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Forensic Implications and Medical-Legal Dilemmas of Maternal Versus Fetal Rights

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ABSTRACT: The purpose of this paper is to review the issue of fetal rights from primarily a legal perspective, with consideration of morals and professional ethics. The practice of medicine is fraught with numerous bioethical dilemmas. These dilemmas often leave the physician wondering if he has made the correct decision. A physician's morals and professional ethics may influence his or her decision in resolving bioethical dilemmas.

The case example is a 34-year-old female with a 41-week intrauterine pregnancy. The mother was refusing induction of labor. Without the labor induction, the fetus may die. Despite this risk, the mother desired to pursue a vaginal delivery.

The AMA's ethics state that a competent, pregnant mother's wishes should prevail and the court should not be involved unless there are unusual circumstances. The mother in the case example was competent and informed consent was provided.

Case law does not specifically address the dilemma of the case example. However, there is case law regarding court-ordered cesarean sections which reveals different opinions. The difference in court opinion encompasses the relative degree of weight given to the fetus's right to be born healthy and alive versus the mother's privacy rights. Some courts describe this ''balancing test,'' whereas others state that the mother's privacy rights prevail unless there are exceptional circumstances, which will be extremely rare. The fetus has acquired rights in other areas of the law; for example, abolishment of the intra-family immunity doctrine and the definition of murder in most states. In considering the legal arena of fetal versus maternal rights, a decision tree is presented to assist physicians in assessing cases of a pregnant mother refusing medical treatment.

There is no precise demarcation in assessing fetal and maternal rights. The greater the degree of fetal viability, the greater degree of fetal rights. Consideration must also be given to the relative degree of invasiveness to the mother for the proposed procedure; the more invasive, the greater degree of maternal rights. Each case must be evaluated on an individual basis and the decision tree can assist a clinician with this process.

KEYWORDS: forensic science, maternal rights, fetal rights, medical dilemmas, legal dilemmas, decision tree

Each individual is the master of his or her own body. For example, an individual has the right to refuse medical treatment even if that treatment is necessary to sustain the individual's life. Psychiatrists intervene legally to provide a safe environment for individuals, often against the individual's will. The treatment of both psychiatric and nonpsychiatric patients against their will has been well established in the legal system. This treatment may initially frustrate and anger the patient, and sometimes, even anger the patient's family. The patient's anger and frustration is often directed towards the psychiatrist. The patient's disapproval of the psychiatrist's prescribed (or forced) treatment presents an uncomfortable situation because, as physicians, their desire is to help patients and have them participate in their treatment plan. These situations are not unique to psychiatry.

With respect to medical ethics, the term ''ethical'' as used in the AMA Opinions of the Council on Ethical and Judicial Affairs (1) refers to matters that involve moral principles or practice and matters of social policy involving issues of morality in the practice of medicine. The American Medical Association has developed principles of medical ethics which are ''standards of conduct defining the essentials of honorable behavior for the physician. . . . Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. . . . In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations'' (1).

A relatively new area that has posed moral and ethical conflicts for the physician has been the concept of fetal rights. The pregnant mother and fetus have a unique relationship, whereby the fetus is dependent upon the mother for nourishment and survival. Additionally, the mother is responsible for all medical treatment decisions that may affect the fetus. Abortion is a legal medical procedure that ends the life of the fetus. Decisions of pre-natal care, alcohol consumption, drug use, and other lifestyle choices are made solely by the mother. Is there a point when the fetus develops rights that override the mother's choice of free will? Does the fetus have the right to be born healthy and alive? If so, at what point in gestation does this right begin? Does society have an interest in the fetus' welfare, and if so, does society possess rights? Should the mother be forced, against her will, to receive medical interventions that improve chances of fetal survival?

A case example is provided and illustrates some of these dilemmas. The case example is followed with issues that should be considered by the physician in making a legally appropriate medical decision. This common situation will be used in this paper as a model of patient-doctor dilemmas in order to address a variety of issues. These issues are not black and white, even in the eyes of the court. Therefore, the information presented and conclusions drawn are not necessarily the right answer, but provide a more detailed examination of these dilemmas. The decision tree can serve as a tool for a clinician faced with fetal-maternal dilemmas, but is by no means all that is necessary for the evaluation and opinion. As in all aspects of psychiatry, the clinician's judgment is of utmost importance. The case example represents an actual

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patient evaluation with minor changes of history to preserve confidentiality.

