professor of Law, Ohio State University, College of Law; B.A., Oberlin College, 1974; J.D., New York University, 1977. I wish to thank John Arras, Alan Fleischman, Jay Katz, and Ruth Macklin for helpful comments on an earlier draft of this article. This research was made possible by the hospitality of Dr. Fleischman and the Albert Einstein College of Medicine and by a grant from the National Endowment for the Humanities and the National Science Foundation.

1. J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

other which comes into play only when an obstetrical tragedy is in the making. The problem is not that these strategies exist, but that physicians' typical approach to uncertainty or to a crisis may be perceived not as one strategy among several, but as the only legitimate approach. Patients see the physician's recommendation as the best or only hope for the baby, and this viewpoint virtually guarantees acceptance of that recommendation, except in cases of exceedingly firm beliefs on the part of the mother.

Part II demonstrates how the almost inevitable nature of consent in obstetrics may mask a number of controversial value judgments regarding the relative importance of the woman's concerns versus the fetus' well-being. Such judgments are inevitable given the nature of obstetrics, where one patient resides silent and hidden within another. But the potential for conflict about judgments is intensifying as burgeoning technology lets doctors visualize and assess the once inaccessible fetus. As cases in which courts have ordered women to submit to Cesareans illustrate, in obstetrics, unlike other areas of medicine, there is increasing conflict over whether a competent patient should have the right to refuse needed medical procedures.

In Part III, I ask how this incipient reallocation of power from patient to physician may affect obstetrical decisionmaking. Although I suggest how Professor Katz's theories could potentially improve obstetrical decisionmaking, my sense is nonetheless that the prognosis for shared decisionmaking in obstetrics is grim.

I. TWO OBSTETRICAL PARADIGMS

Obstetrical decisionmaking is, of course, often quite complex. At the risk of serious oversimplification, I will describe two prototypical decision strategies in obstetrics. The first is the standard American approach to routine obstetrical care. This is to focus on the worst possible outcome—fetal mortality or morbidity—and take aggressive preventive measures, even though the outcome is rather unlikely and the preventive measures have certain drawbacks of their own. This strategy is called the "maximin" strategy in obstetrics.[2] Certain results of this strategy, *i.e.*, the "over-medicalization" of childbirth and the use of arguably unnecessary interventions, have been the impetus for the "natural childbirth" critique of modern American obstetrics.[3]

2. Brody & Thompson, *The Maximin Strategy in Obstetrics*, 12 J. FAM. PRAC. 977 (1981).

3. For a sampling of the large and growing body of literature criticizing the medical interventionism prevalent in American obstetrics, see Y. BRACKBILL, J. RICE & D.

The second approach has received far less attention because it is generally limited to crisis situations. It is simply the quite understandable tendency to intervene aggressively in any crisis where the fetus is imperiled, even though the chances of success, in terms of the infant's intact survival, are exceedingly low. The intervention here, normally a Cesarean, is sometimes troubling, not in the course that is chosen, but because of how that course is chosen.

I should emphasize that the intent of this article is not to criticize either the maximin strategy or what might be called the "only hope" approach. Many, perhaps even most, women would choose these strategies if given a choice. Rather, my criticism is that women are not given the choice, because doctors' responses to situations of uncertainty or crisis in obstetrics are so deeply ingrained, so multiply motivated, and so persuasive to pregnant women that for most women, rejecting medical recommendations is virtually unthinkable.

A. *The Maximin Strategy in Obstetrics*

Uncertainty permeates modern medicine. If doctors waited for certainty to act, they might never do anything at all. But acting under uncertainty requires some sort of strategy for making decisions without all the desirable information. Such strategies, whether conscious or unconscious, explicit or implicit, incorporate an attitude toward risk. Attitudes toward risk may vary widely, from, for example, the risk-averse fellow who carries an umbrella every day of the year to his devil-may-care counterpart who carries one only when he sees that it is pouring. The latter type person is unlikely to make a good doctor: after all, who wants a doctor who cavalierly foregoes performing tests for serious disease on the optimistic assumption that your strange symptoms will go away.

Physicians in general come much closer to carrying umbrellas every day. This is quite understandable. The maximin strategy, a common, albeit often unarticulated medical strategy, has been described as follows: "choosing the alternative that makes the best of the worst possible outcome, regardless of the probability that that out-

---

YOUNG, BIRTHTRAP: THE LEGAL LOW-DOWN ON HIGH-TECH OBSTETRICS (1984); G. CASSIDY-BRINN, F. HORNSTEIN & C. DOWNER, WOMEN-CENTERED PREGNANCY AND BIRTH (1984); M. EDWARDS & M. WALDORF, RECLAIMING BIRTH: HISTORY AND HEROINES OF AMERICAN CHILDBIRTH REFORM (1984); B. ROTHMAN, GIVING BIRTH: ALTERNATIVES IN CHILDBIRTH (1982); THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES (1984); CHILDBIRTH: ALTERNATIVES TO MEDICAL CONTROL (S. Romalis ed. 1981); Corea, *The Cesarean Epidemic*, MOTHER JONES, July 1980, at 28.

come will occur."[4] This conservative, risk averse approach is most appropriate when the level of uncertainty is high and the worst potential outcome extremely bad. This is often the situation in medicine, and certainly is a feature of obstetrical decisionmaking, where the fetus' status cannot be assessed by normal means given its internal location, where unexpected disasters can occur throughout pregnancy and delivery, and where the worst possible outcomes—maternal or neonatal death—are very bad indeed. Hence obstetricians typically take a variety of preventive actions intended to forestall and/or detect potential problems.

