DISTRICT OF COLUMBIA
COURT OF APPEALS
EN BANC

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| In re A.C. | ) | No. 87-609<br>On Rehearing En Banc |

Motion of Now Legal Defense and Education Fund, National Abortion Rights Action League and Sixty-Seven Other Organizations for Leave to File as Amici Curiae and Submission Upon Request

NOW Legal Defense and Education Fund (NOW LDEF), National Abortion Rights Action League (NARAL) and Sixty-Seven other organizations (as set forth in the Brief of Amici Curiae NOW LDEF, NARAL et al. filed herewith) hereby move for leave to file as amici curiae on the grounds, as fully discussed in the brief, that this case is one involving issues of grave public importance. See D.C. App. Rule 29(a). NOW LDEF, NARAL and many of the other groups joining here previously appeared as amici curiae on motion for Rehearing and Suggestion of Rehearing en Banc and in briefing on the question of mootness. This motion is being filed in the event that the order of this Court dated August 3, 1988, did not constitute a bona fide request for briefing of amici curiae pursuant to Rule 29 (a).

Respectfully submitted

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September 6, 1988

DISTRICT OF COLUMBIA
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| In re A.C. | No. 87-609<br>On Rehearing En Banc |

BRIEF OF AMICI CURIAE

NOW LEGAL DEFENSE AND EDUCATION FUND, NATIONAL ABORTION RIGHTS ACTION LEAGUE, AFRICAN-AMERICAN WOMEN'S COLLECTIVE, ALLIANCE AGAINST WOMEN'S OPPRESSION, AMERICAN ASSOCIATION OF UNIVERSITY WOMEN, AMERICAN COLLEGE OF NURSE-MIDWIVES, AMERICAN HUMANIST ASSOCIATION, AMERICAN JEWISH CONGRESS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN NURSES ASSOCIATION, AMERICANS FOR RELIGIOUS LIBERTY, ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSONALS, ASSOCIATION FOR WOMEN IN PSYCHOLOGY, BLACK WOMEN'S AGENDA, BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, CATHOLICS FOR A FREE CHOICE, CENTER FOR CONSTITUTIONAL RIGHTS, CESAREAN PREVENTION MOVEMENT, INC., C/SEC, INC. (CESAREANS/SUPPORT EDUCATION & CONCERN), CITY OF NEW YORK COMMISSION ON HUMAN RIGHTS, COALITION OF LABOR UNION WOMEN, COMISION FEMENIL MEXICAN NACIONAL, COMMITTEE FOR RESPONSIBLE GENETICS, COMMITTEE TO DEFEND REPRODUCTIVE RIGHTS, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, EPISCOPAL WOMEN'S CAUCUS, EQUAL RIGHTS ADVOCATES, INC., FEDERATION OF RECONSTRUCTIONIST CONGREGATIONS AND 7 HAVUROT (NATIONAL AND LOCAL), FEDERATION OF FEMINIST WOMEN'S HEALTH CENTERS, GENERAL BOARD OF CHURCH AND SOCIETY OF THE UNITED METHODIST CHURCH, HOME AND BIRTHING IN BED, INDIGENOUS WOMEN'S NETWORK, INTERNATIONAL COUNCIL OF AFRICAN WOMEN, INTERNATIONAL WOMEN'S HEALTH COALITION, THE LYMPHOMA FOUNDATION OF AMERICA, MADRE, MEDGAR EVERS COLLEGE CENTER FOR LAW & SOCIAL JUSTICE, MIDWIFERY LITIGATORS NETWORK, MIDWIVES ALLIANCE OF NORTH AMERICA, NATIONAL ASSEMBLY OF RELIGIOUS WOMEN, NATIONAL ASSOCIATION OF COMMISSIONS FOR WOMEN, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL BLACK WOMEN'S HEALTH PROJECT, NATIONAL COALITION OF AMERICAN NUNS, NATIONAL COUNCIL OF JEWISH WOMEN, NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, NATIONAL FEDERATION OF TEMPLE SISTERHOODS, THE NATIONAL INSTITUTE FOR WOMEN OF COLOR, NATIONAL LATINA HEALTH ORGANIZATION - ORGANIZACION NACIONAL DE LA SALUD DE LA MUJER, NATIONAL ORGANIZATION FOR WOMEN, NATIONAL WOMEN'S HEALTH NETWORK, NATIONAL WOMEN'S LAW CENTER, NATIONAL WOMEN'S POLITICAL CAUCUS, NEW YORK WOMEN AGAINST RAPE, NORTHWEST WOMEN'S LAW CENTER, NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD OF NEW YORK CITY, PROJECT ON WOMEN & DISABILITY IN MASSACHUSETTS, RAINBOW COALITION WOMEN'S COMMISSION, T.H.E. CLINIC, UNION OF AMERICAN HEBREW CONGREGATIONS, UNITARIAN UNIVERSALIST ASSOCIATION, UNITED CHURCH BOARD FOR HOMELAND MINISTRIES, UNITED CHURCH OF CHRIST COORDINATING CENTER FOR WOMEN, UNITED CHURCH OF CHRIST OFFICE FOR CHURCH IN SOCIETY, WASHINGTON ETHICAL OFFICE, WOMEN'S EQUITY ACTION LEAGUE, WOMEN'S LAW PROJECT, WOMEN'S LEGAL DEFENSE FUND

IN SUPPORT OF THE APPELLANT

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No. 87-609, In re A.C.

Certificate required by Rule 28 (a) (1)
of the Rules of the District of
Columbia Court of Appeals

The undersigned, counsel of record for amici curiae NOW Legal Defense and Education Fund, NARAL et al., certifies that the following listed parties appeared below:

Parties:
A.C. (Angela Carder)
Lindsay Marie C.
George Washington University Medical Center and Hospital
District of Columbia

In addition, counsel of record for amici curiae NOW Legal Defense and Education Rund, NARAL et al. certified that the following listed interveners and amici appeared in connection with the petition for rehearing en banc and subsequent proceedings:

Petition to intervene or be substituted (yet to be ruled upon):
Daniel and Nettie Stoner

Amici in support of petitioner A.C.:

American Academy of Family Physicians
American Association of University Women
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Humanist Association
American Medical Association
American Medical Women's Association
American Psychological Association
American Public Health Association
Americans for Religious Liberty
Association of American Medical Colleges
Association for Women in Psychology
Black Women's Agenda
Boston Women's Health Book Collective
Catholics for a Free Choice
Cesarean Prevention Movement, Inc.
Center for Constitutional Rights
City of New York Commission for Human Rights
Coalition of Labor Union Women
Committee for Responsible Genetics
Committee to Defend Reproductive Rights
Disability Rights Education and Defense Fund
Episcopal Women's Caucus
Equal Rights Advocates, Inc.
Federation of Reconstructionist Congregations and Havurot
General Board of Church and Society of the United
Methodist Church
The Lymphoma Foundation of America
Medgar Evers College Center for Law and Social Justice
National Assembly of Religious Women
National Association of Commissions for Women
National Association of Social Workers
National Black Women's Health Project
National Coalition of American Nuns
National Council of Jewish Women
National Emergency Civil Liberties Committee
National Organization for Women
National Women's Health Network
Northwest Women's Law Center
National Women's Political Caucus
NOW Legal Defense and Education Fund
Nurses Association of the American College of
Obstetricians and Gynecologists
Office for Church in Society, United Church of Christ

Planned Parenthood Federation of America, Inc.
Planned Parenthood of New York City
Project on Women and Disability in Massachusetts
Union of American Hebrew Congregations
Unitarian Universalist Association
United Church of Christ Coordinating Center for Women
in Church and Society
Washington Ethical Office
Women's Equity Action League
Women's Law Project
Women's Legal Defense Fund

These representations are made in order that judges of this court, inter alia, may evaluate possible disqualification or recusal.[1]

Attorney of record for amici curiae
NOW Legal Defense and Education Fund,
National Abortion Rights Action League, et al.

September 6, 1988

[1] More detailed descriptions of the amici curiae organizations are provided as part of the Statement of Interest of Amici Curiae set forth in Appendix A.

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## INTEREST OF AMICI CURIAE

The amici curiae[2] are membership, advocacy and professional organizations representing concerns of women who are persons of all races, creeds and national origins; interests of health care providers and recipients; and values of individuals and groups committed to civil rights and religious and ethical tenets.

In the view of amici curiae, the decisions of the Superior Court to order, and the panel of the Court of Appeals to decline to stay, the performance of cesarean section surgery upon a competent, adult, nonconsenting pregnant woman violates the fundamental constitutional and common law rights of each person to be fully informed about and to determine the course of his or her own medical treatment and not to have the government sacrifice his or her life and/or health. It also defeats the goals of good public health.

## STATEMENT OF ISSUES

Does infringement upon fundamental constitutional and common law rights in connection with health treatment defeat effective public health policy?

Did the court err by forcing a woman to undergo cesarean section surgery, thus violating her fundamental constitutional rights of autonomy, privacy and bodily integrity?

Did the court err by failing in this case to adhere to the common law principles of informed consent?

Did the court err by taking jurisdiction over this matter and granting relief, particularly where:

(a) the court lacked jurisdiction over the person because even the minimal procedural due process requirements of notice and an opportunity to respond were not fulfilled?

(b) the court lacked subject matter jurisdiction whether in equity or at law?

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[2] A specific description and statement of interest of each amicus curiae represented here appears in Appendix A.

## STATEMENT OF THE CASE

Amici curiae set forth here a statement of the case including some factual information which is in the record[3] but was not fully presented at the initial emergency hearing. Amici curiae set forth this information to amplify the statement of the case presented by appellant Angela Carder, which statement amici curiae here adopt. With this information this court en banc will better understand the scope and nature of the profound wrong done, and thus, can better establish the precedent necessary to prevent the recurrence of the tragedy enacted here.

The facts are unique to this case and, at the same time, applicable to each and every case this court can anticipate involving a motion for a court-ordered cesarean over the objection of the woman and her family. The individual patient's lifestory and the specifics of her medical condition will always be unique.[4] However, valid differences of opinion about appropriate medical treatment and other medical uncertainty and ambiguity, acknowledged or not, will always be present in such cases. Inadequacies in the evidence, its development and presentation, will always obtain because of the emergency nature of the proceedings. The patient will always be at a severe disadvantage in advocating her position because of inadequate notice and insufficient access to expertise. In this case, actions were urged and taken allegedly to preserve the health and life of the fetus without the mother's informed consent; those actions were impermissible and they harmed the health and life of the mother. Such injustice will be done in all cases of alleged maternal-fetal conflict unless this court en banc establishes

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[3] Counsel for amici curiae, with the permission of the appellant, have viewed the hospital records maintained in connection with the treatment of Angela Carder. Those records have not been made part of the record; however, counsel for amici curiae have been satisfied that the records are consistent with the information on the record presented here.

[4] Amici note, however, that cancer and pregnancy occur in approximately 3,470 women per year. Ioachim, Non-Hodgkin's Lymphoma in Pregnancy, 109 Arch. of Path. and Lab. Med. 803 (1985) citing W.L. Donovan, Cancer and Pregnancy (1983).

clear rules to curtail this kind of court intervention.

When this matter arose, Angela Carder was a twenty-seven year old woman in approximately her twenty-sixth week of pregnancy. Trial Transcript ("Tr.") at 5. In the 1970's at the age of thirteen, she had been diagnosed as having Ewings sarcoma, described as cancer of the connective tissue in the left thigh. She received a course of experimental treatment at the National Cancer Institute ("NCI") of the National Institutes of Health ("NIH") and was one of the first children to survive affliction with that cancer. In 1984 she had a second malignancy, an osteosarcoma or cancer of the bone-forming cells, and her treatment included chemotherapy and the removal of her left leg and part of her pelvis. Affidavit of Ms. Carder's Cancer Specialist 6, dated November 5, 1987, filed November 10, 1987, In re A.C., Misc. No. 199-87 (D.C. Super. Ct. 1987) (hereinafter "Specialist's Aff.", citations to paragraph numbers).

Sometime after that, having survived cancer for more than thirteen years and "free of all evidence of cancer," id. at 7, Angela Carder married. Then in late 1986, she became pregnant. Id. at 8. On June 9, 1987, when approximately twenty-five to twenty-six weeks pregnant, she suffered pain in her shoulders and shortness of breath. She immediately sought the advice of her cancer specialist at NIH, id. at 9-10, and of Dr. Hamner at the high-risk obstetrics clinic at George Washington University Hospital (the "Hospital" or "GW Hospital", Tr. at 10 11.19-25). She entered the high risk obstetrics clinic at the Hospital on June 11, 1987.

On June 11, the NIH cancer specialist consulted with other specialists at NIH's National Institute of Cancer concerning the treatment issues raised by Ms. Carder's condition, which proved to be a recurrence of cancer. Specialist's Aff. at 13-15. Based upon his familiarity with Ms. Carder's case, his expertise and the advice of these other specialists, he believed that a course of treatment could be followed to produce a "temporary improvement in her condition," id. at 15, and that the necessary

radiation therapy and chemotherapy could be done without substantial risk to the fetus, id. at 16-17. "The consensus of [NIH] physicians ... was that the risk of chemotherapy to the fetus was not nearly as great as the risk of not treating the tumor." Id. at 17. The cancer specialist, who did not have hospital privileges at GW Hospital, had no less than six discussions with the Hospital physicians, who were not cancer specialists, between June 10 and June 16, 1988. Those discussions concerned plans for the diagnosis and treatment of Ms. Carder's condition related to the symptoms that she reported on June 9. The symptoms suggested possible cancer in Ms. Carder's lungs; all the treatment discussions were aimed at prolonging Ms. Carder's life and improving the chances that her fetus would survive. Id. at 1, 12, 20, 22, 23, 28, 30, 31.