Case Example

A 34-year-old Caucasian female gravida-2, para-1 with a 41-week intrauterine pregnancy, presented to Women's Hospital for induction of labor. The patient had tetralogy of fallot (the most common form of cyanotic congenital heart disease consisting of high pulmonic stenosis, ventricular septal defect, dextroposition of the aorta, and right ventricular hypertrophy) and schizophrenia treated with digoxin and haldol, respectively. The patient was post-term, with low amniotic fluid, and there were some fetal heart decelerations. Upon arrival at the Obstetrical Ward, the patient refused a bi-manual exam and labor induction. The obstetrical physician requested a psychiatric evaluation for assistance regarding management of the patient.

During psychiatric evaluation, the patient demonstrated a basic understanding of her clinical condition and the proposed treatment for labor induction. The patient stated that she ''wanted to have her baby naturally despite the risk of fetal death.'' The obstetrical physician described the patient's condition as urgent; the viability of the fetus would decrease as gestation continued past the due date, with significant morbidity at two-weeks post-term. At the time of the evaluation, the fetus was not in imminent danger. Due to circumstances of this pregnancy, however, the medical condition of the fetus could change rapidly. Induction of labor was clinically indicated. Before discussing the specific dilemmas posed by this case, issues related to medical ethics, informed consent, and competency are presented.

Medical Ethics

The AMA Council on Ethical and Judicial Affairs has made the following recommendations regarding court-ordered medical treatments and legal penalties for potentially harmful behavior by pregnant women (1).

1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention.
2. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
3. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
4. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
6. To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.

Informed Consent

Prior to any medical treatment or procedure, from a general physical exam to surgery, the physician must first obtain informed consent. People have the right to bodily integrity such that touching them without their consent constitutes battery. Patients must provide informed consent prior to receiving medical treatment. Implicit in the doctrine of informed consent is the right not to consent to medical treatment.

Ruth Macklin (2) describes informed consent as a process of ensuring that patient's know what doctors propose to do and that the patient freely grants permission for the recommended surgical or medical procedures. Informed consent ''does not serve as a guarantee that the patient has understood,'' but is rather a ''process of communication, on going shared information and developing choices as long as a patient is seeking medical assistance'' (2). The physician must respect the patient's autonomy. If a physician's views on a case are determined by his/her personal ethical, moral, or religious views as opposed to established professional ethics or the practitioners view of what is the most professionally ethical thing to do, then the case should be referred to another physician. Informed consent should always contain at least these elements:

1. Adequate information enabling the patient to make an informed choice;
2. The capacity of the individual to understand what he or she is told, and;
3. To make a reasoned choice based on that information and the voluntariness with which the choice is made (2).

Competency

An integral aspect of informed consent is the patient's competency. Only a judge can give an official ruling as to a person's competency; however, physicians are often called upon to determine if an individual is competent. All patients are presumed competent for medical treatment. The assessment of competency is task specific; that is, a patient may be assessed as competent to consent to a blood draw but not competent to consent to a more highly complicated medical procedure. According to Monagle and Thomasma (3), a patient should be considered competent if the patient is all of the following:

1. An adult (18 years or older) or a qualified minor;
2. Conscious;
3. Able to understand the nature and severity of the illness involved;
4. Able to make an informed choice concerning the course of treatment; and
5. Has not been declared legally incompetent.

If the physician believes a patient is incompetent to give informed consent for necessary medical care, the informed consent can be provided through substituted judgment. The substituted judgment may be given by the legal guardian, spouse, children, or judge (3). ''The incompetent patient's representative, before giving consent, must first determine in good faith that the patient, if competent, would have consented to the proposed health care'' (3). Many physicians abide by the following: in cases of an emergency of imminent danger of loss of life or limb in an incompetent patient, with no representative available, two physicians sign the informed

consent declaring that the treatment is needed to prevent the loss of life or limb.

The patient described in the case example is at the stage of informed consent. Both the obstetrical physician and the consulting psychiatrist engaged the patient in discussions regarding her current medical condition and proposed treatment. In addressing the issue of competency, the patient appeared to understand the nature and severity of her condition; in particular, that her pregnancy is post-term with various complications such that induction of labor is clinically indicated. The patient understood the physician's prognosis that without labor induction, the fetus might die; however, she held the belief that everything would be fine if she had the baby naturally (vaginal delivery). Despite repeating the risk of fetal death without labor induction, the patient desired to await a vaginal delivery. Regarding informed consent, the patient was provided adequate information and appeared to have the capacity to understand what she was told. She was making a voluntary choice; however, whether the choice was reasoned was questionable.