Numerous examples of these preventive actions are available. The supine position most women are placed in in hospital deliveries facilitates vaginal examinations, allows episiotomy (a surgical cutting of the skin around the perineum to increase the opening for birth),[5] and allows for electronic fetal monitoring to assess the fetus' response to labor. Amniotomy (rupturing the membranes) helps speed labor, a result considered valuable inasmuch as a very slow labor is believed to be more hazardous for the fetus.[6] Amniotomy is also necessary for internal fetal monitoring. Instructing the woman in labor not to eat or drink, and instead giving her fluids intravenously, is done in case an emergency Cesarean and general anesthesia are needed. Using electronic fetal monitoring on all women in labor is yet another example of maximin reasoning. While the value of fetal monitoring is unquestioned in high risk deliveries, fetal distress is not very common in low risk pregnancies: one study has calculated that in these cases, monitoring could at best save 3 out of 1000 babies.[7]

Although each of these preventive actions may be justified, critics charge that interventions taken to forestall and/or detect problems have significant and detrimental effects of their own. Specifically, they claim that many such interventions interfere in the delivery process in a way that increases the chances of difficulties and hence make subsequent, and more far-reaching, interventions more likely. Again, there are multiple examples. At the most basic level, critics allege that the supine position itself slows labor and renders delivery more difficult:

---

4. Brody & Thompson, *supra* note 2, at 977.

5. After birth, the episiotomy must be sutured. Y. BRACKBILL, J. RICE & D. YOUNG, *supra* note 3, at 14.

6. *See* U.S. DEPT. OF HEALTH & HUMAN SERVICES, CESAREAN CHILDBIRTH: REPORT OF A CONSENSUS DEVELOPMENT CONFERENCE 342 (1981) [hereinafter CESAREAN CHILDBIRTH] (describing correlation between protracted labor and increased perinatal mortality and morbidity).

7. Neutra, Rienberg & Griedman, *The Effect of Fetal Monitoring on Neonatal Death Rates*, 299 NEW ENG. J. MED. 325 (1978).

as one doctor has put it, "Except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery."[8] Its also been suggested that the supine position renders tears more likely, thus making preventive episiotomy more necessary.[9] Amniotomy, although again not a particularly significant or risky intervention, does increase the risk of infection as labor continues.[10] Because of this risk, women may not be allowed to labor as long with ruptured membranes as without.[11] If labor appears slow, doctors may administer oxytocin to speed it up. Oxytocin, however, can cause unusually intense contractions that reduce fetal oxygen supply and cause fetal distress.[12] Oxytocin administration therefore necessitates electronic monitoring. But because oxytocin causes fetal distress in some cases, this series of interventions can itself lead to a Cesarean. Alternatively, if oxytocin is stopped in an attempt to alleviate the oxytocin-induced distress, labor may stop as well, again necessitating surgical delivery.

Finally, routine use of electronic monitoring entails a high number of false positives—cases in which an abnormal or seemingly abnormal fetal heart rate pattern is not predictive, in actuality, of fetal distress. Even with additional tests to try to rule out false positives, researchers estimate that false positive rates approach forty-four percent.[13] Doctors may differ significantly in their interpretations of fetal heart rate patterns and their responses to potentially ominous patterns.[14] But the caution instilled by obstetrical training, the prevailing maximin strategy, and the fear of legal liability for a bad outcome make the response of performing a Cesarean for even a questionable pattern very appealing. Thus monitoring is another intervention that

---

8. Y. BRACKBILL, J. RICE & D. YOUNG, *supra* note 3, at 12.

9. *Id.* at 13.

10. G. CASSIDY-BRINN, F. HORNSTEIN & C. DOWNER, *supra* note 3, at 139; Brody & Thompson, *supra* note 2, at 980. It is often argued that the cause of the increased infection risk is the frequent vaginal exams conducted in hospitals, and that without exams labor could continue much longer after rupture of membranes. *See* Corea, *supra* note 3, at 30.

11. G. CASSIDY-BRINN, F. HORNSTEIN & C. DOWNER, *supra* note 3, at 139.

12. Y. BRACKBILL, J. RICE & D. YOUNG, *supra* note 3, at 9. In fact, one national expert on fetal monitoring has stated: that the most frequent cause of late decelerations in term labors in the United States must be hypercontractility triggered by the misuses of oxytocic substances. L. CIBILS, ELECTRONIC FETAL-MATERNAL MONITORING: ANTEPARTUM, INTRAPARTUM 229-36 (1981).

13. Banta & Thacker, *Assessing the Costs and Benefits of Electronic Fetal Monitoring*, 34 OBSTET. & GYNECOL. SURV. 627, 629 (1979).

14. Cohen, Klapholz & Thomas, *Electronic Fetal Monitoring and Clinical Practices*, 2 MED. DECISION MAKING 79, 84 (1982) (describing variation in experts' interpretations of abnormal monitor patterns and recommendations for action).

may increase the chances of Cesarean delivery—the last link in the obstetrical intervention chain.

The maximin strategy is a perfectly legitimate strategy for choice under uncertainty. It is intended to optimize fetal outcome, and many pregnant women would choose this approach over all others were alternative decision strategies offered to them. The problem in obstetrical decisionmaking is that they are not. Instead, the maximin strategy is almost synonymous with standard and accepted obstetrical practice. Of course, well-educated women with financial means can seek out private physicians who are less interventionist than others, or they can go to alternative birthing centers. But the general obstetrical population is seldom presented with a choice of approaches to obstetrical care.

Professor Katz describes how doctors are loathe to reveal their uncertainty to patients even when they are fully aware of such uncertainty. Needless to say, doctors are unlikely to tell obstetrical patients that: (a) they are acting with uncertainty; (b) there are multiple decision strategies under uncertainty, ranging from high risk averse ones to less risk averse ones; (c) they, as obstetricians, prefer a strategy that focuses on fetal risk and takes aggressive action to prevent it; and/or (d) this strategy tends to increase maternal risk by increasing the chances of surgical delivery. It is almost impossible to imagine this sort of physician/patient dialogue. Indeed, the maximin strategy is so much a part of the obstetrical profession's "collective unconscious" that the doctor is as unlikely to describe this as one strategy among many as the trial lawyer who long since accepted the adversarial system as the best and only system of justice is to question the system's real value.

B. *The Only Hope Approach*

The second strategy applies only when the fetus is in great peril. Much as doctors using the maximin strategy basically discount the probability of the bad outcome materializing, physicians faced with an obstetrical crisis tend to intervene aggressively to give the baby its last or only hope, even in cases where the chances of success are extremely low. I have participated in retroactive discussions of a number of cases where the issue was whether doctors should have recommended, as they always did, and even urged Cesarean delivery given the fetus' slim chances of intact survival. I will first describe the most common situation where this obstetrical strategy comes into play, and then several variations based on cases or composites of cases that I have seen.