With respect to each such discussion, Hospital personnel never took the diagnostic and treatment steps apparently agreed upon, nor did they contact the cancer specialist to advise him that Ms. Carder had been given no treatment. Id. at 18, 20, 24, 27, 33. For example, although the cancer specialist asked on June 10, 1988 that lung fluid and tissue be taken from Ms. Carder for essential diagnostic purposes, the Hospital never did so. Similarly, on June 12, 1987 the cancer specialist discussed such a biopsy again and Ms. Carder's deteriorating condition with her doctors (Lessin and Hamner) at the Hospital, at which time her doctors apparently agreed that Ms. Carder needed radiation therapy and chemotherapy. No biopsy was taken and no therapy was given to Ms. Carder.

Ms. Carder told her cancer specialist on June 12 that she was concerned about "the fact that nothing was being done to figure out what was wrong and to start treatment." Id. at 19. Nettie Stoner, Ms. Carder's mother, also spoke to the cancer specialist on June 14, 1987 and June 15, 1987, telling him that "nobody was doing anything" and that "no one had talked to them and told them what the plan was or what the doctors thought was going on. She said she and Ms. C. were both scared and worried...." Id. at 24,

25. Between June 12 and June 15, 1987, Ms. Carder received from the Hospital none of the treatment her cancer specialist recommended; the tumor in her lungs grew uncontrolled. Id. at 12, 19, 20, 21, 22, 24, 25.

According to the cancer specialist, telling events occurred on Monday, June 15. Having learned that diagnostic and treatment procedures (that he believed had been agreed upon) had not been followed, the cancer specialist went to GW Hospital. He first went to Angela Carder's room to observe her condition. He then consulted with her attending physicians. His affidavit recounts the events that followed:

> We went back to the ward and met Dr. Hamner outside Ms. C's room. First we went into her room, and Dr. Lessin examined Ms. C. Then we stepped out and talked in the hallway outside her room. Dr. Lessin agreed that Ms. C. was in significant respiratory distress. I again advocated therapy for Ms. C., although at this point I felt we had fewer options than we had had on Friday, June 12. It was clear that any therapy at this point carried a higher risk now that Ms. C. was more ill. Specifically, I recommended:
>
> a) moving Ms. C. to an intensive care unit;
> b) emergency radiation therapy, with adequate shielding for the fetus;
> c) chemotherapy with etoposide and ifosfamide;
> d) the biopsy should be foregone in light of Ms. C's deteriorating condition.
>
> I believed that Drs. Hamner and Lessin agreed with this plan.
>
> Dr. Lessin, Dr. Hamner and I further agreed at this meeting that we could and should do nothing without Ms. C's consent. Both Dr. Lessin and Dr. Hamner stated that, because of my long-standing relationship with Ms. C., they thought it best if I was the one who spoke to her. I agreed to do it.
>
> I spoke to Ms. C. and told her what Dr. Lessin, Dr. Hamner and I had agreed upon. Also present were the medical resident who accompanied Dr. Lessin, and Mrs. S. [Ms. Carder's mother]. Mr. C., Ms. C's husband , was not present. Ms. C. was very short of breath throughout the discussion, and it was difficult for her to speak. However, I felt that she understood what I had told her. I told her that I felt that her baby was too small to survive at that time (meaning too premature to be born at that time) but that a few extra weeks would make a big difference in the baby's ability to survive after birth. ... She indicated that she understood all the information she had been told. I felt that she agreed to treatment and to the approach of trying to extend her life, to give birth to her baby and possibly to go home with it. She further agreed that she could not be transferred to NIH because the facilities at NIH were not appropriate to provide high risk obstetric care or to provide appropriate care for a premature baby if she delivered early.
>
> Afterwards, arrangements were made to transfer Ms. C. to the intensive care unit ("ICU"). I again told Dr. Hamner I felt that Ms. C. had hours to days to live if therapy was not promptly initiated. I wrote a note in the chart documenting the discussion with Ms. C. and my understanding that treatment was to be quickly initiated.

> I also stated that it was unfortunate that they were now in the position of having to treat her without a tissue diagnosis. I again left my phone numbers in the chart.
>
> As of this point on Monday afternoon, June 15, it was my understanding that the family and all of her physicians had agreed to a course of treatment which included intensive care and emergency radiation therapy followed by chemotherapy. At no time was a Cesarean section discussed in my presence. At no time in my presence did Ms. C. or her family consent to a Cesarean section. In my presence Ms. C. and her family only consented to procedures that would be beneficial to both Ms. C and the fetus.

Specialist's Aff. at 30, 31, 32, 33, 34 (emphasis added). See also, Tr. at 46-50.

The course of treatment agreed upon by the physicians and consented to by Ms. Carder on June 15, 1987 was never started. Instead, the very next day, the Hospital and its lawyers precipitated a court hearing. Describing to the press later the events of June 16 leading up to and during the hearing, Angela Carder's mother, Nettie Stoner, said:

> We were having a really hard time anyway without this court business. It was so unfair to Angie and to us.
>
> We were there with Angie. Angie was in a lot of pain - but she knew we were there. On Tuesday morning they called us early to tell us that Angie was not doing very good. We called a priest to come immediately - he gave her her last rights [sic] and then only a few minutes later the hospital staff told us we were needed at a "short meeting". They did not tell us it was a court hearing. It took all day. They didn't tell us it would take us away from her.
>
> Poor Angie, first she's told she's dying and the next thing everybody abandons her and leaves her alone in her room. She must have been just lying there wondering where everyone was. Then even before the hearing was over they started prepping her for surgery -- she was already in so much pain.
>
> We told the judge she didn't want the surgery, that we didn't want her to suffer anymore, that we didn't think the baby would live. But they didn't listen. After the surgery and after they told her the baby was dead, I think Angie just gave up."

Press Statement of Nettie Stoner, dated November 24, 1987.[5]

Ms. Carder was never told about the court hearing before it occurred. Judge Sullivan of the District of Columbia Superior Court never attempted to see her before ruling. As documented at length in appellant Angela Carder's Brief on the Merits, Statement of the Case, the court heard argument and took testimony. Four doctors attached to the Hospital appeared; only

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[5] The press statement is not part of the record but is attached as Appendix B. See also press statement of Daniel Stoner (Ms. Carder's father), November 24, 1987, in Appendix B.

two had attended Ms. Carder, and only three had direct involvement with her. See Tr. 36 (Edwards no direct involvement). The doctors did not advocate a cesarean, acknowledging that it was a decision for Ms. Carder to make and she had not made it. Tr. 17, 21-22, 41, 43, 61, 80. The testimony did not sustain any finding that Ms. Carder was not competent, any firm conclusion that the fetus was viable, see Tr. 15, 33-34, 39, or any clear determination that a cesarean would even serve fetal life.

The court heard argument from Mr. Sullivan, the attorney the court appointed for Ms. Carder; Mr. Burke, attorney for the Hospital; Ms. Mishkin, the attorney appointed by the court to represent the fetus; and Mr. Love, Assistant Corporation Counsel for the District of Columbia. Tr. 63-82. See also, Tr. 96-99 (reargument after Ms. Carder has spoken). Notwithstanding the medical testimony, Burke, Love and Mishkin argued that the alleged best interest of the fetus required a cesarean section. None of these attorneys ever attempted to see Ms. Carder. Their argument, rather than that put forward by the sole attorney representing Ms. Carder's interest, swayed Judge Sullivan. The judge ordered that Ms. Carder should undergo cesarean surgery. Tr. 85. The Burke/Love/Mishkin argument also swayed the three judge panel of the Court of Appeals which, shortly after Judge Sullivan's order was issued, declined to stay it, Appellate Transcript ("App. Tr.") at 17, despite Ms. Carder's statements in the interim that she did not want the cesarean done, Tr. 91-92. The operation was performed against Ms. Carder's will. As Ms. Carder had been told the day before, June 15, 1987, her baby was too small to survive outside her womb. Lindsay Marie Carder, Ms. Carder's baby, died almost immediately. See Statement of the Case, Brief on the Merits of Appellant Angela Carder.

No one told the cancer specialist about the June 16 court hearing until the hearing was over and the cesarean had been performed. He would have appeared at the hearing if he had been told about it. Specialist's Aff. at 36. He was not called by

the Hospital to testify, and Ms. Carder's attorney, appointed by the court on an emergency basis, had no time or opportunity to obtain and develop that doctor's testimony for the hearing. Accordingly, the court heard only the expert testimony that the Hospital arranged for it to hear.

After the operation, Ms. Carder's cancer specialist discussed Ms. Carder's remaining treatment options with her family:

> I went down to GW in the mid-afternoon of June 17 and met Ms. C's family in the ICU waiting area. ...
>
> This conversation took place the day after the court-ordered Cesarean section, which Ms. C's family told me had occurred despite Ms. C's, her family's and her doctor's clear objections. I started the discussion over again. As part of the process of obtaining informed consent, I explained the risks of chemotherapy, such as infections, and the benefits, which I described as a 50-50 chance of a partial remission, but with no real hope of long-term survival. I said that, at best, we might be able to get Ms. C. off the ventilator and home for a short period of time, and that this was a reasonable goal to shoot for if they felt it was important.
>
> Mrs. S. [said that] Ms. C. was so upset and drugged that she couldn't make such a decision and that she felt it was unfair to present such a choice to her. Then she said that they had always offered the hope of long-term survival, but that now the circumstances were quite different.
>
> ... Mrs. S. also stated that she was very afraid of a wound infection at the site of the Cesarean section incision. She said she felt that such an infection, a very definite possible complication of chemotherapy, would be a horrible thing for Ms. C. to endure.[6]
>
> I wrote a note in her chart stating that the family had declined therapy, and that I felt that this was an informed and compassionate decision.
>
> ... At approximately 9:00 p.m. the family called me at my home on June 18 to tell me that Ms. C. had passed away.

Specialist Aff. at 38-46 (emphasis added).

Ms. Carder's death in no way ended the legal proceedings prompted by the Hospital's petition to conduct surgery on her without her consent. On June 26, 1987, attorneys for Ms. Carder served a memorandum that urged the panel not to issue a written opinion or, in the alternative, to reconsider and remand the case for further submission of evidence. On July 8, 1987, the Hospital filed a Memorandum in Support of Petition for Declaratory Relief ("Petition") in which the hospital asserted its belief that courts could properly order pregnant women to

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[6] The incision was a vertical incision from the upper abdomen to lower abdomen.

undergo cesareans without their consent, despite its acknowledgement that it knew in this case that "[s]uch an operation would most likely be fatal to Ms. C." Petition at 2, 7.

The Court of Appeals panel issued an opinion written "after the fact" on November 10, 1987. In re A.C., 533 A.2d 611 (D.C. 1987). The panel refused to stay the Superior Court order for the Hospital to perform surgery on Ms. Carder against her will, despite the likelihood expressly recognized by both a Superior Court and the panel, that the surgery would hasten Angela's death. The panel noted in its written opinion that "[w]e well know that we may have shortened A.C.'s life span by a few hours." 533 A.2d at 613-14.

On November 24, 1987, appellant and approximately forty amicus curiae groups petitioned the Court of Appeals for rehearing with the suggestion for rehearing en banc. Among the responses filed was the Response to Petition for Rehearing or Rehearing En Banc by the Corporation Counsel for the District of Columbia, in which Corporation Counsel concluded that it was inappropriate for the Executive Branch to take positions in cases such as this. On December 15, 1987, the Court ordered appellees to respond. On March 17, 1988, the Court of Appeals granted appellant's petition for rehearing en banc and ordered that the opinion and judgment of November 10, 1987 be vacated. In re A.C., 539 A.2d 203 (D.C. 1988).

On April 28, 1988, this Court ordered appellant to show cause why this case should not be dismissed as moot. On June 30 appellant and amici curiae briefed the issue of mootness. On August 3, 1988, this Court ordered the parties and amici curiae to brief the issues on the merits. This brief is filed pursuant to that order.

## ARGUMENT

For the second time in two years, a panel of this court affirmed a court order for forced cesarean surgery upon a

nonconsenting, competent, adult pregnant woman. The first case, In the Matter of Madyun Fetus, 114 Daily Wash. L. Rep. 2233 (D.C. Sup. Ct., July 26, 1986), affirmed by this court in an unreported opinion, involved a cesarean section performed upon a pregnant woman in labor over her objections made on religious grounds. The assumption underlying that case was that the government has a compelling interest in the fetus such that the court can order a woman to submit to surgery against her judgment and will. It can at least could be said, based upon the record, if the medical analysis were strictly limited to physical well-being, that the order in Madyun Fetus was not made with the conscious awareness that the cesarean would harm the woman's life or health.[7]

In this case the court took the next step dictated by the view adopted in Madyun Fetus that we can and must save the fetus at the expense of the woman's self-determination and at the risk of the woman's well-being. That next step involved consciously ordering that a competent, adult, living woman sacrifice her will, her health and her life by undergoing a cesarean section. Against her expressed wishes, and without the support of the attending physicians, surgery was performed by court order at the Hospital's urging. Medical and forensic evidence related to this case indicate that the coerced surgery also harmed Angela Carder's health and contributed to her death.[8] The trial court[9] and appellate panel[10] have acknowledged that this was the foreseeable result of the court-ordered cesarean.

This court en banc now has the opportunity to confirm certain

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[7] However, serious health risks always attend the use of the cesarean procedure even for a healthy woman. See Section IB infra. The trial court in Madyun discounted this risk as "minimal." 114 Daily L. Rep. at 2240. Serious physiological harm can result from disregard for psychological factors as well. See Section IID infra.

[8] Angela Carder's death certificate lists as a contributing cause of death the "status post-Cesarean section". Certificate of Death of Angela Carder, June 18, 1987 filed as Supplementation of the Record by Court-Appointed Attorney for "Carder Fetus" on July 1, 1987.
The baby was not viable and died.