Given the above situation, the question of fetal rights now emerged. If the fetus does not have any rights, the mother's wishes prevail and a vaginal delivery should be pursued. If the fetus does have rights (i.e., the right to be born healthy and alive) such that at 41 weeks' gestation these rights would govern medical decisions, then the mother may then be forced, even if against her will, to undergo labor induction. Case law has addressed similar dilemmas.

Case Law

In researching the area of fetal versus maternal rights, no statutory law was found which focused on these issues, while case law presented opposing opinions. Since there is no case law dealing with the same dilemma as the case example, it will be necessary to review cases with similarities. Pertinent case synopses are presented in the following section to provide the reader a perspective of the varied opinions from the courts.

Case Law: United States Supreme Court

Roe v. Wade (4) was decided by the United States Supreme Court on 22 January 1973. An unmarried pregnant woman who wished to terminate her pregnancy through abortion, instituted an action in court seeking a declaratory judgment that the Texas criminal abortion statutes were unconstitutional. These statutes prohibited abortions except for the purpose of saving the life of the mother as medically indicated. The plaintiff also sought an injunction against the abortion statutes' continued enforcement. Some of the holdings from this case by the United States Supreme Court included:

1. The right of privacy encompasses a woman's decision whether or not to terminate her pregnancy;
2. A woman's right to terminate her pregnancy is not absolute, and may to some extent be limited by the state's interest in safeguarding the woman's health, in maintaining proper medical standards, and in protecting potential human life;
3. The unborn are not included within the definition of ''person'' as used in the Fourteenth Amendment;
4. Prior to the end of the first trimester of pregnancy, the state may not interfere with or regulate an attending physician's decision, reached in consultation with his patient, that the patient's pregnancy should be terminated;
5. From and after the first trimester, and until the point in time when the fetus becomes viable, the state may regulate the abortion procedure only to the extent that such regulation relates to the preservation and protection of maternal health;
6. From and after the point in time when the fetus becomes viable, the state may prohibit abortions altogether, except those necessary to preserve the life or health of the mother (4).

Another case involving abortion, Webster v. Reproductive Health Services (5), was decided 3 July 1989, by the United States Supreme Court. State-employed health professionals and private nonprofit corporations providing abortion services brought suit for declaratory judgment and injunctive relief challenging the constitutionality of a Missouri statute regulating the performance of abortions. Some of the Court's statements include the following:

1. The Missouri statute specified a testing provision, namely, that a physician, before performing an abortion on a woman he has reason to believe is carrying an unborn child of 20 or more weeks gestational age, shall first determine if the child is viable . . . the Court stated this is constitutionally permissible because it furthers the State's interest in protecting potential human life;
2. Under the Roe framework, the State may not fully regulate abortion in the interest of potential life (as opposed to maternal health) until the third trimester; in order to save the Missouri testing provision of requiring a physician to determine the viability of a 20 (or more) week fetus (second trimester) before performing an abortion, the Court found it necessary to throw out Roe's trimester framework.

Case Law: Maternal Rights Prevail

On 22 April 1990, In re A.C. (6) was decided by the District of Columbia Court of Appeals. The case involved a pregnancy with a viable fetus at 26 weeks. There was substantial history leading up to the legal case. A.C. was first diagnosed with cancer at age thirteen. She was married at age 27 and soon became pregnant. At the 25th week of her pregnancy, A.C. was diagnosed as having an inoperable tumor in her lung. One week later, A.C. agreed to medical treatment to extend her life past the 28th week of pregnancy, at which point she would give up her life for the fetus. The next day, A.C.'s condition rapidly deteriorated such that she was not competent to consent to surgery. A.C.'s wishes were only known for when she would be at the 28th week of pregnancy, and there was no evidence before the Court that A.C. consented to or even considered a cesarean section before this time.

The Appellate Court held that the terminally ill woman's constitutional ''right to refuse treatment'' overrode the state's interest in protecting the fetus. The trial court applied a balancing test of the state's interest in a viable human versus the mother's privacy rights. The Appellate Court stated that such a test was improper and the mother's wishes controlled ''unless there are truly extraordinary or compelling reasons to override them . . . Such cases will be extremely rare and truly exceptional'' (6). The Appellate Court further stated that the mother has no duty to risk her health for a child, ''A fetus cannot have rights . . . superior to those of a person who has already been born'' (6). This Court also reasoned that court-ordered cesarean sections would erode the trust between a pregnant woman and her physician. Judge Belson was the lone dissenter on this case and advocated a ''balancing test'' (6).

The Appellate Court described how a trial judge should approach similar cases. Is the patient capable of making an informed decision about the course of medical treatment? If yes, then the patient's

wishes are controlling in virtually all cases. If the Court finds the patient is incapable of making an informed decision, then the Court makes a substituted judgment (what the patient would want if competent).