The issue of Cesarean delivery arises when a woman comes to the hospital in premature labor that cannot be stopped, or when she has a medical condition in late pregnancy that necessitates premature delivery. Premature fetuses may be endangered by the labor process, and may do better if delivered surgically.[15] When harm from vaginal delivery is feared, and the baby is very likely to survive intact if delivered by Cesarean—*i.e.*, the pregnancy has progressed beyond the twenty-eighth week and there are no complicating factors, then recommending Cesarean delivery to give the baby its best chance is fairly uncontroversial. But as gestation length decreases, a dilemma arises.

Babies born after twenty-four weeks of gestation are at the threshold of viability.[16] A few infants born this early will thrive. Others will survive, but with lingering neurological deficits. Many more will die, though perhaps after harrowing weeks or months in the neonatal intensive care unit. Chances of survival, and of intact survival, increase with every week of gestation from weeks twenty-four to twenty-eight, after which time about eighty percent of infants survive.[17] There is, however, no question that an infant born even at week twenty-eight will require months in the intensive care unit, and will face an increased risk of death or disability. Thus these cases entail radical uncertainty about the baby's prospects, but certainty as to the need for lengthy, intensive care.

Compounding this is the fact that while Cesarean section is at any time a more hazardous mode of delivery for the woman than vaginal delivery,[18] early in pregnancy it is more hazardous still. Because of the underdevelopment of the lower segment of the uterus until sometime after about the thirtieth week, an early Cesarean cannot be the standard low transverse kind, but must be a classical vertical incision.[19] This is a more serious operation, and one that definitely renders Cesarean delivery necessary for any subsequent births.[20] Thus

---

15. In general, the more immature the fetus, the greater the risks from labor and delivery. J. PRITCHARD, P. MACDONALD & N. GANT, WILLIAMS OBSTETRICS 756 (17th ed. 1985).

16. *See id.* at 143 (fetuses born at 24th week almost always die shortly after birth).

17. *See* P. BUDETTI, P. MCMANUS, N. BARRAND & L. HEINER, THE IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS OF MEDICAL TECHNOLOGY: THE COST AND EFFECTIVENESS OF NEONATAL INTENSIVE CARE 32 (1981) (greater than 80% survival rate for infants between 1000 grams, the mean weight at 28 weeks, and 1500 grams).

18. Figures vary, but a general estimate is that Cesarean birth carries 2-4 times the risk of mortality as vaginal birth. CESAREAN CHILDBIRTH, *supra* note 6, at 16.

19. Interview with Dr. Joanna Shulman, Assistant Professor of Obstetrics and Gynecology, Albert Einstein College of Medicine, in New York City (Jan. 24, 1986) [hereinafter Shulman interview].

20. *Id.*

another feature of these cases is increased maternal risk. In this instance, the decision to be made is whether the infant's chances of intact survival warrant this increased maternal risk.

Women faced with these dilemmas most often desperately want a child. Hence, even if the chances for intact survival are slim, they can be readily persuaded to go for the long shot. In some cases, it may be highly questionable whether the infant's chances really warrant aggressive intervention. But even in these cases, it is extremely hard for physicians to stand by and not perform surgery if there is any hope at all, even the slimmest thread.

A case in which a woman came to the hospital in her thirty-first week reporting no fetal movement for two to three days illustrated this latter reality. Ultrasound examination showed quite significant growth retardation in the fetus, with its size appearing to be consistent with twenty-seven to twenty-eight weeks gestation. Because of the intrauterine growth retardation, her fetus' chances were not nearly as good as the chances of a fetus at thirty-one weeks with normal size for its gestation age. Moreover, two days of no discernible fetal movement were ominous signs, and electronic fetal monitoring confirmed that the fetus was in extreme distress. In fact, physicians classified the fetus' heart pattern as "early terminal," indicating a strong probability of either early death or severe retardation if it survived.

The woman was not in labor, and fetal death was virtually inevitable absent Cesarean delivery. She initially stated that she did not want a Cesarean, which would have to be a classical one, because she did not want to have a retarded child. Although physician opinion was mixed, one of the doctors convinced the woman to have surgery, stressing that it was her baby's only hope, and at one point implying that with surgery her baby's chances were perhaps fifty percent. The Cesarean was performed, and the baby was born weighing 735 grams. For its gestational age, it should have weighed 1,000 to 1,400 grams. The baby lived approximately forty-eight hours. In subsequent discussions, various medical personnel questioned the influence exerted on the woman and suggested that although it was very hard to estimate the infant's chances of intact survival with all of its risk factors, they were nowhere near fifty percent. Several female physicians and midwives stated that they would not have wanted a Cesarean under those circumstances.

In that case, the woman involved expressed an opinion even though she was talked into having surgery anyway. Often, however, a woman may have no opportunity to say anything at all. For example,

in another case, a pregnant woman came in at term reporting several days of no fetal movement. Doctors initially tried to induce labor by giving her pitocin. Electronic fetal monitoring, however, showed fetal distress. A fetal scalp blood sampling indicated a pH of 7.02. A normal pH level is between 7.2 and 7.25 while a pH of 7.02 shows severe anoxia and one below 7.0, if sustained for long, is consistent with cellular death.[21] A second fetal scalp blood sample was done to confirm the severity of the fetus' condition and it showed a pH of 6.8—a level that is basically incompatible with life. At this point, the fetal heart tracing was terminal. Doctors then told the woman that the only hope for her baby's survival was an emergency Cesarean. They did not present her with a choice about surgery, nor did they tell her how unlikely intact survival was no matter what they did. The doctors performed the Cesarean, and the baby lived about fifteen hours.