[9] Tr. at 84.

[10] 533 A.2d at 613-14

fundametnal principles of law. First, that a woman's health and life are never to be sacrificed by government intervention for any reason. Second that a competent adult woman, including when pregnant, is entitled to be fully informed about and to determine the course of her own medical treatment. Third that respect for individual autonomy, bodily integrity and self-determination is essential for effective public health policy. Fourth, that respect for these rights requires a most vigorous defense for women, particularly those vulnerable because of societal prejudice or economic social disadvantage. Finally, that the court's authority is strictly limited, as defined by the doctrines of jurisdiction and due process even in emergency actions.

## I. FORCED CESAREANS DEFEAT EFFECTIVE PUBLIC HEALTH POLICY BECAUSE THEY ARE DISCRIMINATORY AND VIOLATE LEGAL PRINCIPLES THAT EACH INDIVIDUAL, WHATEVER HER STATUS OR CIRCUMSTANCE, IS ENTITLED TO LIFE, BODILY INTEGRITY AND INDIVIDUAL SELF-DETERMINATION.

While the possibilities of science change with passing generations, the claims of human dignity do not. Nor is the need for vigilance mitigated by the sincerity and good faith of those who seek to substitute medical prediction and court-ordered treatment for individual choice and self-determination. As Justice Brandeis observed sixty years ago:

> Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent....The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning, but without understanding.

Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) (footnote omitted).

### A. Forced Cesarean Surgery Uniquely Harms Women, Has Been Disproportionately Imposed Upon Women of Color, Economically Disadvantaged Women and Women Who Speak English as a Second Language

The United States Supreme Court has recognized that an individual's constitutional rights include the right to be free from governmentally forced body intrusion, including forced surgery. See, e.g., Winston v. Lee, 470 U.S. 753 (1985) (refusing to allow law enforcement authorities surgically to remove for evidence bullet lodged in individual's chest); Roichin

v. California, 342 U.S. 165 (1952) (police cannot force a suspect's mouth open and pump his stomach to retrieve narcotics for evidence). Except in the cases of pregnant women, courts have refused to force such intrusion for the sake of any interest other than the health of the person upon whom surgery is performed. Only the strictest adherence to verbal abstraction, as for example in Geduldig v. Aiello, 417 U.S. 484 (1974), can sustain an argument that court-ordered cesareans are not discrimination against women. See generally, Johnsen, The Creation of Fetal Rights: Conflicts With Women's Constitutional Rights to Liberty, Privacy and Equal Protection, 95 Yale L. J. 599, 620-25 (1986).

Women have long been treated paternalistically by hospitals and doctors. The present-day controversy about cesareans represents only the most recent in a series of chapters on excessive intervention in childbirth which also include controversy about the use of forceps and of diethylstilbestrol (DES).[11] Historians of childbirth have identified pressures on

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[11] "What happened with DES is only one example of the consequences of thinking that modern medicine is infallible, that the physician is sacrosanct and that the patient (particularly the women) is an object to be 'done to.'" Orenberg, DES: The Complete Story xiii (1981). "It has been estimated that between four and six million Americans, mothers, daughters, and sons were exposed to its use in pregnancy and that it was most widely used for this purpose between 1945 and 1955." National Women's Health Network Resource Guide 3 (1980). "DES . . . was prescribed for 3 to 6 million women in the United States between 1941 and 1971." Boston Women's Health Book Collective, Our Bodies, Our Selves 497 (1984). Some experts place the number of mothers, sons and daughters exposed to DES at 10 million. Meyers, DES: The Bitter Pill 13 (1983).

Doctors prescribed DES because the Smith report came from one of the most influential doctors in the country and "physicians were motivated by a genuine desire to help them have a successful pregnancy. And the Smiths' argument for DES was persuasive." Orenberg, DES: The Complete Story 27 (1981). "By the mid-50's, several impressive studies had been done, showing that DES was a complete failure: using precise techniques to eliminate their own biases, they marshalled convincing evidence that DES did not prevent miscarriages." Id. at 18.

The methods by which DES was prescribed to pregnant women shows that women were placed on DES unnecessarily and women were given either no information or false information about DES and were sometimes given DES against their will. "Many obstetricians routinely prescribed the drug to women without a history of miscarriage on the unsubstantiated theory that it would ensure a strong pregnancy." Corea, The Hidden Malpractice 242 (1977). "It was given to some women who had never been pregnant before; it was given to pregnant women who had been experiencing no problems in their pregnancies; it was given to

doctors to "intervene" over a century ago:

> Walter Channing, Professor of Midwifery at Harvard Medical School in the early nineteenth century, remarked about the doctor, in the context of discussing a case in which forceps were used unnecessarily, that he "must do something...." [e]ven though well-educated physicians recognized that natural processes were sufficient and that instruments could be dangerous, in their practice they also had to appear to do something for their patient's symptoms, whether that entailed giving a drug to alleviate pain or shortening labor by using the forceps. The doctor could not appear to be indifferent or inattentive or useless.

Wertz & Wertz, Lying-In: A History of Childbirth in America 64 (1977).

Documentation of court-ordered cesareans over the past few years supports the truth of this lesson and shows the particular vulnerability of minority and poor women to the humiliation and pain of forced or unwanted surgery.[12] A recent study published

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others who had had one or two miscarriages or had had a baby and then a miscarriage. It was given for short periods of time, long periods of time, to women who experienced nausea while taking it, to women who were told they were taking only vitamins." Meyers, DES: The Bitter Pill 18 (1983).

The reluctance of physicians to give their patients information, coupled with the faith that women had in their doctors, led to more problems, "some women had not known what drugs they were taking during pregnancy. When women did ask, some doctors replied, 'The name wouldn't mean anything to you, dear,' or 'This is a hold-the-baby-in pill.'" Corea, The Hidden Malpractice 245 (1977).

In some instances, doctors gave incorrect medical information. Concerning in utero DES effects on her teenage daughters, "[o]ne mother. . .asked her physician about DES effects and was told that a very high amount of the drug would have to be present to have an adverse effect on the fetus and that had not been true in her case." Id. This was found to be false in medical reports written in the 1970's. Nevertheless, such answers alleviated any fears that patient might have had about DES. Perhaps worst of all, DES was prescribed to women over the protests of pregnant women. Id.

Despite the so-called wisdom of hundreds of thousands of doctors across the country, DES was found to cause cancer in 1971.

[12] This is no new vulnerability. Historians of medical interventions in childbirth have documented similar "well-meaning" attitudes and practices of nineteenth century doctors towards certain of their women patients least able to insist on their own rights to self-determination and bodily integrity:

> Another reason for the development of a readiness to intervene in birth was the nature of the patients in maternity hospitals in the closing decades of the nineteenth century. Doctors saw these women -- the charity patients and the unwed mothers who sometimes paid for part of their care -- as defective both in health and in moral ability, and thus as in greater need of assistance from medical arts than were healthy and respectable women. A doctor trained in Vienna reported in 1886 that he needed to use forceps in only 5 percent of his cases in Vienna, but in New York he found it necessary to use them in 40 percent of his cases, partly because his colleagues advised him to do so, and partly

in The New England Journal of Medicine found that, among 21 requests by doctors and hospitals for court-ordered obstetrical intervention, 81% of the women involved whose decisions doctors sought to overrule were black, Asian or Hispanic and 24% did not speak English as their primary language. All of the women involved were treated in a teaching hospital clinic[13] or were receiving public assistance. Of the 15 orders sought for cesarean section, all but one were granted, and minority women were again involved in greater numbers (47 percent were black, 33 percent were African or Asian, and only 20 percent were white). Orders were obtained in 86 percent of all the cases of requested forced intervention. Kolder, Gallagher & Parsons, Court-Ordered Obstetrical Interventions, 316 New Eng. J. Med. 1192 (1987). As a matter of public health policy as well as of anti-discrimination policy, these statistics are deeply troubling. See National Health Law Program, Court-Ordered Cesareans: A Growing Concern for Indigent Women, 21 Clearinghouse Review 1064 (1988).

B. Cesareans Pose Serious Public Health Risks Which Women Are Entitled To Refuse To Undergo, Even In Emergency Situations

It is important to remember that women have legitimate public health reasons to oppose cesarean surgery. Cesareans have an average maternal mortality rate (the relative incidence of death) four times higher than that of vaginal births (41 deaths per 100,000 births for Cesareans as compared to 10 deaths per 100,000

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> because he believed that his patients were less healthy. A recent study of case reports in a Boston maternity hospital in the 1890s found that instrumental interventions were often justified with moral judgments about the patients as too lazy or too stupid to deliver by themselves. How often interventions were expressions of impatience, of therapy for weak women, or even of punitive treatment for having "fallen" cannot be known, but doctors seem to have felt licensed to do what was best for the women who were not in a social position to complain.

Wertz & Wertz, Lying-In: A History of Childbirth in America 138-9 (1977) (footnote omitted).

[13] George Washington University Medical Center is a teaching hospital and had extended treatment for Ms. Carder in the high risk obstetrics clinic under its teaching function.

vaginal births).[14] One study found a 26-fold increase in maternal mortality with cesareans as compared to vaginal delivery, with one third of those deaths occurring in cases of repeat cesareans.[15] Cesarean sections also involve five to seven times higher rates of maternal morbidity (the relative incidence of disease).[16] Although complications from cesareans vary, the incidence of postpartum infection increases markedly among low-income women.[17]

The infant also faces greater risks from cesarean delivery, including higher rates of medically induced prematurity and respiratory distress.[18] This risk appears to be even higher for the children of low-income and minority women, who are more likely to be born prematurely and/or with low birth weight. Data from New York City, for instance, shows that, for infants weighing less than 2,501 grams, cesarean delivery presents a consistent neonatal mortality disadvantage as compared with vaginal births.[19]

In light of these disturbing statistics, one might expect the number of cesareans performed per year to be on the decline. The reverse is true. The use of cesarean sections in the United States has climbed steadily since 1970. Notzon, Placek & Taffel, Comparisons of National Cesarean Section Rates, New Eng. J. Med. 316, 386 (1987). It is a chilling backdrop to Angela Carder's unnecessary cesarean that three-fifths of the cesarean sections performed in the District of Columbia in 1986 were reported to be unnecessary. Tanio, Manley & Wolfe, Unnecessary Cesarean

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[14] National Inst. of Health, HHS, Cesarean Childbirth, Report of a Consensus Development Conference 255 (1981) [hereinafter Cesarean Childbirth].

[15] Evrard & Gold, Cesarean Section and Maternal Mortality in Rhode Island: Incidence and Risk Factors 1965-75, 50 Obstetrics & Gynecology 594, 595 (1977).

[16] Cesarean Childbirth, supra note 14, at 260.

[17] Id. at 262.

[18] Petitti, Olson & Williams, Cesarean Section in California - 1960 Through 1975, 133 Am. J. Obstetrics & Gynecology 391 (1979).

[19] Cesarean Childbirth, supra note 14, at 11.

Sections: A Rapidly Growing National Epidemic (1987).

It can never be assumed that cesarean surgery is necessary, even in the most extreme apparent emergencies. This is clear from at least two of the court-ordered cesarean cases. In Jefferson v. Griffin Spalding County Hospital Authority, 247 Ga. 86, 274 S.E. 2d 457 (1981), Mrs. Jefferson was told that due to her complete placenta previa, a vaginal delivery would expose her fetus to a 99% chance of dying and would expose her to a 50% chance of dying. Despite this medical "uncertainty" which formed the basis of the court-ordered surgery over Mrs. Jefferson's objections, Mrs. Jefferson actually delivered a healthy baby through natural labor. Nelson, Buggy & Weil, Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest," 37 Hastings L. J. 703, 707 (1986). In a similar Michigan case, a woman with placenta previa objected to a cesarean, went into hiding in order to escape forced surgery, and delivered vaginally without complications. In re Baby Jeffries, No. 14004 (Jackson County, Mich., May 24, 1982) (case reported in Detroit Free Press, June 16, 1982, at 3A, 7A and by Rhoden, The Judge in the Delivery Room: The Emergency of Court-Ordered Cesareans, 74 Cal. L. Rev. 1951 (1986).

### C. Failure to Respect Pregnant Women's Rights Violates Women's Trust in the Medical Profession and Will Deter Some Women From Seeking the Medical Treatment They Need

For every court-ordered cesarean on a nonconsenting woman, an uncountable number of women will receive the message that their wishes count for nothing in the face of a hospital's desire to perform surgery. Some of these women will inevitably refuse to seek vital prenatal care because of this feared lack of respect for their health decisions.

One research group has noted:

> While the true impact of court-orderd Cesareans is not yet clear, the potential ramifications are startling. Many women who refuse surgical deliveries for personal or religious reasons may begin avoiding hospital deliveries or prenatal care altogether. In several of the cases discussed in this article, the women who were targets of court-ordered surgery chose to forego a hospital delivery and risk a home birth. The fact that low-income and minority women are more likely to be compelled by the courts to undergo surgical deliveries is

> especially troubling, since a hesitancy to seek prenatal care for fear of possible judicial action could have devastating effects on these women and their babies.
>
> Furthermore, court-ordered Cesareans may be just the first step toward even greater medical and judicial intervention into the lives of pregnant women. Several fetal rights advocates suggest that, in addition to Cesarean section, the law could require in utero fetal surgery, the institutionalization of mothers abusing drugs or alcohol, force-feeding of anorexic or neglectful mothers, compulsory hospital delivery instead of births attended by midwives or undertaken at home, and prenatal screening with a corresponding duty to abort defective fetuses.

National Health Law Program, Court-Ordered Cesareans, supra at 1070 (footnotes omitted).