A more recent case where maternal rights prevailed was decided by the Illinois Appellate Court in In Re Baby Boy Doe (7). A mentally competent woman refused the cesarean section recommended by her doctor who stated that her 35-week-old fetus would die or suffer mental retardation without this intervention. The fetus was suffering from placental insufficiency. Doe and her husband refused to consent to the cesarean section or labor induction based upon religious reasons. The Appellate Court reasoned that ''The state's compelling interest in the potential life of the fetus is insufficient to override the woman's interest in preserving her health'' (7). Therefore, the woman's choice to refuse medical treatment should not be balanced against the fetus' right to life, even when the woman's choice might be harmful to the fetus.

Case Law: Fetal Rights Prevail

The Georgia Supreme Court decided Jefferson v. Griffin Spalding Hospital Authority (8) in February 1981. This case was initiated when Griffin Spalding Hospital petitioned the Court for an order authorizing it to perform a cesarean section and any needed blood transfusions in the event that Mrs. Jefferson presented herself to the hospital for delivery. Mrs. Jefferson was 39-weeks pregnant and had been presenting herself to the hospital for pre-natal care. The physician determined that she had a complete placenta previa making vaginal delivery extremely dangerous to the fetus and the mother. She was refusing cesarean section and blood transfusions based upon religious beliefs. The trial court granted an order authorizing the hospital to administer all medical procedures deemed necessary to preserve the life of Mrs. Jefferson's unborn child. The order was only valid if Mrs. Jefferson voluntarily sought admission to Griffin Spalding County Hospital. The court was also requested to order Mrs. Jefferson to submit to cesarean section before the onset of labor. The court was reluctant to grant such an order; however, it noted that should some agency of the state seek such relief through intervention in a suit, they would promptly consider the request (8).

The following day, the Georgia Department of Human Resources petitioned the Juvenile Courts for temporary custody of the unborn child, alleging that the child was deprived and they, therefore, requested an order requiring the mother to submit to a cesarean section. The court found that the child (39-week fetus) is a human being fully capable of independent life. As a viable human being, the child was entitled to the protection of the Juvenile Court. Temporary custody of the child was granted to the State of Georgia Human Resources and the County Department of Family and Children Services. The Department was given full authority to make all decisions including giving consent to the cesarean section. The temporary custody would terminate when the child ''has been successfully brought from its mother's body into the world.'' Mrs. Jefferson appealed the trial court's decision to the Georgia Supreme Court. This Court acknowledged the patient's right to refuse medical treatment and constitutionally protected right to freely exercise her religion; however, it still compelled Mrs. Jefferson to undergo the surgery (8). The Court relied on principles of Roe v. Wade (4) that the state had a ''compelling interest'' in human life after viability.

Another case upholding fetal rights is that of In Re Jamaica Hospital (9) decided by the New York Supreme Court. The patient was 18-weeks pregnant. Both the mother and her fetus were in imminent danger of death as a result of bleeding from the mother's esophageal varicies. The mother was refusing blood transfusion based upon religious grounds. The New York Supreme Court acknowledged the mother's right to refuse medical treatment but also that a woman can be forced to receive a blood transfusion against her will to save the life of her non-viable fetus. The standard came from Roe v. Wade (4) that a state can interfere with a woman's reproductive choices when it has a compelling interest. With respect to a non-viable fetus, the Court reasoned the state does not have a ''compelling interest; '' but the highly ''significant interest'' it does have, outweighs the patient's right to refuse a blood transfusion on religious grounds. The Court further expressed that the potentially viable fetus was a human being, to whom the court had a parens patriae duty to protect (9).

Overview

Reviewing the above case law acquaints the reader with the varied opinions regarding fetal rights. All of these cases struggle in the determination between the pregnant mother's right to privacy and bodily integrity, and the fetus's right to be born healthy and alive.

The First Amendment embodies freedom to believe and freedom to act. Freedom of religion is as old as this country and was a primary reason for the colonization of the United States of America. The Courts have drawn a distinction between the free exercise of religious beliefs and religious practices that are inimical or detrimental to public health or welfare (8). Freedom to believe is absolute while freedom to act is not. Personal conduct remains subject to regulation for the protection of society (8).

According to Epstein (10), privacy rights include the right to be left alone, the right to refuse medical treatment, and the right to have possession of, and power over, one's own person. The bodily integrity doctrine contains concepts of assault and battery, search and seizure, informed consent, and the right to refuse medical treatment.