Subsequent rounds again questioned the advisability of performing a Cesarean in this case, or at least of performing it without explaining to the woman just how grave the situation was, despite the obviously extreme time constraints. One of the obstetrical experts said that with a pH of 6.8 only ten percent of babies will survive, with about fifty percent of the survivors being normal. Of course, a Cesarean would be perfectly appropriate if an informed mother wished it, but this woman had no chance to make an informed decision.[22]

The problem that these cases illustrate relates neither to actual outcome, nor to the choice to intervene aggressively. Rather, the problem is the near inevitability of this choice and the reasons that underlie it. Most women would probably choose aggressive intervention when there is any hope at all, and one certainly does not want doctors to readily "write-off" imperiled fetuses. As with catastrophic illnesses, when an extraordinary or even experimental treatment may be the only hope, doctors' strong personal and professional inclination in obstetrical crises is to seize that slim chance. But at some point, as the baby's chances decrease, intervention begins to seem less like a realistic effort to save and becomes more of a rescue fantasy, or an attempt to vanquish the doctor's feelings of helplessness and fulfill a deeply ingrained personal and professional need to *do something*. Doctors'

21. Physicians provided these figures in discussion of the cases, and the severity of the pH level is confirmed by discussions in various texts. *See, e.g.*, Haverkamp, *A Controlled Trial of the Differential Effects of Intrapartum Fetal Monitoring*, 134 AM. J. OBSTET. GYNECOL. 399, 401 (1979) (pH of 7.20-7.25 problematic; below 7.20 an indication for immediate action).

22. I should emphasize that cases such as these are standard: the only unusual feature may be the subsequent ethical analysis.

inclinations here may color how they present the chances to the woman. Moreover, even if they fully inform her of her baby's grim prospects, it is still true that surgery is the child's only chance, and that in some cases, if the baby lives despite foregoing surgery, it could be worse off than if the Cesarean had been performed. Some women may nonetheless prefer almost inevitable fetal death to a strong possibility that the baby will live but with severe retardation. Yet they may feel enormous guilt at even thinking this, much less expressing it to a doctor who appears unreceptive. Doctors need only to suggest, "Don't you want to do everything for your baby?" for the woman's questions about surgery, prognosis, etc., to be submerged into the drive to give her child its only chance for life.[23]

Thus we have two prevalent, but largely implicit and unquestioned, approaches to decisionmaking in obstetrics. Women are often told nothing more than that a particular procedure is necessary for their baby's health. Given the circumstances, it is no wonder that the recommended procedure is almost always performed. Indeed, perhaps what is surprising is that some women steadfastly refuse recommended interventions. In the typical case where the woman consents, whether readily, desperately, or reluctantly, a set of value judgments are often obscured in the process. It is therefore worthwhile spelling out the various value judgments implicit in both routine and crisis-oriented obstetrical decisions, as well as briefly describing the emerging conflict over who decides.

II. OBSTETRICAL VALUES AND OBSTETRICAL RESPONSIBILITY

It is quite obvious that decisionmaking in obstetrics differs from decisionmaking in other areas of medicine, in that only in obstetrics is one patient within and dependent upon another. It has not been until recent years, with the development of new techniques allowing the doctor to visualize and assess the fetus' status, and the possibility of taking various actions (e.g., monitoring, surgical delivery) solely for the fetus' benefit, that the full implications of this dual patienthood have started to emerge.[24] In the past, because nothing much could be

---

23. Dr. Joanna Shulman, among others, has emphasized doctors' enormous influence, particularly when recommendations for intervention are expressed in this way. Shulman interview, *supra* note 19.

24. There is a burgeoning literature on these potential conflicts, much of it analyzing the potential impact of *in utero* fetal therapy. *See, e.g.*, Barclay, McCormick, Sidbury, Michejda & Hodgen, *The Ethics of In Utero Surgery*, 246 J. A.M.A. 1550 (1981); Fletcher, *Healing before Birth: An Ethical Dilemma*, TECH. REV., Jan. 1984, at 27; Hubbard, *Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy*, 7

done for the invisible and inaccessible fetus, the woman was, by default, the primary focus of the physician treating the maternal/fetal unit. Today, however, there is more of a gestalt at work in whether one sees the woman as primary, or the fetus, or each at different times. Electronic fetal monitoring, for example, makes the fetus the focus of the delivery process: a common complaint is that the blips on the monitor screen tend to displace attention from the laboring woman. In a very real sense, the woman is a barrier which must be overcome in order to assess fetal status. As technology improves medicine's ability to "penetrate" this "maternal barrier," the possibility for value conflicts in obstetrics concomitantly increases.

One potential value conflict that may permeate routine obstetrical decisionmaking arises from the juxtaposition of the medical maximin strategy, which emphasizes fetal outcome, and an individual woman's views about the importance of the birthing process. While many women may share a desire to avoid any fetal risks at all costs, others may reject much medical intervention because of religious views, desires for a natural childbirth, or other reasons. Pregnant women, as the ones who experience the process of pregnancy and childbirth, naturally have a greater interest and concern about the process itself. Some doctors scoff at concerns about process. One researcher on the increasing Cesarean rate reports repeatedly being asked by physicians: " 'What's so great about delivering from below [vaginally] anyway?' "[25] Others may recognize the legitimacy of these concerns, and be willing to let them influence their mode of practice, but because it is the patient's birth process, not the physician's, the obstetrician can never actually share the concerns.

It is, of course, a truism that no doctor can fully embrace and accept a patient's feelings—the fundamental isolation of an individual in one's own subjectivity is inescapable. But the barriers to achieving at least empathy are higher than usual in obstetrics, because of the different ways to perceive the maternal/fetal unit. The maximin strategy, by focusing on the fetus, inclines its adherents to see the fetus as figure and the woman as ground, at least metaphorically. Thus the doctor might view the woman's concerns about process as trivial or frivolous in comparison to the overriding goal of achieving optimal fetal outcome, and the woman who senses this may find it harder to express her concerns.

WOMEN'S RTS. L. REP. 201 (1982); Ruddick & Wilcox, *Operating on the Fetus*, HASTINGS CENTER REP., Oct. 1982, at 10.

25. Corea, *supra* note 3, at 31 (quoting Dr. Helen Marieskind).

The potential conflict between a physician's focus on fetal outcome and some women's concerns about the birthing process will be intensified in the cases in which the woman believes outcome and process are not entirely separate. Doctors using a maximin strategy make a strong dichotomy between process and outcome. A woman, however, may believe that her baby will do better if she does not take drugs, or walks around during labor (and thus is not continuously monitored), or even if she gives birth in a more relaxed and intimate home environment. Whether or not process ordinarily affects outcome, it will be at least somewhat more likely to do so if the woman strongly believes it will: for example, monitoring can slow labor or even cause decreased oxygen flow to the fetus if the woman experiences a great deal of anxiety about the monitor.[26] Because virtually all maximin-type interventions are aimed at optimizing fetal outcome, doctors may have good scientific reason to reject a woman's idea that a more natural process will enhance outcome. But this may give too little importance to the subjective force of the woman's beliefs.