The interests of public health and individual liberty coincide. Only by allowing women their full rights as citizens to life, bodily integrity and individual self-determination can courts and hospitals maintain the trust in the medical profession essential to public health. Cesareans are not a public health panacea. Even if they were, no woman should ever be forced to undergo one against her will or against her judgment of what is best for herself or her child. Legal action for forced surgery drives a wedge between doctors and the public, and in so doing, it makes bad public health policy.[20]

## II. A PREGNANT WOMAN'S RIGHTS TO LIFE, BODILY INTEGRITY AND SELF-DETERMINATION ARE PARAMOUNT AND UNEQUIVOCAL.

It is a central principle of law that the government may not order any person to submit to surgery for the benefit of another, even if the other's life is actual, rather than potential. Assuming what is not true either in fact or in law, that a fetus may be treated as the equivalent of an adult woman, it is still not permissible under law to require one person to make bodily sacrifices for the benefit of another person. "For our law to compel [a person] to submit to an intrusion of ... body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn. McFall v. Shimp, 10

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[20] Amici curiae refer this court to the Brief of Amici Curiae American Public Health Association et al. for further discussion of the public health implications of this case.

D. & C. 3d 90, 91 (Pa. Com. Pl. 1978) (emphasis in original).[21] Pregnancy does not constitute an exception to the general legal principles concerning bodily integrity and personal autonomy.[22] The court here violated this central principle of fundamental law and ordered Angela Carder to undergo surgery and suffer all the attendant risks, not for her own sake, but for the sake of another. The law cannot and should not exercise the power to impose such a detriment.

Courts have denied orders to perform forced medical interventionon pregnant women in at least six instances. Kolder, Gallagher & Parsons, Court Ordered Obstetrical Interventions, 316 New Eng. J. Med. 1192 (1987). One commentator noted a case in which California social service authorities attempted to assert jurisdiction over the fetus of a young pregnant woman dying of cancer:

> The agency sought to reverse the patient's instruction to her doctors. The woman, six months pregnant, did not want an abortion. She had asked that, should she suffer cardiac arrest from chemotherapy, doctors resuscitate her before working on the fetus. If she did go into cardiac arrest, it would have been unlikely that the doctors could have saved both her and the fetus. "The Ob/gyn staff did argue

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[21] In McFall v. Shimp, 10 D. & C. 3d 90 (Pa. Com. Pl. 1978), the plaintiff sought an injunction to compel another to donate bone marrow. The court in an opinion written by Judge Flaherty, now a Justice of the Pennsylvania Supreme Court, cited:

> The common law [which] has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue. For a society which respects the rights of one individual to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence.

Id. at 91-92 (emphasis in original).

[22] The United States Supreme Court's most recent statement on this topic, in the abortion context, confirms this:

> Our cases have long recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government.....That promise extends to women as well as to men.....Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all.

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 772 (1986). See also, Johnsen, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection, 95 Yale L. J. 599 (1986).

> for compelling her to undergo a Cesarean however all the other doctors agreed that would result in her immediate death [sic]." An appellate court ultimately ruled that juvenile court jurisdiction had been improper.

Gallagher, Prenatal Invasions and Interventions: What's Wrong with Fetal Rights, 10 Harv. Women's L. J. 9, 48 (1987) (footnotes omitted). The same author recounted:

> In two cases where the woman's successful vaginal delivery made surgery unnecessary, judges had already refused to override the patient's decision based on the woman's rights of bodily integrity and non-subordination. In a case described by New York Judge Margaret Taylor, the judge refused to authorize forced surgery based on the patient's competence to make decisions for the medical treatment of her own body.... In a Washington State case, social services attorneys sought an order to compel a cesarean section on a pregnant woman who tested positive for herpes. The judge refused to grant the order, stating, "I just don't feel that the State has the power to require a parent to undergo what I consider a major surgical procedure -- and I use the term 'major' because it does require anesthetic and there are certain risks in any caudal block...surgical procedure are always life-threatening." The judge also noted that he "would not have the right to require Mrs. [name omitted] to donate an organ to one or her other children if that child were dying... That's her decision to make."

Id. at 51 n. 215.

A. Whatever Interest May Exist in the Potential Life of a Fetus, Such Interest Can Never Be Pursued at the Expense of the Paramount Interests of the Pregnant Woman in Her Life and/or Health.

For purposes of government intrusion upon a woman's constitutional rights to autonomy and privacy, the fetus is not a person with rights equivalent to a woman's. In Roe v. Wade, 410 U.S. 113 (1973), the United State's Supreme Court established that "[i]f a State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."[23] 410 U.S. at 163-64 (emphasis supplied). The Court observed that "the word 'person,' as used in the Fourteenth Amendment, does not include the 'unborn'" and "the unborn have never been recognized in the law as persons in the whole sense." 410 U.S. at 162. The import of these principles

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[23] In Colautti v. Franklin, 439 U.S. 379, 394 (1979) the Court clarified the definition of 'health' as including "all attendant circumstances--psychological and emotional as well as physical--that might be relevant to the well-being of the patient."

is that at no stage of development is a fetus a 'person' with legal rights or interests equal to or greater than the woman's.

In a series of decisions since Roe, the Court has reemphasized the rule that, a woman's interests are paramount. For example, in Colautti v. Franklin, 439 U.S. 379, 400 (1979), the Court struck down a statute in large part because it failed to "clearly specify.....that the woman's life and health must always prevail over the fetus' life and health when they conflict." A fetus may never attain the status of born, legal personhood. Its existence as an autonomous being separate from the mother is hypothetical, speculative, tentative and conjectural until the moment of live birth, despite all the inventions of modern technology. Since this is so, the woman's well-being must be treated as paramount.[24]

Most recently, the Court repeated the theme that the woman's rights prevail over concerns with respect to a fetus. In Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986), the Court examined a statute that, inter alia, required for post-viability abortions that a physician "exercise ... that degree of professional skill, care and diligence which such person would be required to exercise ... to preserve the life and health of the fetus..." and in the case of abortion to use the technique that would best guarantee that the "unborn child" would be born alive unless "that technique 'would present a significantly greater medical risk to the life and health of the pregnant woman.'" Id. at 768. The Court found the statute facially invalid because, inter alia, "the language

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[24] It is a perversion of juvenile law for courts to appoint counsel to represent a fetus. Juvenile law requires the appointment of a guardian ad litem for a minor person, but not a non-person. Although it has apparently become standard practice for courts to appoint attorneys to represent the interest of a fetus, as the court did here, the practice is conceptually troubling since it presumes that the interest of the fetus can be separate from and in conflict with those of the mother and it provides equal representation for the legal person and the legal non-person. This imbalance undoubtedly skews the outcome of such cases, so that fetal interests are automatically presumed to be adverse to the mother and 'heard' with more authority than is warranted. The only safeguard would be to make clear that the interest is the state's interest which can never put the fetal concerns above the life and health of the mother.

of the statute 'is not susceptible to a construction that does not require the mother to bear an increased medical risk in order to save her viable fetus.'" Id. citing the court of appeals opinion, 737 F.2d at 300.

A woman has a constitutional right to an abortion without regulation in the first trimester, and a right circumscribed only by regulations which will safeguard her own health until approximately the end of the second trimester, whenever viability occurs.[25] After viability, her right remains paramount, but is tempered by the state's interest in the potential life to the extent that the state can regulate abortion in such a manner as to protect the health and life of the mother and the potential health and life of the fetus. When the woman's interests in her own life and health conflict with that of the fetus, however, the woman is constitutionally free to choose her own interest, and

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[25] Moreover the court here erred seriously by assuming viability, without making the appropriate fact-based inquiry concerning viability. As the U.S. Supreme Court has explained, viability is the point at which the fetus is:

> "potentially able to live outside the mother's womb, albeit with artificial aid." [citing Roe v. Wade, 410 U.S. at 160.] We added that there must be a potentiality of "meaningful life", id., at 163, ... not merely momentary survival. And we noted that viability "is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." Id. at 160....

Colautti v. Franklin, 439 U.S. at 387. The Court explained that a determination of viability is " 'a matter of medical judgment, skill, and technical ability'" and rejected a contention that "'a specified number of weeks in pregnancy must be fixed by statute as the point of viability.'" Colautti, 439 U.S. at 388, citing Roe, 410 U.S. at 63-65. The Court said:

> We reaffirm these principles. Viability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability - be it weeks of gestation or fetal weight or any other single factor - as the determinant of when the State has a compelling interest in the life or health of the fetus.

439 U.S. at 388 (emphasis added).

There was never a bona fide inquiry on the particular facts of the case into a determination of viability in the case of the Carder fetus. The court relied upon the general statistics related to probability of survival at twenty-six weeks of gestation (which was carefully qualified by the attending physicians to suggest probability of non-viability in this case, tr. 15, 33-34, 39) and the testimony of neonatologist Dr. Maureen Edwards, who had no direct involvement with Ms. Carder, tr. 36, for its apparent, though not express, conclusion that the fetus was viable, tr. 83.

the state is constitutionally required to respect that choice. Roe v. Wade, 410 U.S. 113, 163-64 (1973). The trial court, affirmed by the panel, failed to differentiate between the legal status of the woman and her fetus. As a result, it engaged in a 'balancing' test and assumed the equivalency of two entities which the law does not consider equal. This was a fundamental error of law. Even after viability, if the woman is sick and fetus well, the woman's interests predominate; if the woman is well and the fetus is sick, the woman's interests predominate; if, as was sadly the case with Angela Carder, both woman and fetus are sick, the woman's interests predominate.

B. The Court Erred When It Considered the Speculated Length of Angela Carder's Life in Deciding Against Her Paramount Interests

A woman's interests in her life and health remain as long as she is alive. A person is a person until the moment of death. In Angela Carder's case, the speculated amount of time left to her life, which is irrelevant in any case, was a disputed question.[26] The trial court, however, treated Angela Carder as if she were virtually dead:

> "MR. SYLVESTER [counsel for Angela Carder]: As I see this, as I understand the medical testimony, if we were to do a c-section on this woman in a very weakened medical state, we would in effect be terminating her life, and I can't ...
>
> THE COURT: She's going to die, Mr. Sylvester."

Tr. p. 76, ll. 1-5. See also, tr. 78.

The appellate panel devalued Angela Carder's life:

> The court based it's decision to deny a stay on the medical judgment that A.C. would not survive for a significant time after the surgery ... Though A.C. might have lived twenty-four to forty-eight hours, the surgery might have hastened her death.

533 A.2d at 613 (emphasis added), vacated and rehearing en banc granted,

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[26] Indeed, the court's decision to balance the putative interests of the fetus as compared with the quantity of life left to the pregnant woman invites an Orwellian construction of quality of life as well. If a woman's interest in personal autonomy is diminished by the number of days or hours she has left to live, it is logical to assume that the court may also consider the quality of life remaining to the woman. For example, a woman's right to self-determination may be diminished by the fact that she is poor, has any permanent physical or mental impairment, is a prostitute or is by any other subjective standard, less worthy than a "healthy" woman.

In re A.C., 539 A.2d 203 (D.C. 1988).

The panel acknowledged:[27]

> Performing Caesarean sections will, in most instances, have an effect on the condition of the mother. That effect may be temporary in otherwise normal patients. The surgery presents a number of common complications, including infection, hemorrhage, gastric aspiration of the stomach contents, and post operative embolism. 4C Gray, Attorney's Textbook of Medicine 308.50 (3d ed. 1987). In some cases, the surgery will result in the mother's death.

533 A.2d at 617 (footnote omitted). The opinion notes in footnote that "the death rate of women upon whom Caesarean sections have been performed is ... significantly higher than the death rate of women who have delivered their babies vaginally." Id. at n. 5. The opinion concluded: "Even though we recognize these considerations, we think they should not have been dispositive here. The Caesarean section would not significantly affect A.C.'s condition because she had, at best, two days left of sedated life; the complications arising from the surgery would not significantly alter that prognosis." 533 A.2d at 617 (emphasis added).

Obviously the panel lacked understanding about the meaning of medical prediction of death.

> "[P]rognostication near the end of life is notoriously uncertain.[28] At best, confidence in predicting death is

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[27] The panel opinion rejected any application of Colautti or Thornburgh on the grounds, inter alia, that those cases were concerned that "the woman's well-being [not] be sacrificed for the life of her viable fetus." 533 A. 2d at 615 n. 4. The panel took the position, effectively, that since A. C. did not have "good health," this case was outside the ambit of Colautti and Thornburgh; that "her condition was clearly affected" was deemed of no relevance. See id.

[28] In support of this point the President's Commission said, in footnote:

> "Physicians' predictions of prognosis were relatively inaccurate, with actual survival plus or minus one month coinciding with that predicted in only 16% of patients. Except in patients who were very ill and had short prognosis of three to four months, survival was consistently underestimated." [citing Aiken & Marx, Hospices: Perspectives on the Public Policy Debate, 37 Am. Psychologist 1271, 1275 (1982) (reporting data from Yates, McKegney & Kun, A Comparative Study of Home Nursing Care of Patients with Advanced Cancer, Proceeding of the Third National Conference on Human Values of Cancer, American Cancer Society, New York, 1982)].
> The subjective nature of prognoses affects the types of treatment that are encouraged, which in turn

> possible only in the final few hours. Patients with the same stage of a disease but with different family settings, personalities, and 'things to live for' actually do live for strikingly varied periods of time.[29]

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 25-26 (1983) (hereinafter "President's Commission"). Notably, even after the Hospital's failure to give Angela Carder life-prolonging treatment, the ordeal of the forced cesarean, the resulting loss of her fetus' life, Ms. Carder lived two more days.[30] Perhaps with antibiotics and radiation therapy, instead of a forced cesarean, she would have had months to live. Neither a court nor a hospital has the authority to determine, shorten or take away that time.