In an article on fetal rights (11), Johnsen wrote, ''Our legal system has historically treated the fetus as part of the woman bearing it and has afforded it no rights as an entity separate from her.'' ''Fetal rights'' view the fetus as an independent entity, separate from the mother and with interests that may be hostile to hers. The mother may be forced to have a cesarean section against her will. The child may sue their mother for injuries resulting from the woman's actions, or lack of, during pregnancy (11).

The view of the fetus by the legal system is a social and not a biological one. According to Robert H. Blank (12), ''The term 'fetal rights' is a distortion of the real issue and obscures what ought to be the primary concern; the health of the unborn child . . . It is not the fetus that has rights; rather, it is the child once born that must be protected from avertable harm during gestation . . . The technological removal of the fetus from the 'secrecy of the womb' through ultrasound and other pre-natal procedures gives the fetus social recognition as an individual separate from the mother'' (12). The goal of any policies designed to make the fetal environment as safe as possible should be to maximize the birth of healthy children (12).

The fetus is represented in many different areas of the law.

The abolishment of intra-family immunity has been seen in courts holding parents liable for prenatal injuries (12). This opens the process for courts to define parental responsibility. The definition of murder, according to the California Jury Instruction's, include, ''every person who unlawfully kills a human being or fetus with malice aforethought or during the commission or attempted commission of (statutory felony) is guilty of the crime of murder (13). These laws point to the personhood of the fetus.

Agota Peterfy (14) stated, ''The controversy surrounding the pivotal role of viability is about deciding when human life begins, or becomes worthy of the law's protection.'' The beginning of human life is not able to be defined but reflects an individual's religious beliefs, morals, and ethics. Catholic Ethical and Religious Directives (15) state, ''From the moment of conception, life must be guarded with the greatest care . . . Any deliberate medical procedure, the purpose of which is to deprive a fetus or embryo of its life, is immoral'' (15). As can be seen, many believe that the Court is not responsible for defining the beginning of human life; instead, it is society's task to do so.

Does society impose a moral responsibility upon a pregnant mother for her fetus? In the Board of Trustees Report for the American Medical Association (16), a pregnant woman's moral responsibility, was described as, ''A woman who chooses to carry her pregnancy to term has a moral responsibility to make reasonable efforts toward preserving fetal health . . . This moral responsibility, however, does not necessarily imply a legal duty to accept medical procedures or treatment in order to benefit the fetus.''

In assessing fetal and maternal rights, it is important to be aware of case law on abortion which tends to hinge on the fetus's viability. The case law discussed in this paper indicates that before a fetus is viable, a mother has the right to determine the outcome of her pregnancy. Any regulation of the woman's pre-viable pregnancy must not place an ''undue burden'' upon the mother (17). After the point of viability, a mother may abort her pregnancy, only if, as a result of the pregnancy, the abortion is necessary for the preservation of the life or health of the mother.

Discussion of Decision Tree

The initial part of treating any patient includes informed consent and the decision tree begins here (Fig. 1). As part of that process a general idea of competency must be ascertained. If there is a question as to the patient's competence, a more detailed evaluation must be conducted to determine the patient's understanding of her condition and the proposed treatment, including the treatment's risks and benefits. Although, only a judge can make an official determination of competency, a physician's assessment of competency and clinical impression may substantially alter the course of treatment. If the patient is assessed and considered incompetent, then substituted judgment must be obtained either from relatives