Of course, the woman also is concerned about her outcome. Her concern may encompass not only objectively devastating outcomes such as death, disability, or loss of reproductive capacity, but also feelings about pain, bodily invasion, recovery time from giving birth (which is greater with surgical than vaginal delivery), future Cesareans, and scarring. These concerns are similar to those of any medical patient and again, while doctors can try to understand, they cannot really know or adopt the patient's values. Here, however, her values potentially can harm the fetus, at least if she strongly opposes medical or surgical intervention. Thus the physician may be more apt to discount them or deem them illegitimate.

The potential conflicts discussed thus far have involved the maximin strategy's focus on the fetus versus the woman's incorporation of concerns for her health, her religious beliefs, or her views about the birthing process. Routine obstetrical decisions, while they often involve trading off some increased degree of fetal safety for maternal comfort, seldom involve extreme threats to the fetus that involve value judgments about the possible quality of its life. Judgments in crisis situations, however, do. Although in the two specific examples discussed under the "only hope" strategy the baby died anyway, acts of last-ditch intervention often mean the difference between life and death. But often the life that is saved is not a normal life. These cases, therefore, involve a value judgment directed solely at the fetus: does

26. Cibils, *supra* note 12, at 478.

the woman want her child to survive at all costs, or would she consider some types of existence as either worse than death, or at any rate, a burden she does not wish to accept? Like the woman in our first example, who initially said no to a Cesarean because she did not want a retarded child, some women may rank severe disability in a child as worse than death. These women would choose not to intervene aggressively if the situation was extremely grave.

Conflicts can arise, of course, if the doctor treating the patient ranks death worse than disability, or worse than this infant's projected disability. However, conflicts can arise even if the doctor and the woman share similar values. A number of factors appear to influence doctors to act *as if* they ranked death as necessarily the worst outcome. For example, quite understandably, they are influenced by the almost inevitable uncertainty in these cases: there is usually some chance, albeit slim, that the baby will be fine, or at least do better than expected, and it is very hard not to intervene when this possibility still exists. As in cases of terminal illness, allowing the death of a patient may feel to the doctor like giving up, and in obstetrics, it may feel like giving up unnecessarily. They are likewise influenced to intervene by the presence of technology: it is difficult not to use technology when it is there, especially given medical training and socialization in favor of intervention. The legal system magnifies the force of this imperative: if the infant is impaired and the doctor has just stood by, the doctor may face legal liability, whereas if he has done a Cesarean, the doctor has the strong defense of having done everything.[27]

An additional legal factor is beginning to make itself felt, in the wake of the now infamous "Baby Doe" case, where parents of a baby born with Down's Syndrome and a correctable esophageal defect refused consent to esophageal surgery. When the state courts refused to intervene, the Department of Health and Human Services promulgated regulations designed to prohibit withholding of treatment from handicapped newborns.[28] The principle underlying the regulations—

27. *See* Marieskind, *Cesarean Section*, 7 WOMEN & HEALTH 179, 188 (1982) (fear of legal liability often plays role in decision to deliver by Cesarean).

28. The Department initially "reminded" health care providers receiving federal financial assistance that newborns with handicaps were protected by § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1982), which prohibits discrimination against the handicapped by any program or provider receiving federal financial assistance. 47 Fed. Reg. 26,027 (1982). This notice was followed, a year later, by an "Interim Final Rule" which not only prohibited such "discrimination" but required each hospital to post a sign in the newborn nursery stating that it is unlawful to fail to provide food or treatment to handicapped newborns and advising of the availability of a "hotline" to report violations. 48 Fed. Reg. 9630 (1983). After this regulation was invalidated on the grounds that the

that it is discriminatory to withhold beneficial treatment from a handicapped infant if such treatment would be provided to a normal one—appeared to apply not only to handicaps such as Down's Syndrome, but to far more devastating ones, which dramatically shortened life and/or resulted in profound physical and mental deficits.[29] The regulations were invalidated on a number of grounds by a series of federal courts,[30] culminating with the Supreme Court decision in *Bowen v. American Hospital Association*,[31] which emphasized that hospitals have no duty, and indeed, no right, to treat infants without parental consent. The Court found that the Department presented insufficient evidence of hospitals failing to report parental refusals of treatment for handicapped newborns to warrant the regulations.[32] Thus far, the end

---

Department had failed to follow the notice and comment procedures required by the Administrative Procedure Act, American Academy of Pediatrics v. Heckler, 561 F. Supp. 395, 404 (D.C. Cir. 1983), the Department then followed proper procedures, issuing a Final Rule, 49 Fed. Reg. 1621 (1984), which modified the requirements for posting of signs, and used slightly more moderate language. The rule still provided that it was discrimination to fail to treat any newborn who could benefit from treatment, no matter how severe the degree of handicap.

29. For critiques of the application of the principle of nondiscrimination in the newborn nursery, see, *e.g.*, Arras, *Ethical Principles for the Care of Imperiled Newborns: Toward an Ethic of Ambiguity*, in WHICH BABIES SHALL LIVE: HUMANISTIC DIMENSIONS OF THE CARE OF IMPERILED NEWBORNS 83, 100-05 (T. Murray & A. Caplan, eds. 1985) (analyzing various interpretations of "discrimination" in the context of treatment decisions); Rhoden, *Treatment Dilemmas for Imperiled Newborns: Why Quality of Life Counts*, 58 S. CAL. L. REV. 1283, 1298-1302 (1985); Rhoden & Arras, *Withholding Treatment from Baby Doe: From Discrimination to Child Abuse*, 63 MILBANK MEM. FUND. Q. 18, 24-29 (1985).

30. United States v. University Hosp., 729 F.2d 144, 161 (2d Cir. 1984) (invalidating regulations on primary ground that the Rehabilitation Act of 1973 was never intended to apply to complex treatment decisions in the newborn nursery), *aff'g* 575 F. Supp. 607, 614 (E.D.N.Y. 1983) (denying government access to records of "Baby Jane Doe," an infant with spina bifida upon whom surgery had not been performed, on the grounds that the hospital had not violated the Rehabilitation Act).