The panel heard predictions of days or hours of life remaining and counting them up decided that having such a short time meant that life was somehow diminished. When one has so little life left, how can it be less rather than more precious?[31]

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> affects patients' outcome. In one study, physicians who preferred to intubate and artificially ventilate a patient with severe chronic lung disease projected that the patient would survive about 15 months; other physicians who decided against artificial ventilation when presented with the same case predicted that, even with artificial life support, the patient had only 6 months to live. [Citing, among others Dunphy, Annual Discourse On Caring for the Patient with Cancer, 295 New Eng. J. Med. 313, 314 (1976); Siegler, Pascal's Wager and the Hanging of Crepe, 293 New Eng. J. Med. 853 (1975); cf. Motulsky, Biased Ascertainment and the Natural History of Disease, 298 New Eng. J. Med. 1196 (1978)].

Id. at 25.

[29] The President's Commission, id. at 26 used, in footnote, the following support: Pattison, The Will to Live and the Expectation of Death, in The Experience of Dying 61 (Pattison, ed., 1977).

[30] However, apparently sometime on June 16, the hospital did finally give Ms. Carder antibiotics to treat the pnenmonia that was a major factor in her breathing difficulties.

[31] Reflecting on the loss of a loved one, C.S. Lewis has said:

> It is hard to have patience with people who say, "There is no death," or "Death doesn't matter." There is death. And whatever is, matters. And whatever happens has consequences, and it and they are irrevocable and irreversible. You might as well say birth doesn't matter. I look up at the night sky. Is anything more certain

C. The Court Erred in Equating this Case with the Cases in Which a Court Found a Compelling Interest to Override Refusal of Treatment

This case is not a case where the court ordered medical treatment to aid the health or life of an individual who was refusing treatment or on whose behalf, because of minority or incompetency, treatment had been refused. This case is quite the opposite. Here, the Hospital effectively declined to provide the treatment that would have helped save or prolong the life of Ms. Carder and to which she had competently consented. Instead, it sought to impose an alternative treatment that purportedly served the interest of some other potential life, at the expense of Ms. Carder's health and life.

The court appeared to use a "compelling state interest" rationale for its action here. To allege a "compelling state interest" based on the rights of a fetus in opposition to the health and life rights of its mother, is however, contrary to

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> that...in all those vast times and spaces, if I were allowed to search them, I should nowhere find her face, her voice, her touch? She died. She is dead. Is the word so difficult to learn?

Lewis, A Grief Observed (1961), as cited in Stress and Survival: The Emotional Realities of Life-Threatening Illness xii (Garfield, ed. 1979).

Those who have studied reponses of patients, loved ones and medical staff to death and dying have commented upon the problem that loved ones and medical staff frequently withdraw and become busy with practicalities leaving the terminal patient isolated. The process of dying, when death is not sudden, involves a complicated psychological development that demands care and attention. The impulse to deny death and to substitute intervention for real care can deprive both loved ones and the terminal patient of some of the most important interaction in the lives of either. Honesty in confronting death on the part of the terminally ill and those around him or her can lead to revelations. See generally Kubler-Ross, On Death and Dying (1969).

> When we honestly ask ourselves which persons in our lives mean the most to us, we often find it is those who, instead of giving much advice, solutions or cures, have chosen rather to share our pain and touch our wounds with gentle hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not knowing, not curing, not healing, and face with us the reality of our powerlessness, that is the friend who cares.

Nouwen, Out of Solitude (1959) as cited in Stress and Survival: The Emotional Realities of Life-Threatening Illness 7 (Garfield, ed. 1979).

Sadly, Angela Carder and her loved ones were deprived of important time together because, despite their clear wishes, the Hospital found it more important to hold a court hearing, and the court permitted that to happen.

constitutional law, see section IIA supra, and has no sound basis in cases involving refusal of life-sustaining treatment. In In re Boyd, 403 A.2d 744 (D.C. 1979), a panel of this court recited, quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, __, 370 N.E. 2d 417, 425, (1977), the rationales used to support "compelling state interest" assertions: "'As distilled from the cases, the State has claimed [an] interest in (1) the preservation of life; (2) the protection of the interests of innocent third parties [e.g., minor children]; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession.'" Boyd, 403 A.2d at 748 n.9. None of those aims were served in this case.

The interest in the "preservation of life" and/or the "prevention of suicide" as discussed in cases concerning refusal of life-sustaining treatment, is the state's interest in saving the life of the person to whom treatment is to be applied. In this case, Angela Carder was the person to whom treatment was to be applied. She was not refusing treatment such that the state had to act to save her. She wished to live, and had consented to treatment for that purpose. The state has no interest in hastening the death of its citizens.

The cases involving "protection of the interests of innocent third parties" concern instances in which the refusal of treatment is made by one person on behalf of a separate other person who, like a child or mentally incompetent individual, is unable to decide for himself or herself. See, e.g., In re B.B.H. 111 Daily Wash. L. Rep. 1929 (D.C. Sup. Ct., Aug.18, 1983). These cases do not and should not apply to the circumstances where an individual is refusing treatment or medical procedures involving risks to his or her own health that are proposed to serve the needs of another.[32] Where such is being done,[33] it

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[32] In the Matter of Madyun Fetus is arguably the one exception to this line of cases and the assumptions underlying that case are challenged in this brief. The instant case is the obvious tragic result of embarking upon a course of forcing intrusive surgery upon one individual purportedly to serve the interest of another.

surely cannot satisfy the final requirement of maintaining "the ethical integrity of the medical profession." The state itself has conceded that it was inappropriate for it to intervene to make any argument of state interest in this case. The court was clearly in error.

### D. A Competent Individual, Most Particularly a Pregnant Woman, Should Determine the Course of Her Own Medical Treatment According to the Principles of Informed Consent; Violation of this Principle of Self-Determination Negates the Very Essence of Human Life

Constitutional law and the law of informed consent placed the decisions about her medical treatment solely with Ms. Carder. Substituting its own choice for Ms. Carder's decision-making, the court negated the very essence of human life -- the profound power of human will. "[T]he will to live is not a theoretical abstraction, but a physiologic reality with therapeutic characteristics ... [A] highly developed purpose and the will to live are among the prime raw materials of human existence .... [T]hese materials may well represent the most potent force within human reach." Cousins, Anatomy of an Illness 44, 71 (1979).[34]

The law has long recognized that issues of life and health do not uniquely concern physiological function.[35] The concept of

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[33] Indeed it was not clearly established that the fetus was better served by forced cesaraean than by nonintervention. See Statement of the Case, supra, and Section IID, infra.

[34] Literature on spontaneous regression, particularly of cancer, documents the importance of a patient's mental involvement in both treatment and cure. See, e.g., Booth, Psychobiological Aspects of "Spontaneous" Regressions of Cancer, 1 J. Am. Academy of Psychoanalysis 303 (1973), reprinted in Stress and Survival: The Emotional Realities of Life-Threatening Illness 99-107 (Garfield, ed. 1979).

[35] Declining to order blood transfusion for a pregnant woman who had consented to a cesarean but not to a blood transfusion on the grounds that as a Jehovah's Witness, she believed that for her to receive a blood transfusion would deprive her of everlasting life, the Superior Court in In re Bentley, 102 Wash. Daily L. Rep. 1221, 1225 (D.C. Sup. Ct., April 25, 1974), said:

> Respondent's freedom of choice in the basic decisions of one's own life is guaranteed by the right of privacy. The detriment that the state would impose upon this woman by denying her choice is obvious. To receive blood by any means might deprive her of everlasting life. Psychological harm is imminent and her mental and physical health may be taxed permanently by the continuing stigma of sin.

health encompasses the total person. As the U.S. Supreme Court said in United States v. Vuitch, 402 U.S. 62 (1971), "the general usage and modern understanding of the word 'health', ..... includes psychological as well as physical well being. Indeed Webster's Dictionary, in accord with that common usage, properly defines health as the '[s]tate of being ... sound in body [or] mind.'" Individual responsibility and autonomy central to psychological well-being are enhanced by the constitutional rights to liberty, physical integrity and privacy.[36]

These rights have their corollary in medical treatment contexts, in the right of an individual patient, in consultation with attending physicians, to determine the course of his or her own medical therapy.[37] "The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body'...." Canterbury v. Spence, 150 U.S. App. D.C. 263, 464 F.d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) (footnote omitted), quoting Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

This right of patient self-determination extends to the situation where the patient disagrees with her physicians on what

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(Emphasis added).

[36] "[T]he unwritten constitutional right of privacy exist[s] in the penumbra of specific guarantees of the Bill of Rights...Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." In Re Quinlan, 70 N. J. 10, 41, 355 A.2d 647, 663, cert. denied, 429 U.S. 922 (1976) (citations omitted). (However, the New Jersey Supreme Court's later decision, In re Conroy, 98 N. J. 321, 486 A.2d 1209 (1985), rested entirely upon the common law right of refusing medical treatment.)

[37] "The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions.....Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion." Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, 301 (1986) (citations omitted).

is the correct course of treatment, and declines treatment.[38] Full information is a prerequisite of valid determination of treatment alternatives by the patient: "Adequate disclosure and informed consent are, of course, two sides of the same coin--- the former a sine qua non of the latter." Canterbury v. Spence, 464 F.2d at 780 n. 15. In analyzing the parameters of informed consent,[39] the Canterbury court said: "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie." Id. at 781 (footnote omitted).[40] Accordingly, in Tune v. Walter Reed Army Hospital, 602 F. Supp. 1452, 1455 (D.D.C. 1985), the competent

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[38] Perhaps it is understandable that doctors become perplexed when a woman who wants to have her baby refuses treatment. However, that does not justify involving lawyers and courts in difficult medical treatment decisions. See Nelson, Buggy & Weil, Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest," 37 Hastings L. J. 703, 712-714 (1986). See also, Nelson & Milliken, Compelled Medical Treatment of Pregnant Women, 259 JAMA 1060 (1988).

Doctors faced with a treatment refusal may protect themselves by obtaining a signed and witnessed form which attests to the information given the patient about the possible consequences to the patient and her fetus of alternative courses of action. The form should describe the patient's mental capacity at the time, so that there is evidence of her competence; it should be placed on the patient's chart. Research shows that full disclosure and genuinely informed consent greatly reduce the likelihood of malpractice suits. Capon, Tort Liability in Genetic Counseling, 79 Colum. L. Rev. 618, 671-72 (1979), as cited in Gallagher, Prenatal Invasions and Interventions: What's Wrong With Fetal Rights, 10 Harv. Women's L. J. 9, 52 (1987). "Because no statute, regulation or judicial decision places an affirmative duty on physicians or other practitioners to seek a court order that would override the wishes of any competent adult patient, including a pregnant woman, it is unlikely that a practitioner could be held legally liable for honoring a pregnant woman's informed refusal of treatment." Nelson, Buggy & Weil, Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest," 37 Hastings L. J. 703, 725 (1986) (emphasis added).

[39] The Canterbury court defined both the patient's right and the doctor's duty, id. at 780; the scope of both the doctor's duty and the patient's right, id. at 788; the standards by which each should be measured, id. at 787; the topics to be communicated, id. at 787; who bears the burden of proceeding, id. at 791; and the proper standards of proof in a suit alleging lack of informed consent, id.

[40] Treatment performed on a patient who has not given her explicit, informed consent may constitute tortious conduct: "It is the settled rule that therapy not authorized by the patient may amount to a tort -- a common law battery -- by the physician." Canterbury v. Spence, 150 U.S. App. D.C. 263, 464 F.2d 772, 783 (D.C. Cir. 1972), citing Bonner v. Moran, 75 U.S. App. D.C. 156, 126 F.2d 121, 121-23 (1941).

patient desired that life-sustaining tubes be disconnected, and the court ordered this done, stating that "[i]t is now a well-established rule of general law, as binding upon the government as upon the medical profession at large, that it is the patient, not the physician, who ultimately decides if treatment--any treatment--is to be given at all".[41]

From these principles, it naturally follows that Ms. Carder, like all patients of either sex, was entitled to be informed about her treatment options and to decide among them, even to refuse treatment. On the day of the court-ordered cesarean in this case, all the evidence indicated that what she desired was to pursue a course of treatment to prolong her life and carry the fetus to at least 28 weeks or beyond. See, e.g., Tr. at 12, 14, 16; Specialist's Aff. 32. On the afternoon of June 15, she had specifically and expressly elected a course of treatment consistent with that desire. See Specialist's Aff. 32. Once having decided, she was entitled to have her wishes promptly respected, particularly where as here the efficacy of the selected treatment required emergency response. See Specialist's Aff. 33 (transfer to ICU and start of radiation therapy must be done on emergency basis; otherwise she has hours to live). Or she was entitled to be presented with a new set of options. The record indicates that the Hospital neither pursued her treatment choice nor presented new options. Instead the Hospital effectively refused to provide the treatment she had elected and asked the court to order treatment that the Hospital admits was never discussed with her.

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[41] This approach was endorsed by a recent presidential commission and approved by the American Hospital Association and the Council on Ethical and Judicial Affairs of the American Medical Association. Council on Ethical and Judicial Affairs of the American Medical Association, Withholding or Withdrawing Life Prolonging Medical Treatment (March 15, 1986); American Hospital Association, Policy and Statement of Patients' Choices of Treatment Options (1985); Presidential Commission, supra, at 5.

Even once a patient is dead, hospitals and courts are not free to make extractions from a dead body; persons now dead or their families must have consented before an organ is removed for transplant. See D.C. Code Ann. 32-1501--1508 (1981) (anatomical gifts).