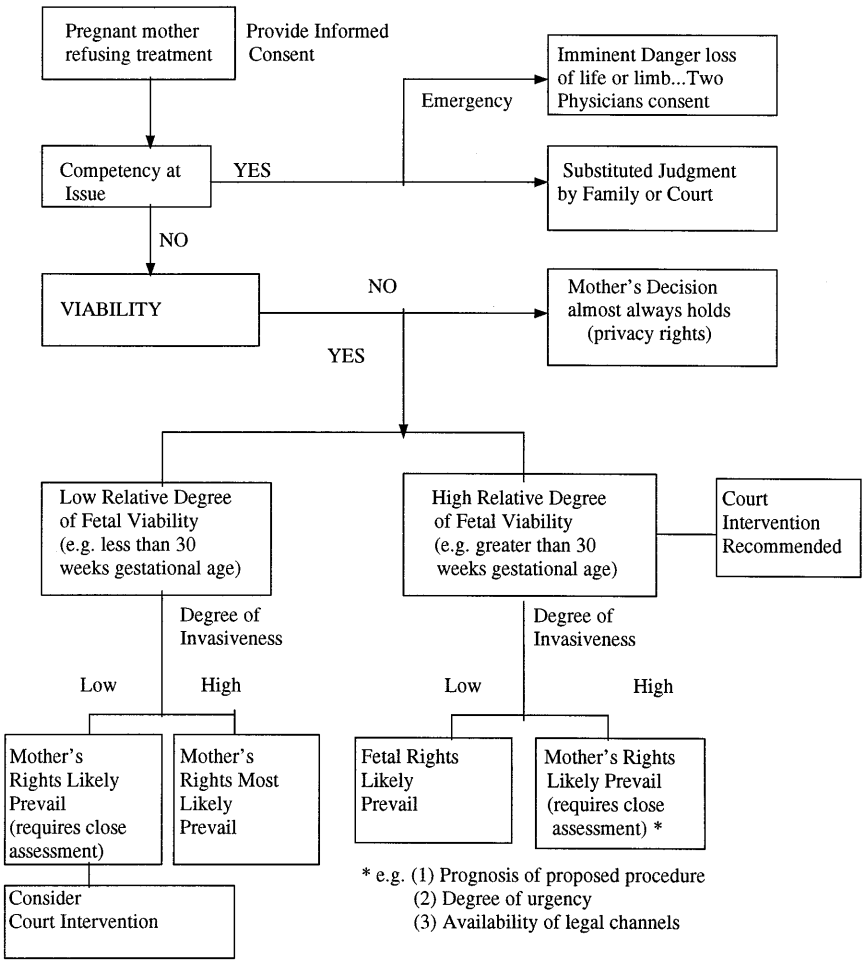

FIG. 1—*Decision tree.*

or the Court, which may necessitate a delay in treatment. The substituted judgment is supposed to represent the patient's wishes if the patient were competent (3). An incompetent patient has the right to refuse treatment if through substituted judgment it is determined that the patient would not have desired the proposed treatment. If there is an issue of fetal well being in a competent patient provided informed consent who refuses the recommended treatment, then viability of the fetus must be determined.

In issues where fetal and maternal interests are in conflict and a physician believes further intervention may be necessary, case law points to determining viability of the fetus. Viability can be defined as, ''A viable human fetus is one who has attained such form and development of organs as to be normally capable of living outside of the uterus'' (13). In Webster v. Reproductive Health Services (5), the Court stated that viability could occur any time after the 20th week of pregnancy and imposed a duty on the physician to make a determination of the fetus's viability prior to performing an abortion.

Case law places great emphasis on viability regarding the state's interest in protecting potential human life. Roe v. Wade (4) found, ''The state had no legitimate interest in protecting a fetus until it reached the point of viability.'' However, there are some cases that protect a pre-viable fetus. In Re Jamaica Hospital (9) found a highly ''significant interest'' in a pre-viable fetus (18 weeks). The Court in People v. Davis (18) held that viability of the fetus is not an element of fetal murder (intentional killing of a pre-viable fetus constitutes murder), ''When a mother's privacy interests are not at stake, legislature may determine whether, and at what point it should protect life inside the mother's womb from homicide; without the viability component at least . . . where fetus is beyond the embryonic stage.''

If the fetus is not viable, then the mother's decision almost always stands. Prior to viability, a woman has a right to abort the fetus and any state regulation regarding the pregnancy before viability must not be an ''undue burden'' (17). In Re Jamaica Hospital (9) is the only case known to the authors in which medical intervention was ordered for a pre-viable fetus against the wishes of the mother. A competent pregnant mother with a pre-viable fetus almost always has complete determination concerning treatment decisions of herself and the fetus.

Once the fetus becomes viable, the state has an interest in the potential life. It is this arena that has varying opinions within the case law. Induced abortion is allowed only if the woman requires the procedure for the preservation of her life or health. Both In Re A.C. (6) and In Re Baby Boy Doe (7), involved a viable fetus and held that the woman's right to refuse treatment overrode the state's interest in protecting the fetus. In Re Jamaica Hospital (9) and Jefferson v. Griffin Spalding Hospital (8) ordered interventions against the woman's will, reasoning that the state had a ''highly significant interest'' and ''compelling interest'' in the pre-viable and viable fetus, respectively. This difference demonstrates that decisions between a mother's privacy right and the viable fetus' right to be born healthy and alive, are not consistent among courts.

The American Medical Association's Ethics opinions (1) indicate that a competent pregnant mother's wishes should always take priority in her decisions for medical care. For example, the AMA Ethics advocate that court involvement is inappropriate when a pregnant mother has made an informed refusal of a treatment designed to benefit her fetus. The courts have made rulings that differ from AMA's Ethics (8,9).