31. 106 S. Ct. 2101 (1986). Lower court decisions in the *American Hospital* litigation had been expressly based upon the Second Circuit's holding in *University Hosp.*, 729 F.2d 144. *See*, American Hosp. Ass'n v. Heckler, 585 F. Supp. 541 (S.D.N.Y. 1984), *aff'd* Nos. 84-6211 and 84-6231 (2d Cir. Dec. 27, 1984).

32. *Bowen*, 106 S. Ct. at 2114-20. It is true, and quite important, that hospitals cannot treat a baby without parental consent. However, the Supreme Court majority's emphasis on the theory that hospitals cannot violate Section 504 by withholding treatment when parents have refused consent distorts the way that treatment decisions are made in hospitals. As the dissent notes, parental decisions do not occur in a vacuum, but are made in conjunction with physicians. Physicians may treat handicapped newborns differently from non-handicapped ones by encouraging, or not discouraging, parental inclinations to withhold treatment. *Id.* at 2128, (White, J., dissenting). As for the majority holding that there is no evidence that hospitals discriminatorily fail to report non-treatment decisions for handicapped newborns, anyone who has talked with physicians about these issues knows that, as the dissent puts it: "It is . . . obvious that whoever is making them, *decisions* to

result of the public attention given to the dilemma of treatment of imperiled newborns is the invalidation of the very rigid Baby Doe regulations. In the interim, however, Congress passed the 1984 Amendments to the Child Abuse Prevention and Treatment Act[33] which mandate treatment unless the infant is dying, permanently comatose, or the treatment is futile or virtually futile and under the circumstances inhumane.[34] Although these Amendments are more flexible than the former Baby Doe regulations, they still indicate a strong intent to decrease parental and physician discretion and require aggressive treatment if the infant will have even a very minimal level of consciousness.

Given these various developments, it is not at all surprising that even though many physicians may believe that withholding or terminating treatment for seriously impaired infants is appropriate in certain cases, they increasingly feel constrained to treat all infants aggressively. Moreover, as parental discretion immediately after birth is increasingly limited, doctors may wonder whether a woman should be able to opt for death over disability in the moments before birth, as well as whether the doctor might risk legal liability if he accedes to such wishes. Thus even if doctors have values similar to those of their obstetric patients, and even if doctors, were they personally faced with such a situation, might forego aggressive treatment, their professional training, fears of malpractice liability, concerns created by the "Baby Doe" rules, etc., may come between their beliefs and actions.

My experience at hospitals suggests that a physician is relatively unlikely to go to court to attempt to force treatment in a crisis situation where the fetus' chances, even with treatment, appear seriously compromised. For one thing, if it is a crisis situation where "last ditch" intervention is being urged, the woman probably lacks firm religious or philosophical objections to such intervention—as opposed to a situation where a woman had informed health care personnel from the beginning that she would oppose certain procedures. Rather, she is just trying, like the doctors, to weigh the risks of intervention—both the risk to her and the chance of a severely impaired child—versus the

withhold treatment from such infants are in fact being made." *Id.* I believe that the regulations warranted invalidation on a number of grounds, including excessive interference with parental and medical discretion, the fact that the Rehabilitation Act was never intended to apply to such situations, and that the principle of nondiscrimination is grossly oversimplified for these difficult decisions in the newborn nursery. My quarrel with the majority opinion in *Bowen* is not about its outcome, but its misrepresentation of the medical context in an attempt to rationalize the outcome.

33. 42 U.S.C. §§ 5101-5115 (Supp. III 1985).

34. 42 U.S.C. § 5102(2)(b)(3) (Supp. III 1985).

potential benefits of saving a child who turns out to be fine, or at least relatively normal. When the physician is offering even a slim chance of saving the infant, it is likely that the combination of uncertainty, guilt, hope, and desperation will influence the woman ultimately to follow the physician's suggestion. And, in the rare case where desperate or reluctant consent is not forthcoming, doctors would be relatively unlikely to seek a court order, both because of the time constraints and because they are less likely to challenge the woman's decision if they believe that even with treatment, the infant is likely to die or be severely impaired. If, however, doctors believe that with the treatment the child can be fine, they are increasingly apt to challenge the woman's decision in court.

Most such suits so far have involved women's refusals to submit to Cesareans needed for the fetus', and sometimes their own, health. In the two cases reported in the legal or medical literature, the courts have granted the order,[35] and this has similarly been true in most of the additional unreported cases of which I am aware.[36] These cases are still, at present, few and far between, and they have involved, for the most part, women with unusual religious beliefs about medical intervention. But they have an import beyond their numbers. These cases raise the ultimate issue in obstetrics of whether women can choose a course of action that reflects their own beliefs and concerns, but that puts the fetus at risk. This issue is not limited to Cesarean versus vaginal delivery: courts have ordered blood transfusions for pregnant Jehovah's Witnesses, both before and after fetal viability,[37] and a court has ordered insulin treatment for a pregnant diabetic who refused it on religious grounds.[38] These judicial interventions into wo-

35. *See* Jefferson v. Griffin Spaulding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981); Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTET. & GYNECOL. 209, 211-12 (1981).

36. *See, e.g.*, *In re* Baby Jeffries, No. 14004 (Probate Ct., Jackson Cy, Mich., May 24, 1982) (order authorizing surgery); North Central Bronx Hosp. v. Headley, No. 1992/85 (S. Ct., Special Term, Bronx Cy, N.Y., Jan. 6, 1986) (order authorizing surgery). Some cases arise and are decided so quickly that no written order is issued. Interview with Judge Margaret Taylor, Family Court, in New York City (Nov. 6, 1985) (describing 1982 case where attorneys for St. Vincent's Hospital sought an order but she refused to issue one).

37. Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (1964). This case was decided long before Roe v. Wade, 410 U.S. 113 (1973), and is thus of somewhat questionable precedential value. A much more recent case is *In re* Jamaica Hosp., N.Y.L.J., May 17, 1985, at 15 (Queens Cy., S. Ct., Special Term, Part 2) (fetus was 18 weeks in gestation).