Ms. Carder was legally competent to make her own medical decisions.[42] The Hospital did not take this matter to Court for the sake of determining competency. The Hospital made no allegation of legal incompetency and made no attempt to put forward the clear and convincing evidence of incompetency that would have been required. See, e.g., In re Harris, 477 A.2d 724, 725 (D.C. 1984).[43] According to the trial court transcript, various doctors indicated that when the court arrived at the hospital Angela Carder was under sedation and would remain so for several hours; however, it was not established that she was unable, while under sedation, to respond and comprehend. Moreover, after the trial court's ruling and before panel review, as reported on the record, she was advised by a doctor that it was "deemed" that she should have a cesarean. Tr. 89. Upon reflection she made clear that she did not want it done. Tr. 92. The court and the panel should have respected her view.

An expert in this area, Yale law professor Robert Burt effectively cautions that medical treatment decisions made at a

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[42] Even if Angela Carder had been adjudicated incompetent to direct the course of her own treatment, the doctrine of substituted judgment should have applied. The substituted judgment doctrine requires that a treatment decision made for another individual incorporate the personal values of the patient. In re Boyd, 403 A.2d 744, 751 (D.C. 1979), discussed and reaffirmed in In re Bryant, 542 A.2d 1216 (D.C. 1988). In Boyd, a woman who had been adjudicated mentally ill nevertheless asserted her right to refuse medication for religious reasons. This appeal court found that the trial court must "determine what course of action Mrs. Boyd would choose now". Id. at 753 (footnote omitted). The court must never forget that this is "an individual with free choices and moral dignity" not "someone whose preferences no longer matter." Boyd, 403 A 2d at 751 n. 11. Information made available to the court during the hearing made very clear what Angela Carder's wish was: to attempt therapy to prolong her life and increase gestational age and, failing that, not to intervene for the fetus. Indeed, Mr. Burke speaking for the hospital made clear that this was why they were in court: Not to respect her wishes but to override them.

[43] Where a medical treatment proposed to override a patient's right to make any medical treatment decision the patient has a right to a court-held hearing. The moving party must present both clear and convincing evidence to show that the patient lacks competence and that the medical condition is so imminently threatening that immediate action is necessary. Id. For a discussion of the stringency of the standards that must be met to sustain a finding of legal incompetence, see United States v. Charters, 829 F.2d 479, 494-99 (4th Cir. 1987).

distance may not be in the interest of the subject.[44]

Burt analyzed the record in Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 4117 (1977). In Saikewicz, a mental health facility joined by a guardian ad litem petitioned the court concerning medical treatment of a mentally retarded man Joseph Saikewicz, who was a resident of the facility who was suffering leukemia. The court adopted a recommendation against chemotherapy to prolong the patient's life, rationalizing that the life-prolonging treatment withheld would impose more suffering than the course of the illness and would be incomprehensible and thus, less bearable, to a mental incompetent. While not purporting to know the "right answer," Professor Burt commented:

> Unwillingness to enter into a direct struggle with an apparently dying person was an explicit, and ultimately most clearly dispositive reason offered by Joseph Saikewicz's physician for their decision to withhold treatment from him. The decision to withhold chemotherapy during this time may have saved Saikewicz from needless pain and perhaps even quicker death. But this decision was reached with no effort to test a central factual premise on

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[44] As this court has noted about cases involving competency and medical treatment self-determination: "Whenever possible it is better for the judge to make a first-hand appraisal of the patient's personal desires and ability for rational choice." In re Osborne, 294 A. 2d 372 (D.C. 1972) (affirming trial court's refusal to order blood transfusion over religious objection of patient; hearing held at patient's bedside). The judge here made no attempt to see Ms. Carder.

In reported forced treatment cases raising the issue of competency in this jurisdiction, the judge before ruling went to see the person on whom treatment was sought to be ordered or specifically delegated that duty to a person required to report back to the court. See, e.g., Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1007 (D.C. Cir. 1964) (judge went to patient's room); Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452 (D.D.C. 1985) (court appointed guardian ad litem reported to court "having spoken personally with plaintiff"); In re Bryant, 542 A.2d 1216, 1217 n.2 (D.C. 1988) (patient appeared before judge at competency hearing); In re Harris, 477 A.2d 724, 725 (D.C. 1984) (court ordered extensive psychiatric testing of plaintiff in preparation for further court hearing on competence); In re Boyd, 403 A.2d 744, 747 (D.C. 1979) (judge had direct contact with plaintiff in jury trial on commitment); In the Matter of Madyun Fetus, 114 Daily Wash. L. Rep. 2233 (patient testified at hearing); In re Bentley, 102 Daily Wash. L. Rep. 1221, 1224, (D.C. Sup. Ct., April 25, 1974) (patient attended hearing held in hospital). One commentator, arguing that judges should never go to hospitals to make emergency treatment decisions, nevertheless found one exception to his rule: the only reason a judge should ever go to a hospital is to meet a patient in order to determine the competence of the patient. Annas, She's Going to Die, Hastings Center Rep. 23 (Feb. 1988).

> which it rested - whether Saikewicz's acquiescence in treatment could somehow be obtained... All such efforts might have failed. But... none were tried.
>
> Most fundamentally, this omission reflected everyone' unwillingness to enter into sustained interaction with Joseph Saikewicz, everyone's wish to absent themselves from any transaction with him.

R. Burt, Taking Care of Strangers 155-158 (1979).

Those who knew Ms. Carder, her condition and her struggle--her family and her doctors -- respected her decision. They could not place medical guesswork and the hubris of intervention above her own self-determination. Those who had never even seen her could and did. By deciding what was best for Angela Carder and her fetus based upon the narrowly circumscribed information presented to it, the court deprived Ms. Carder[45] and her fetus of Ms. Carder's commitment to try to prolong her life and carry the fetus to 28 weeks or beyond. That commitement had been made only the day before on the basis of Ms. Carder's much fuller understanding of her own life and health. Who is to say whether Ms. Carder, if left to the decisions that she made on June 15, would have achieved her aim to live a longer, better life and in so doing provided the opportunity for the fetus to achieve development to ensure survival? Ms. Carder was a woman who had defied the odds before. Told at the age of thirteen that she had only a few years to live, she had survived to the age of twenty-seven.

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[45] We cannot fully grasp the deep humiliation imposed by the act of forcing Angela Carder to undergo surgery. Commenting upon and rejecting in another case, proposed surgery on a criminal defendant, the United States Supreme Court noted the profound difference between the same surgery depending upon whether it is consented to or not;

> When conducted with consent of the patient, surgery requiring general anesthesia is not necessarily demeaning or intrusive. In such a case, the surgeon is carrying out the patient's own will concerning the patient's body and the patient's right to privacy is therefore preserved. In this case, however, the Court of Appeals noted that the Commonwealth proposes to take control of respondent's body "to drug this citizen...into a state of unconsciousness" and then [to submit him to surgery]. This kind of surgery involves a virtual total divestment of respondent's ordinary control over surge[ry]...."

Winston v. Leo, 470 U.S. 753, 765 (1985) (rejecting proposed order for surgery upon a criminal defendant to recover evidence).

The hospital and court deprived Ms. Carder of the treatment option that she had elected, seriously impaired her health, altered the last days and hours of life left to her and finally contributed to her death. To extract from Angela Carder such heroic sacrifices, to confront her with the options proposed and, second, to allow her to make her own decision.

## III. ORDERING ANGELA CARDER TO UNDERGO AN UNWANTED CESAREAN EXCEEDED THE BOUNDS OF THE COURT'S AUTHORITY

The panel's holding in this case offends the "central principle of a free society that courts have finite bounds of authority, some of constitutional origin, which exist to protect its citizens from the ... wrong ... [of] the excessive use of judicial power. The courts, no less than the political branches of the government, must respect the limits of their authority." United States Catholic Conference v. Abortion Rights Mobilization, Inc., 487 U.S. ___, 108 S.Ct. ___, 101 L.Ed. 2d 69, 77 (1988). The finite bounds of a court's authority are defined by, inter alia, the doctrines of jurisdiction and due process. Analysis of these doctrines and their unfortunately flawed application under the emergency conditions of this case reveals how private decisions about Angela Carder's fate were wrongly taken out of her hands and made instead by a well-meaning but usurping court. Amici urge this court to establish stringent guidelines for the application of these essential doctrines of jurisdiction and due process to cases involving efforts to obtain court-ordered surgical procedures.[46]

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[46] In addition, if the hospital's assertions are true, this case was never justiciable because no issue ripe for judicial resolution existed. The hospital has asserted that:

> the Hospital sought declaratory relief. It requested the Court to decide its responsibilities, a decision in which [sic] it would abide by and act on, regardless of which way the court would rule. The Hospital presented no arguments at the hearing or before this Court on review. It merely asked direction from the Court. It did not ask to override the expressed wishes of a patient, and it did not request a specific treatment.

Response of the George Washington University To Appellant's Memorandum Addressing Why This Case Should Not Be Dismissed As

A. The Court Did Not Have Proper Jurisdiction Over the Person of Angela Carder

It is a basic principle that no court may hear a case in which it does not have personal jurisdiction over all parties. Jurisdiction over the person of the non-initiating party must, in fact, be proved affirmatively by the initiator of suit to ensure correct application of this rule. Snyder v. Laboy, 291 A.2d 194, 197 (D.C. 1972). A court can acquire in personam jurisdiction over a non-initiating party only through: (1) voluntary appearance, or (2) service of valid process in an authorized

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Moot And Amici Curiae's Brief On The Issue Of Mootness at 4. ("Hospital Response"). A case is justiciable only when it involves a definite and concrete case or controversy, touching the legal relations of parties having adverse legal interests, where one party proposes to take an action that another opposes. See Aetna Life Ins. Co. v. Haworth, 300 U.S. 227, 240 (1937); Himmelfarb v. Horwitz, 536 A.2d 86 (D.C. 1987); Smith v. Smith, 310 A.2d 229 (D.C. 1973). See also Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1004 n.9 (D.C. Cir. 1964). Furthermore, it is "not one of the purposes of the ... declaratory judgment acts to enable a prospective negligence action defendant to obtain a declaration of non-liability." 10 Wright, Miller & Kane, Federal Practice and Procedure 2765, at 729 (1983). See Cunningham Bros. Inc. v. Bail, 407 F.2d 1165, 1167 (7th Cir.), cert. denied, 395 U.S. 959 (1969), citing Sun Oil Co. v. Transcontinental Gas Pipe Line Corp., 108 F. Supp. 280, 282 (E. D. Pa. 1952), aff'd, 203 F.2d 957 (3d Cir. 1953).

However, the Hospital's claims that it did not advocate a cesarean are not true. The transcript of the Superior Court hearing reveals that the Hospital's position was very much to urge, in the guise of argument that there was a compelling state interest in the life of the fetus, that the appropriate course of action was a cesarean despite "the apparent desire of the patient and her family ... if the patient is to die, that no intervention be done on behalf of the fetus." Tr. at 5 (Burke arguing for Hospital). Naturally, in terms of survivorship or wrongful death liability, the hospital (or perhaps its legal counsel) would be more concerned about damages based upon the probable life span of the fetus than upon the probable life span of Ms. Carder; this may explain why, despite doctors' recommendations, see Statement of the Case, the Hospital never finally undertook specific diagnostic procedures or radiation or chemotherapy designed to prolong Ms. Carder's life but instead opted to seek a court-ordered cesarean ostensibly to save the fetus. This may also explain why the Hospital is now disavowing the clear import of its earlier arguments. To the extent that the forced cesarean procedure was contrary to accepted ethical and medical requirements (such that the Hospital's own doctors did not endorse it), the Hospital is in a difficult position now vis a vis malpractice and violation of civil rights if it admits advocating the cesarean.

In an alleged emergency where a hospital or doctor suggests a course of action with consequences of the magnitude here, that party must be required to commit to a particular treatment option. How else can a court, which is not qualified to make medical judgments, be assured that the party is providing its best medical judgment and ensure that the court is not being used as a shield for liability?

manner. Devoto v. Devoto, 358 A.2d 312, 313 (D.C. 1976). Jurisdiction over a non-initiating party, not otherwise obtained, cannot be acquired by the appearance, without her consent, of court-appointed counsel. Snyder, 291 A.2d at 197.

The Hospital has conceded:

> that A.C. was not told about the hearing and did not know what steps the University was taking until after the order; that A.C.'s attorney never met A.C. and had no opportunity to speak with her; that A.C. never appeared before the court...

Hospital Response at 3.[47] At no time did the trial judge, who held the hearing at the hospital, go to Ms. Carder's bedside. At no time, therefore, did the Superior Court have basic jurisdiction over the person whose fate it decided.

The emergency circumstances of the action provide an explanation for this astounding lapse in application of jurisdictional rules, but not an excuse. It is of the utmost importance that courts do not, in the excitement of an emergency application, betray the public's trust by failing to insist on satisfactory answers to the threshold jurisdictional questions that provide the checks and balances on judicial power. As one commentator has stated:

> [a] note of warning is in order with respect to the ... criterion of procedural regularity: even the most awful tortures, it must be remembered, can be cloaked with such clockwork logic that many become persuaded of their perverse justice.... It should be even clearer that, when an individual's bodily integrity is at stake, a determination that the state has indeed accorded procedurally adequate protection should not be made lightly.

Tribe, American Constitutional Law 1332 (2nd ed., 1988) (footnote omitted). Due process of law requires that a court have jurisdiction over parties in proceedings to determine their personal rights and obligations. Pennoyer v. Neff, 95 U.S. 714 (1877). Angela Carder had a constitutional right to effective notice and an opportunity to be heard. See Mullane v. Central

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[47] Indeed Angela Carder's parents, Nettie and David Stoner were called to a "meeting" but not told that it was a court hearing. See Press Statement of Nettie Stoner, November 24, 1987, in appendix B. Naturally under such a circumstance, the Stoner's did not know to call experts, for example, Ms. Carder's cancer specialist, who would have appeared at the hearing if called.

Hanover Bank & Trust Co., 379 U.S. 306 (1950). Those principles have not been respected and fundamental due process has been denied here.