It appears that as the pregnancy advances, so does the fetus's rights. The fetus has few rights prior to viability. The right to life of the fetus increases with development and as potentiality matures (19). From the point of viability until birth, the fetus's rights continue to increase. Some courts have described a balancing test of the mother's privacy interests and fetus's right to be born healthy and alive (8,9). Inferred from this balancing test is the necessity to weigh the relative degree of invasiveness of the proposed medical intervention and the degree or chance of viability. The further along in gestation and greater the chance of viability, the greater degree of fetal rights to be born healthy and alive (Fig. 2). Consideration must be given to the proposed medical intervention. The greater degree of invasiveness of the medical procedure to the mother increases the degree of maternal privacy rights or bodily integrity (Fig. 3). There is no clear demarcation and each dilemma must

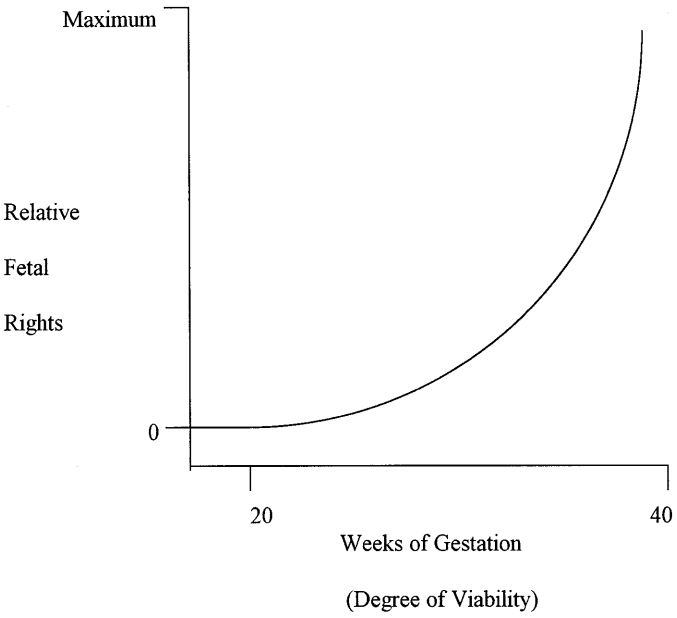

FIG. 2—*Degree of fetus viability vs. relative fetal rights.*

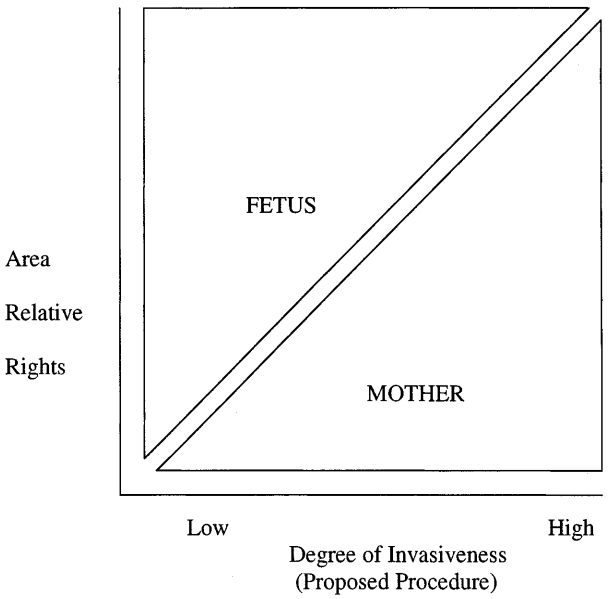

FIG. 3—*Degree of invasiveness of procedure vs. maternal/fetal rights.*

addressed on its own merits. As case law continues to evolve, so will the degree of weight applied to maternal privacy rights or the fetus's right to be born healthy and alive.

To provide a greater understanding of the decision tree, the case example will be reviewed. As discussed earlier in this paper, the patient was provided informed consent and believed to be competent. Despite the risk of fetal death, the patient continued to refuse the necessary labor induction and insisted upon a vaginal delivery. The next step on the decision tree which the physician needed to assess was the relative degree of viability. The fetus was 41 weeks and, referring to Fig. 2, the fetus had maximum relative rights. Given this, the clinician should follow the course of ''High Relative Degree of Fetal Viability.'' The degree of invasiveness of the proposed procedure must next be determined. This is a difficult determination because every procedure from a blood draw to a cesarean section involves some degree of invasiveness. It was determined that labor induction had a low relative degree of invasiveness, certainly lower than a cesarean section. Figure 3 reflects that a procedure with a low degree of invasiveness has a higher degree of relative fetal rights. Therefore, following the decision tree, when there is a high degree of fetal viability and the proposed procedure has a low degree of invasiveness, a determination that fetal rights likely prevail is made.