38. *In re* Unborn Baby Wilson, *cited in In re* Baby Jeffries, No. 14004 (Probate Ct., Jackson Cy., Mich., May 24, 1982) slip op. at 7. Hospital personnel are increasingly beginning to contemplate numerous potential involuntary treatments. I have participated in ethics rounds at several hospitals where the issue was whether a pregnant patient whose

men's choices are in striking contrast to the trend in other areas of medicine, which is to accept patients' rights to refuse medical treatment of any kind. In obstetrics, however, doctors and others in society are increasingly questioning whether women have the right to take actions or refuse therapies which might imperil the healthy fetus.[39]

Thus far, doctors have sought judicial intervention only when they believed that without treatment the fetus would die or be damaged, but with treatment would probably be fine. But if overriding women's choices becomes established judicial fare, doctors may begin seeking judicial intervention, or threaten to seek it, in cases where the infant might be compromised even with maximal treatment. This would, after all, make sense, if the thrust of the Child Abuse Amendments—that handicapped newborns have the same rights to treatment as non-handicapped ones—is considered to apply *in utero* as well.

The potential for reallocation of decisionmaking authority in obstetrics does not stop here, either. Although cases thus far have involved maternal actions that have created grave risks for their fetuses, many women take actions that physicians consider less than optimal during pregnancy. For example, many women refuse electronic fetal monitoring, or even choose to give birth at home. Whether or not the long arm of the law ever reaches women who have fled the hospital,[40] when the woman is in the hospital it is not too far-fetched to imagine that doctors may challenge refusals of procedures such as fetal monitoring.[41] Concern for the fetus, as well as concern about malpractice liability, has inspired hospital risk managers, legal counsel and counsel for New York City public hospitals sometimes to advise doctors just to do whatever is best for the fetus, notwithstanding maternal refusal.[42]

---

conduct was harmful to the fetus in some way could be forcibly hospitalized and/or treated.

39. In a recent article, the author describes a situation where a woman was seven months pregnant and at a cocktail party, when "a stranger walked over and wordlessly removed a glass of white wine from her hand." The author also reports being pregnant herself and having dinner at a Chinese restaurant when a woman she didn't know stopped at her table tapped her plate, and said, "Uh, uh, uh, MSG." Quindlen, *The New Rules for Pregnancy*, N.Y. Times, Sept. 28, 1986, Part II (Magazine) at 82, 86. The author refers to these intervenors as the "fetus police." *Id.*

40. In one court-ordered Cesarean case, the order authorized police to seek out the pregnant woman and forcibly return her to the hospital. *In re* Baby Jeffries, No. 14004 (Probate Ct., Jackson Cy., Mich., May 24, 1982) slip op. at 9.

41. The order in another case appointed the chief of obstetrics as *guardian ad litem* for the fetus, with authority to consent to necessary diagnostic or therapeutic procedures if the woman came to the hospital. North Central Bronx Hosp. v. Headley, No. 1992/85 (S. Ct., Special Term, Bronx Cy., N.Y., Jan. 6, 1986) slip op. at 2.

42. Interview with Salvatore Russo, Associate Counsel, N.Y.C. Health & Hospitals Corp., in New York City (Jan. 10, 1985) (stating opinion that city hospital should be able

Even though this advice reflects fears of financial responsibility, it constitutes an assumption of medical responsibility for fetal outcome and obstetrical decisionmaking. Thus along with the existing potential value conflicts is emerging a conflict on a higher level: to what extent should pregnant women have the authority and responsibility for making the sorts of medical decisions that, under the informed consent doctrine, patients ordinarily, or at least theoretically, make?

III. CAN ANYTHING BE DONE?

Professor Katz's central thesis, of course, is that truly shared decisionmaking in medicine requires that physicians reflect upon and discuss among themselves the underlying influences on their decisions, including psychological motives, professional values and socialization, and that they enter into an open-ended dialogue with patients in which they share their uncertainties. By listening to patients, physicians may be at least partially able to overcome what Katz calls one of the most pernicious problems in medicine: "that in their professional interactions with patients, physicians view themselves as too rational and their patients as too irrational" (p. 150). If physicians take the time to analyze their own unconscious motivations and to realize how their non-medical values seep into judgments they had heretofore conceptualized as purely, or at least largely, medical, they will achieve an enhanced regard for the differing values that could underlie patients' inclinations to act differently.

Obstetrical decisionmaking would undoubtedly be improved if physicians were, for some reason, inspired to take Professor Katz's suggestions seriously and to seek to implement them. Obstetricians are, of course, aware that diagnostic technologies in obstetrics have their limitations, and that they may therefore "diagnose" problems that do not in fact exist. But many obstetricians are not fully aware that they are trained to react to uncertainty in a particular manner: they may believe that their response is the only possible response or, because uncertainty makes them so uncomfortable, may fail to take it fully into account. Doctors feel an understandable discomfort in admitting, and especially in revealing to patients, the fact that the machines upon which they are so dependent are far from infallible. But

---

to perform procedures necessary for fetus' health, despite maternal refusal, and that obtaining court order helpful but not necessary); Interview with Patty Lipschitz, Counsel, North Central Bronx Hospital, in New York City (Jan. 13, 1985) (confirming that the Health and Hospital Corporation does not think court orders necessary, but expressing disapproval of this stance).

doctors clearly need to tell patients, preferably early in the course of pregnancy and long before a crisis could arise, of the limitations of diagnostic technologies and of the possibility that they will need to act under conditions of uncertainty.

Providing information about technological limitations and the possibility of unclear diagnoses or prognoses is not enough, however. Physicians must come to understand both why they react to diagnostic and prognostic uncertainty the way they do and why a patient might react differently. In other words, they need to go the very difficult extra step of recognizing that there are sometimes legitimate alternatives to the approaches that have come to seem so natural and so right. Such awareness is difficult to attain.[43] Awareness of alternative approaches to decisionmaking under uncertainty comes at a cost: in a field where quick, decisive action is so often needed, it is difficult to be quick and decisive when one's certainty is diminishing.

This, however, is the point at which shared decisionmaking is helpful. A doctor who unequivocally is not sure of the "right" way to proceed is far more likely to make the choice in conjunction with the patient, taking her values into account. In obstetrics, because there are situations that indeed require quick, decisive action, exploration of the woman's values should ideally take place long before pressured or emergency decisionmaking is necessary. Because in an emergency there is so little time for exploration of the values of doctor and patient, it is crucial that whenever possible, such conversations be held in advance of any emergency. If the doctor has taken the time to discuss the sorts of dilemmas that may arise, even though such discussions may be disturbing and frightening, the physician will then have a much better sense of the woman's own concerns and values, and conversations during a crisis will be more profitable.