B. The Court Lacked Subject Matter Jurisdiction.

The Superior Court's lack of jurisdiction over the merits of this case followed as a natural consequence of its lack of personal jurisdiction. Firestone Tire & Rubber Co. v. Risjord, 449 U.S. 368, 379 (1981) (a court lacks discretion to consider the merits of a case over which it is without jurisdiction). However, even if Angela Carder or an authorized representative had been given adequate notice of the hearing, the court had no jurisdiction over the subject matter of the hearing or to order the relief it ordered. The declaratory judgment provisions apparently relied on by the Hospital in approaching the court do not create subject matter jurisdiction independent of the subject matter of the underlying claims. See Cadillac Publishing Co. v. Summerfield, 227 F.2d 29 (D.C. Cir.), cert. denied, 350 U.S. 90 (1955); Senate Select Committee on Presidential Campaign Activities v. Nixon, 366 F. Supp. 51 (D.D.C. 1973).

At no point did the trial court or the appellate panel discuss the basis of the subject matter jurisdiction in this case. The appointment of a guardian ad litem for the fetus points, however, to the possibility that the court considered itself to be proceeding according to the statutory mandate of the District of Columbia child neglect laws. See D.C. Code 16-2301--2365 (Family Division Proceedings). See also, Memorandum Addressing Why This Case Should Not Be Dismissed as Moot (Submitted on Behalf of A.C.), Appendix A (Affidavit of Diane Weinroth, Esq., attorney who represented parents in In the Matter of Madyun Fetus, and who believed she was so appointed because her name appears on a list of Office of Counsel for Child Abuse and Neglect). The child neglect laws did not give the court jurisdiction to consider the Hospital's petition and to enter the relief it did. The child neglect laws apply to neglected

children who are "without proper parental care ... necessary for [their] physical, mental, or emotional health" or "whose parent ... is unable to discharge his responsibilities to and for the child because of ... physical ... incapacity." D.C. Code 16-2301(9)(B) & (C). The term "child" is defined in the relevant provision of the Code as "an individual who is under 18 years of age," D.C. Code 16-2301(3) (emphasis added), something a fetus can never be while in utero and unindividuated.

While the Superior Court does have jurisdiction over neglected child cases, see, e.g., In re B.B.H., 111 Daily Wash. L. Rep. 1929, 1932 (D.C. Sup. Ct., August 18, 1983). (discussion by Schwelb, J. of threshold question of Superior Court jurisdiction in child neglect proceedings), "[u]ntil it is determined whether a person is a "child" within the statutory definition [D.C. Code 16-2301], there is no jurisdiction." United States v. Bland, 472 F.2d 1329, 1335 (D.C. Cir. 1972). The child neglect provisions have never been interpreted to apply to fetuses and were not intended by the legislative branch to apply in this manner.

In addition, it would be a grossly offensive and an unconstitutional interpretation of the provisions to suggest that a woman who refuses major life-threatening surgery during the few weeks of life remaining to her is in any way neglecting to discharge responsibilities to her fetus. See section IIA, supra; In re B.B.H., 111 Daily Wash. L. Rep. at 1933 (rejecting as offensive any use of child abuse and neglect law as basis for court-ordered transfusion to newborn over objections of Jehovah's Witness parents). Indeed Roe v. Wade and related cases establish firmly that a woman has no responsibility to incur risks to her life or health for the sake of the fetus.

In the absence of statutorily bestowed jurisdiction, the trial court did not articulate any basis for subject matter jurisdiction.[48] Presumably, the court decided to postpone a

[48] Because a private party instituted the action (and the D.C. Executive Branch if ever legitimately in the case has withdrawn), this is not a valid exercise of government police power.

decision on the question of subject matter jurisdiction because it perceived the matter to be an emergency. While the D.C. Superior Court is a court of equity jurisdiction, enabling it to act before subject matter jurisdiction is established, D.C. Code 11-921, such jurisdiction does not give a court power to order the drastic life-threatening relief it ordered under these circumstances. The only relief appropriate where general equity jurisdiction is assumed pending an opportunity for judicial review of the merits is relief which preserves the status quo. See United States v. Mine Workers, 330 U.S. 258, 292, 293 (1947) ("Pending a decision on a doubtful question of jurisdiction, the District Court [in another case] was held to have power to maintain the status quo.... In the case before us, the District Court had the power to preserve existing conditions while it was determining its own authority....").

Application of the President and Directors of Georgetown College, Inc., 331 F.2d at 1000 (D.C. Cir. 1964), is not to the contrary. There, the court took jurisdiction to preserve the existing conditions. "Because of the demonstrated imminence of death from loss of blood, signing the order was necessary to maintain the status quo ....," namely to preserve the life of the person who was the object of forced treatment. 331 F.2d at 1005. The status quo in the instant case was a live woman attempting to carry a 26 week fetus to 28 weeks gestation or beyond. This status quo was not preserved by the court's decision to order removal of the 26 week fetus by cesarean section, a procedure the court knew would hasten that woman's death.

This court must prevent further tragedies of this kind by emphasizing the bounds of subject matter jurisdiction and the clearly limiting equitable jurisdiction in the absence of clear existence of subject matter jurisdiction.

## CONCLUSION

For all the above reasons, amici curiae urge this court to rule that the infringement upon fundamental constitutional or common law rights in this case defeats effective public health policy; that the court below erred in forcing a woman to undergo cesarean section surgery, thus violating her fundamental rights of autonomy, privacy and bodily integrity; that the court below erred by failing to adhere to the principles of law that a competent individual is entitled to be fully informed about and to determine the course of her own medical treatment; and that the court below erred in its failure to respect application of the vital principles of personal and subject matter jurisdiction limiting its own authority.

Respectfully submitted this
6th day of September, 1988

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APPENDIX A

STATEMENTS OF INTEREST
OF AMICI CURIAE

NOW LEGAL DEFENSE AND EDUCATION FUND (NOW LDEF) is a non-profit civil rights organization that performs a broad range of legal and educational services nationally in support of women's efforts to eliminate sex-based discrimination, secure equal rights, and preserve reproductive options under law.

THE NATIONAL ABORTION RIGHTS ACTION LEAGUE (NARAL) is an organization with a national membership of more than 100,000, in addition to 34 state-based affiliates. Because NARAL believes that reproductive self-determination is central to the lives and health of women, NARAL is dedicated to keeping abortion legal, safe and accessible. In addition, NARAL works to educate the public and policy makers about the importance of creating social conditions that allow women to exercise freely the full range of reproductive choices.

THE AFRICAN-AMERICAN WOMEN'S COLLECTIVE is a coalition of women of African ancestry who are deeply involved in education and humanitarian social issues which affect African women. The coalition joins the brief out of deep concern that the challenged court decision dehumanizes women, undermines women's reproductive rights and sanctions government control over the most basic right of all human beings -- the right to bodily integrity. The coalition is deeply concerned that the effects of court-ordered cesarean sections disproportionately affect women of African descent.

THE ALLIANCE AGAINST WOMEN'S OPPRESSION (AAWO) is a national, multiracial organization of lesbian and straight women with an internationalist and a racist perspective. AAWO believes that a woman's right to control her reproductive capacity is fundamental to her full participation in society. The AAWO was a founding

member of the National Campaign to Restore Abortion Funding and opposes outside intervention into a woman's decision regarding when and under what conditions she gives birth.

THE AMERICAN ASSOCIATION OF UNIVERSITY WOMEN (AAUW), a national organization of over 150,000 college-educated women and men, is strongly committed to achieving legal, social, educational, and economic equity for women. From its inception, AAUW has expressed and acted upon its concern for the rights of the individual and has chosen "promoting individual liberties" as a program emphasis for 1987-1989. AAUW supports basic constitutional rights for all persons, including First Amendment rights, the right to privacy, and equal protection of the laws. Because of this case's severe impact upon women, AAUW has a particularly strong interest in its outcome.

THE AMERICAN COLLEGE OF NURSE-MIDWIVES (ACNM) is the professional organization for certified nurse-midwives in the United States. ACNM's 2,700 members are registered nurses with advanced education who care for women and their infants in the childbearing years. It is the view of the College that In re A.C. opposes the belief of the organization that "every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations. The individual has the right to self-determination, to adequate information, and to active participation in all aspects of care." This is from the philosophy of ACNM, April 1983. The legal precedent set in this case would contradict such efforts by women and their health care providers to make appropriate decisions regarding their care.

THE AMERICAN HUMANIST ASSOCIATION is a non-profit philosophical and religious educational organization with 4,500 members nationwide. The American Humanists Association supports the

separation of church and state, individual freedom of conscience, and freedom of choice in personal matters.

THE AMERICAN JEWISH CONGRESS (AJ Congress) is a national organization founded in 1918 to protect the civil, political, religious and economic rights of American Jews and all Americans. AJ Congress has shown a long standing interest in insuring that American women have the right to make reproductive choices. Cases involving questions of reproductive choice where AJ Congress has intervened as amicus curiae include Roe v. Wade, 410 U.S. 113 (1973), Doe v. Bolton, 410 U.S. 179 (1973), Polker v. Doe, 432 U.S. 519 (1977) and Commonwealth of Massachusetts v. Otis R. Bowen, pending before 1st Cir. No. 88-1279 (1988).

THE AMERICAN MEDICAL WOMEN'S ASSOCIATION (AMWA) is the sole national professional association representing women physicians and medical students. AMWA's members share an interest in making certain that, when a patient seeks medical care and treatment, state laws do not unduly interfere with the physicians's ability to exercise his or her best judgment in carrying out the patient's decision in the manner most suited to the patient's particular health needs.

THE AMERICAN NURSES ASSOCIATION

AMERICANS FOR RELIGIOUS LIBERTY is a nationwide educational organization dedicated to defending religious liberty, individual freedom of conscience, and the constitutional principle of separation of church and state. The ARL is opposed to any interference with reproductive freedom.

ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS is an organization of physicians, researchers and allied health professionals with a special interest in reproductive health. ARHP in a 501(c)(3) non-profit organization. A pregnant woman's

right to self determination and to bodily integrity (the ethical principle of autonomy) must not be subverted by any claimed opposing societal interest.

THE ASSOCIATION FOR WOMEN IN PSYCHOLOGY (AWP), a national organization founded in 1969 to support women's interest within psychology and society at large, has a special interest in legal cases which involve women's reproductive rights. As mental health researchers, clinicians and educators, members of the AWP are deeply aware of the pressures exerted on women and the conflicts that exist in the area of reproduction. Nevertheless, the fact that interventionist technologies and treatments exist, or that other social interests are at stake in reproduction, must not interfere with women's right to full and sensitive education and counsel regarding reproductive choice, their right to an opportunity for reflection on that choice, and the right to have their ultimate decision carried out. Whether it is sterilization, abortion, contraception, treatment during pregnancy or delivery -- women are entitled to exercise personal choice and that right must be protected.

BLACK WOMEN'S AGENDA (BWA) is a private organization which aims to improve the status of black women and their families. BWA supports equal access to reproductive freedom.

THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE is a non-profit organization devoted to education about women and health. Their many projects and services include a women's Health Information Center, which is open to the public, as well as the extensive distribution of materials to the public about women and health. In addition, the Collective has authored a major publication concerning women and health, Our Bodies Our Selves, which has been translated into thirteen foreign languages. They are also the publishers and distributors of the United States Spanish Edition of Our Bodies Our Selves. In 1984, in response to

setbacks such as increasing medical intervention in normal childbirth and the abuse of cesarean sections, the Collective published The New Our Bodies Our Selves.

CATHOLICS FOR A FREE CHOICE, established in 1973, is a national educational organization that supports the right to legal reproductive health care, especially to family planning and abortion. CFFC also works to reduce the incidence of abortion and to increase women's choices in childbearing and childrearing through advocacy of social and economic programs for women, families, and children. They believe that women are to be respected as moral agents who can be trusted to make decisions that support the well-being of their families, children and society and enhance their own integrity and health.

THE CENTER FOR CONSTITUTIONAL RIGHTS (CCR) is a non-profit litigation and educational organization founded in 1966 to provide legal support to the Southern civil rights movement. CCR has been, and continues to be, a national resource for the furtherance of civil rights and social justice. CCR believes that securing access to full reproductive rights for all women is one of the central issues facing constitutional rights advocates today, and the effort to secure these rights has long been a priority of the Center.

THE CESAREAN PREVENTION MOVEMENT, INC. (CPM) is a not-for-profit organization founded out of concern that many of the rising numbers of cesarean operations are not performed for sound medical reasons. Even caesareans with "successful" outcomes have serious disadvantages over normal birth. CPM provides education and support to help women avoid unnecessary cesareans and take responsibility for all phases of their birth experience. CPM members believe fully informed women are best able to decide whether to accept the use of medical technologies or procedures. Legal intervention on behalf of a fetus seriously limits a

woman's right to determine how and where her baby will be born. A legal balancing of interests is unnecessary because a pregnant woman is motivated to care for both her own well-being and that of her fetus, while the interests of hospitals and medical personnel may run contrary to those interests. Informed consent is a right, not a privilege, that must never be denied women during pregnancy, labor or childbirth. CPM has 62 chapters, including two in the metropolitan Washington, D.C. area, and members throughout the United States and six foreign countries.

CESAREANS/SUPPORT EDUCATION AND CONCERN (C/SEC, Inc.) is a national non-profit organization founded in 1973 to provide support and information on cesarean childbirth, cesarean prevention and vaginal birth after cesarean (VBAC) to parents and professionals. They firmly support a woman's right, and her family's right, to make informed decisions about her health care in consultation with her provider. They are gravely concerned about the instances of court-ordered obstetrical interventions, notably cesarean sections, many of which have been shown not to have been the only or the best medical choice for that woman.