Even though the decision tree leads to the direction that fetal rights prevail, the case did not necessitate action because the situation was urgent and not emergent. The obstetrical physician's description of the prognosis included that the fetus's viability would continue to decrease the further past the due date (40 weeks), with significant morbidity risk at 42 weeks. The fetus was at 41-weeks and the clinical situation of low amniotic fluid, some fetal heart decelerations, and post-term pregnancy made the situation urgent. There was no emergency, however, because the fetus could remain healthy for another five days, yet the fetus's condition could change rapidly.

The consulting psychiatrist's recommendations to the obstetrical physician included the following. Administration of Haldol (antipsychotic) should be continued as the patient had a long history of schizophrenia and her illness may have influenced her treatment decisions; although, this was not evident during the evaluation. If the patient continued to refuse a bi-manual examination, involuntary medication (IM Haldol) should be administered to sedate the patient and the bi-manual examination performed. Without an adequate physical examination, the health of the fetus and patient cannot be determined. By not being able to determine their health, the type of intervention, if any, cannot be assessed. The bi-manual exam has a low degree of invasiveness and was a necessary component to determine prognosis. If the fetus was in emergent danger of death, it was recommended that a cesarean section should be performed. If the mother continued to refuse labor induction over the next 24 to 48 h, then the pursuit of a court order for labor induction should be considered.

The consulting psychiatrist's clinical impression of the patient was that she would consent to the labor induction over the next few days. The patient was pleasant and cooperative with the clinical evaluation. She was not anxious or agitated. Her thoughts appeared clear and she had tight associations. The psychiatrist believed that he developed a good rapport with the patient and this would hopefully ease the dilemma. The patient's family was present and appeared to be supportive. The patient was comfortable in the hospital and, therefore, the issue of involuntary psychiatric hospitalization did not have to be entertained.

After the consulting psychiatrist left the obstetrical ward, the patient consented to a bi-manual exam which she had been refusing. Approximately 12 h later, the patient had a vaginal delivery, without labor induction.

The decision tree provides a schematic approach to cases involving fetal and maternal conflicts. If there is no urgency to a case and no agreement or consent reached, the decision should almost always be made by a court. When a dilemma presents, the hospital administrator or risk management should be contacted. Hospital administration should contact the proper legal channels to review the dilemma and, if necessary, apply for a court order for medical intervention. One study found that 86% (18 of 21) of the court orders sought for obstetrical procedures were granted (20). Of these cases, 88% (16 of 18) were received within six hours (20). A court order, however, may not be an option if there are time constraints. In such cases, the physicians may be required to make a treatment decision.

In all cases, it should be remembered that the purpose of consultation and liaison in psychiatry is to assist the treating doctor and patient in resolving areas of conflict or disagreement. It is preferable to resolve these dilemmas by consultation with the patient, family, and the treating physician and every effort should be made to do so.

Summary

In performing any assessment of a patient for medical treatment, the first step involves informed consent. Part of the process of informed consent includes the evaluation of the patient's competence. If the patient is not competent, substituted judgment is obtained.

The issues discussed in this paper are not about the beginning of life or when the fetus becomes human; rather, does the fetus have the right to be born healthy and alive? If the fetus does have this right, how does this right compare with the pregnant mother's right to bodily integrity and right to privacy?

In case law, fetal rights have been determined as minimal prior to viability. It is legal for a pregnant mother to abort her pre-viable fetus; therefore, the fetus's right to be born healthy and alive does not exist. After the point of viability, the fetus's rights to be born healthy and alive increase and are greatest just prior to delivery.

In evaluating the possibility of instituting a medical procedure against a patient's will, consideration must be given to the risk of the medical procedure, the degree of invasiveness, and potential benefits both to the mother and fetus. Cases more likely to be granted a court order for intervention would include a pregnancy at term with a proposed medical procedure that has a low degree of invasiveness and, therefore, minimal risk to the mother and fetus. Less likely to receive a court order for intervention would include a viable fetus (around 24 weeks' gestation) and a proposed medical procedure that has a high degree of invasiveness and a high degree of risk factors to the mother and fetus.

The purpose of this paper and the decision tree is to assist clinicians in their approach to these difficult dilemmas. There are no clear demarcations and each case must be evaluated on an individual basis. It is always preferable to resolve these dilemmas through consultation with the patient, family, and the treating physician. In an ideal world, these dilemmas would never occur, but they do and a systematic approach to their evaluation allows for a more thorough assessment.

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