Few women will come for prenatal care with a rigidly established set of priorities to be applied to a situation in which their health interests and those of the fetus might conflict. Some observers have suggested a broad spectrum of possibilities in discussing innovative fetal surgery—from the woman placing her health and welfare first and foremost, to subsuming her interests to those of the fetus, to seeking a reasonable center ground.[44] Moreover, with any set of preferences,

---

43. At the two hospitals affiliated with Albert Einstein College of Medicine at which Dr. Fleischman and I led Perinatal Law and Ethics Rounds, lengthy and sustained discussion regarding the medical uncertainties involved seemed to help physicians feel more comfortable with, and less responsible for, uncertainty.

44. Ruddick & Wilcox, *supra* note 24, at 12-13. Ruddick and Wilcox suggest three possible therapeutic contracts between woman and physician: (1) gynecological—the wo-

women will differ in whether they would rather risk fetal death—often by refraining from intervention—or neurological disability—sometimes by intervention when the diagnosis is ominous.

Obviously, if the woman's preferences, values and inclinations toward particular approaches to uncertainty differ radically from the physician's, serious problems will arise. Because of the potential consequences to the fetus, obstetricians find it particularly hard to defer to patient's wishes. Serious conflicts unearthed early in pregnancy may warrant a change in physician. But public patients, or ones who come in later in pregnancy, may not have this luxury. In these cases, physicians face the difficult task of learning to respect and honor the woman's choices even when they differ somewhat from their own, and in the course of doing so, treating her not simply as a patient, but as an equal partner in the obstetrical undertaking. They must see value conflicts not as a threat to their authority, but as a challenge—how to provide the best care possible that is nonetheless consistent with the woman's values.

Of course, these suggestions do not answer the question that is unique to obstetrics: how to proceed in cases of irreconcilable conflict, when honoring the woman's choice almost surely will endanger the fetus. Professor Katz astutely notes the extent to which judges are inclined to distrust patients and uphold medical authority (p. 59). This inclination often will prevail in obstetric conflicts, especially given the dreadful and irrevocable consequences of upholding, for example, a woman's refusal of a Cesarean which is needed for the fetus' life or health. A judge's tendency to grant the doctors' request, illustrated in almost all the cases thus far, may be reinforced by the fact that the women in these cases are seldom represented by counsel. But even though they can probably succeed, individual obstetricians and the obstetrical profession in general, need to seriously consider the prior question of whether, in the long run, it is wise to ask courts to replace informed consent with enforced acquiescence.

One potential drawback of seeking judicial intervention to override treatment refusals of pregnant women relates to the informed consent doctrine itself. When a woman comes in for prenatal care and indicates that she has unusual religious or medical beliefs that would cause her to oppose surgical intervention, doctors should have an obligation to tell her that if a crisis arises, they will not honor these beliefs.

---

man's health coming first, with pregnancy as a complication of her gynecological condition; (2) pediatric—the fetus treated as if it were a child, with its needs and interest paramount to those of the woman's; and (3) obstetric—some middle ground between (1) and (2). *Id.*

Her response may be to find another doctor, a response that is probably agreeable to all concerned. But if she is a public patient, she may have no alternative, and may end up foregoing prenatal care. Significantly, in several cases where a court order has been obtained, the woman did not return to the hospital and in one case a very high risk woman had a home birth.[45] If this occurs with any frequency, the doctors' fetal protection policy will backfire, putting the fetus at even greater risk than would a hospital birth where surgery is refused.

Even if the woman bows to this powerful combination of obstetrical and judicial authority, however, the obstetrical physician-patient relationship may suffer more subtle erosion as a result of this reallocation of power. The possibility of involuntary commitment looms over certain psychiatrist-patient encounters and may make those encounters far more problematic than when such a threat is absent. Patients, whether psychiatric or obstetric, who know that their doctors can forcibly treat them in a way they abhor may view those doctors differently from patients who unambivalently believe their doctors are there to help them. Even though in individual cases the consequences of abiding by a maternal refusal will be tragic, the consequences of patients losing their right to choose and seeing their obstetricians as adversaries may be ultimately at least as disturbing. Moreover, as doctors assimilate their newfound power to direct women to "follow doctor's orders," and increasingly view themselves in the role of fetal protectors or advocates, these doctors will lose whatever incentive they now have to share decisionmaking in any meaningful way.

CONCLUSION

In summary, there is reason to be profoundly pessimistic about the chances for shared decisionmaking in obstetrics. The intense analysis and ongoing dialogue for which Professor Katz pleads could undoubtedly do much to improve the situation. But already lurking beneath the obstetrical dialogue are unchallenged and sometimes problematic decision strategies compounded by technological limitations, the "technological imperative," the looming threat of malprac-

45. This occurred in North Central Bronx Hosp. v. Headley, No. 1992/85 (S. Ct., Special Term, Bronx Cy., N.Y., Jan. 6, 1986); Shulman interview, *supra* note 19. An indication of the uncertainty inherent in medical predictions and the possibly alarmist nature of certain predictions is that this woman had a vaginal birth in which she and the baby were fine, *id.*, as did the woman in *In re* Baby Jeffries, No. 14004 (Probate Ct., Jackson Cy., Mich., May 24, 1982). Mrs. Jefferson, in Jefferson v. Griffin Spaulding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981), likewise gave birth vaginally. *See* Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REP., June 1982, at 16.

tice liability, and numerous but often unexplored value judgments and potential conflicts. Already, the woman is in an extraordinarily vulnerable position, given her concern and anxiety for her baby's welfare. If we add to all this doctors' emerging ability to override treatment refusals they view as risky or unwise, Professor Katz's vision of shared decisionmaking fades into the realm of imaginary obstetrical encounters. Except when the doctor's recommendation is really optional, the woman's choices may soon be reduced to gracefully submitting to the medical recommendation, resulting in the appearance of informed consent. If she is compelled to submit, there is not even this comforting fiction. Hence, in obstetrics, informed consent may soon pass from being a necessary illusion to an illusion that is not necessary at all.