THE CITY OF NEW YORK COMMISSION ON HUMAN RIGHTS ("Commission") is the municipal agency empowered to enforce the New York City Human Rights Law. New York City Administrative Code, Title B1-1.0 et seq. The Commission is given broad mandate to eliminate and prevent discrimination in its many forms. To this end, the Commission has aggressively prosecuted thousands of, inter alia, sex-and disability-based cases of discrimination.

THE COALITION OF LABOR UNION WOMEN is a membership organization of female and male trade unionists who promote the rights of working women. The Coalition of Labor Union Women has long maintained that the road to women's economic independence, and their resulting secured position in the American workforce,

begins with a recognition of a woman's right to control her reproductive cycle.

COMISION FEMENIL MEXICAN NACIONAL

COMMITTEE FOR RESPONSIBLE GENETICS is a non-profit public interest organization consisting of scientists, public health and public policy professionals, trade unionists, bioethicists, environmentalists and other concerned citizens. The Committee has several task forces which monitor and analyze the social impacts of biotechnology. One of these is the Women and Reproductive Technology group, whose primary concern is with the ways the new technologies affect women's reproductive rights and the right to bodily integrity and privacy.

THE COMMITTEE TO DEFEND REPRODUCTIVE RIGHTS (CDRR) is a San Francisco community-based organization with 1,000 members throughout California and several other states. For ten years, CDRR has been dedicated to ensuring women's reproductive freedom by engaging in public education issues concerning reproductive rights and the freedom of all women. CDRR also works to prevent forced sterilization or coercive reproductive surgery or treatment as part of a woman's right to bodily integrity.

THE DISABILITY RIGHTS EDUCATION AND DEFENSE FUND is a national disability civil rights organization dedicated to securing equal citizenship for disabled Americans. The right of disabled people to lead independent lives includes the right to make decisions about medical treatment and to be free from policies and procedures which discriminate on the basis of disability.

THE EPISCOPAL WOMEN'S CAUCUS (EWC) is an organization of Episcopal laity, bishops, priests, and deacons who are committed to the full inclusion of women in all aspects of life of the church and the world. The EWC, and the Episcopal church as a

whole, have long been on record as strong supporters of women's right to make informed decisions about issues of their own health and reproductive functions. The EWC is particularly interested in In re A.C. because of the threat it poses to women's responsibility for making such moral decisions.

EQUAL RIGHTS ADVOCATES, INC. (ERA) is a San Francisco based public interest legal and educational corporation dedicated to working through the legal system to secure equality for women. ERA has a long history of interest, activism, and advocacy in all areas of the law which affect equality between the sexes. To this end, ERA believes that sex-based equality is only possible in a society where women maintain control of their reproductive lives. Requiring a cesarean section against a woman's will is a direct attack on her fundamental right to reproductive choice.

THE FEDERATION OF FEMINIST WOMEN'S HEALTH CENTERS is a non-profit association of women's health projects and their supporters who provide health services to women. Their goals are to promote and protect reproductive rights for women and men, to educate women about the healthy functioning of our bodies, to improve the quality of women's health care. The Federation has a large interest in this appeal as the impact is significant to the future of women's right to choose and to quality reproductive health care.

THE FEDERATION OF RECONSTRUCTIONIST CONGREGATIONS 7 HAVUROT (National and Local)

THE GENERAL BOARD OF CHURCH AND SOCIETY OF THE UNITED METHODIST CHURCH, through its executive committee, has voted to go on record as supporting the amicus in the case In re A.C. The Board, reinforced by the policy decisions of the general conference of the United Methodist Church, affirms the rights of women and their families to make decisions regarding health care

and reproductive rights without undue interference from government or the courts.

HOME AND BIRTHING IN BED (HABIB) is a Washington, D.C. based educational organization. HABIB focuses on preventing infant mortality, parent-centered birthing, community education and teen sexuality.

INDIGENOUS WOMEN'S NETWORK (IWN) is an international coalition of grass roots indigenous women organizers, artists and workers who provide an ongoing network for support of grass root indigenous women through education, informational materials, networking and gatherings and strategy sessions on various issues including health, environment, family and economic development, legal rights and community organizing/education and a mechanism, as needed, to conduit this information. As indigenous women who have had many forms of genocide committed against ourselves and our people, including sterilization, we view forced cesarean sections as a continuation of violation of women's bodily integrity.

INTERNATIONAL COUNCIL OF AFRICAN WOMAN (ICAW) is a coalition of leaders of black women's organizations. One of the issues we work on is reproductive rights, with a specific focus on teen pregnancy and abortion rights. We are deeply concerned about the A.C. case. We have followed cases of medical abuse against women for the last four years, and In re A.C. is an egregious example of abuse of women's reproductive rights by the medical and legal professions.

INTERNATIONAL WOMEN'S HEALTH COALITION is a private, non-profit organization that promotes high quality reproductive health care for women in the third world. Based on its support of innovative health care projects, policy-oriented field research and public education, IWHC serves as an advocate and a catalyst for change

in national and international policies and programs. Our goal is to ensure that reproductive health services are comprehensive, client-centered and premised on informed choice. This case is of concern to IWHC because the court-ordered obstetrical intervention has both denied and rejected the basic human right to self determination.

THE LYMPHOMA FOUNDATION OF AMERICA is the only national cancer organization devoted to lymphoma patients and their families. It is a charitable and educational foundation, organized in 1986. Cancer patients, no matter what their condition or state of health, have the right to determine what treatment they receive. Suffering from a life-threatening illness is no reason for denial of the right to decide how to be treated.

MADRE is a friendship association between women and children in the United States and women and children in Central America and the Caribbean. We are concerned about the health and wellbeing of all women and children and that is why we sign with the other organizations in this amicus brief. As women concerned with international issues and policies, we make the connection between how money spent on the U.S. military is money taken away from domestic programs ranging from job training to eduction, health and child care. We see the relationship between aggression overseas and neglect at home; exposing this relationship is an essential step as we reach out to people in all walks of life across the country. Setting priorities based on human needs, we say yes to constructive action and resist mindless destruction at home, in Central America, the Middle East or anywhere else.

THE MEDGAR EVERS COLLEGE CENTER FOR LAW AND SOCIAL JUSTICE (CLSJ) is a public interest organization committed to addressing civil rights issues in the City of New York. CLSJ has done research and advocacy work on such issues as patients' right to decide on medical treatment based on informed consent, the inadequate level

of prenatal care received by poor women and women of color in this city and other health issues affecting women. CLSJ respectfully disagrees with the panel's decision in this case. We are aware that a significant portion of pregnant women whose rights to bodily integrity have already been violated are Black, Hispanic, Asian, or non-English speaking. Because the issues raised in this appeal will have an impact on these women and their families in the New York community, CLSJ joins with the amici in submitting this brief.

THE MIDWIFERY LITIGATORS NETWORK is a group of attorneys who have joined together to represent midwives in civil, regulatory and criminal actions throughout the United States and Canada, usually on a volunteer or minimal fee basis. The purpose of the Network is to provide experienced, knowledgeable counsel to a group of health professionals whose work is relatively unknown and misinterpreted. Midwives, and thus their legal counsel, are primarily interested in providing the care of choice for their clients entirely free of coercion and without any fear of forced procedures or requirements in the birthing process.

THE MIDWIVES ALLIANCE OF NORTH AMERICA includes midwives in the United States, Canada and Mexico from all education and training routes. Primary in the philosophy of the Alliance is the fostering of self-determination of care by the birthing mother and her family.

THE NATIONAL ASSEMBLY OF RELIGIOUS WOMEN (NARW) is a grassroots organization of approximately 2,000 women of faith committed to working for social change and to building a world of peace with justice. Since its inception in 1970, NARW's agenda has always emphasized the "participation of people in the decisions that affect their lives." For this reason, the case of In re A.C. is of special concern to us, as it seriously challenges a woman's right, in consultation with others, to determine her own future.

THE NATIONAL ASSOCIATION OF COMMISSIONS FOR WOMEN was created as a result of a study undertaken by Eleanor Roosevelt under a directive from President Kennedy. Commissions on the status of women were organized nationally and regionally to study the status of women in the United States. There are 120 member commissions across the country which do studies, research and advocacy on the whole range of women's interests.

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW), a non-profit professional association with over 115,000 members, is the largest association of social workers in the United States. Founded in 1955, NASW has chapters in every state, as well as the Virgin Islands, Puerto Rico, and Europe. NASW is devoted to promoting the quality and effectiveness of social work practice, to advancing the knowledge base of the social work profession, and to improving the quality of life through utilization of social work knowledge and skills. NASW is deeply committed to the principle of self-determination and to the protection of individual rights and personal privacy. The Association is concerned, in particular, that the state not override a pregnant woman's autonomy, nor violate an adult's right to bodily integrity.

THE NATIONAL BLACK WOMEN'S HEALTH PROJECT is a health, education and advocacy organization which works to improve the quality of life for Black women. Its work is based on the belief that Black women, including poor Black women, should have access to abortions and other health services which reduce infant mortality and produce healthy babies. The project strives towards securing the full range of reproductive choices. Since 81 percent of the women who have undergone unconsented court-ordered obstetrical interventions have been women of color, (Kolder, et. al, Court-Ordered Obstetrical Interventions, 316 New Eng. J. of Med. 1192 (May 1987)), the Project has marked interest in this case.

THE NATIONAL COALITION OF AMERICAN NUNS (NCAN) represents 2,000 sisters from different Catholic orders all over the United States. It is dedicated to studying, speaking about and working for human rights and social justice. Funded 18 years ago as the first feminist organization within the Catholic Church, NCAN supports respecting the rights of women, including the right of a woman to make the ultimate decision about issues affecting her own body.

THE NATIONAL COUNCIL OF JEWISH WOMEN (NCJW), founded in 1893, is the oldest Jewish women's volunteer organization in America. NCJW's 100,000 members in more than 200 Sections across the United States keep the organization's promise to dedicate themselves, in the spirit of Judaism, to advancing human welfare and the democratic way of life through a combination of social action, education and community services.

THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE (NECLC) is a non-profit organization, dedicated to the preservation and extension of civil liberties and civil rights. Founded in 1951, it has brought numerous actions in the federal courts to vindicate constitutional rights. Through its educational work, it likewise has sought to preserve our liberties. The NECLC participates as amicus curiae when it believes issues of particular import to civil liberties are at stake.

THE NATIONAL FEDERATION OF TEMPLE SISTERHOODS bands together more than 100,000 Reform Jewish women in over 600 Sisterhoods throughout the United States. NFTS has long been committed to preservation of a woman's right to reproductive freedom.

THE NATIONAL INSTITUTE FOR WOMEN OF COLOR (NIWC) hereby affirms its intent to join in the case of In re A.C. before the District of Columbia Court of Appeals. As the only national organization

focused on the needs and concerns of all women of color (i.e., Black, Hispanic, Asian-American, Pacific Islands, Native American, Alaskan Native), NIWC feels a special obligation to participate in this legal case because of the long range detriment for women of color unless the social and economical implications are addressed immediately. Specifically, the instances of court-ordered cesarean sections disregarding the expressed wishes of women have involved primarily low-income women of color. The conclusion of this is that either the opinions of women of color are not as valued as others, or low-income women do not have the right to the same legal standing as women with private funds -- or both. Any way the situation is considered, the effect is discrimination. One of the prime directives of NIWC is to assist women of color to achieve economic equity. NIWC fulfills this responsibility by speaking out against injustices suffered by women of color. In re A.C. represents a grave injustice which NIWC must address.

NATIONAL LATINA HEALTH ORGANIZATION - ORGANIZACION NACIONAL DE LA SALUD DE LA MUJER

THE NATIONAL ORGANIZATION FOR WOMEN (NOW) is a national membership organization of approximately 150,000 women and men in about 700 chapters throughout the country. It is a leading advocate of women's equality in all areas of life. NOW has as one of its priorities the preservation of the right to reproductive freedom.

THE NATIONAL WOMEN'S HEALTH NETWORK (NWHN) is a public interest organization whose membership, comprised of 10,000 individuals and 400 organizations representing 500,000 women, seeks to give women a voice in the health care system in the United States. NWHN supports women's rights to have complete control over their bodies, particularly the right to decide when, where and how to give birth.

THE NATIONAL WOMEN'S LAW CENTER (NWLC) is a non-profit legal advocacy organization, dedicated to the advancement and protection of women's rights and the corresponding elimination of sex discrimination from all facets of American life. Since 1972, the Center has worked to secure equal opportunity in the workplace through the full enforcement of Title VII of the Civil Rights Act of 1964, as amended, and other civil rights statutes, and through the implementation of effective remedies for long standing discrimination against women and minorities. The National Women's Law Center is also dedicated to securing equality for women in their private lives. The right of a woman to control her body and make decisions regarding her health is basic to her individual self determination. We therefore join as amicus and request that the court find that the lower court erred in ordering the hospital to perform a cesarean over the objections of Angela C., her family and her physicians.

THE NATIONAL WOMEN'S POLITICAL CAUCUS (NWPC) is a non-profit corporation supporting the election and appointment of women to public office. It also supports legislative and public policy issues of concern to women, such as freedom of choice and reproductive rights, the Equal Rights Amendment and economic and legal equity for women.

NEW YORK WOMEN AGAINST RAPE is a not for profit feminist women's organization dedicated to ending sexual violence. The center supports reproductive rights for women. The center works primarily with women and children who have suffered sexual violence by providing counseling, education, training and individual and community organizing programs.

New York Women Against Rape views the In re: A.C. case as another attempt to control the most basic right of a woman -- the right to control her reproductive life. The center is also concerned about the pattern of racism in cases of forced cesareans across the country, and the pattern of judicial

intervention in these case which seems to exemplify the same oppression that survivors of rape experience at the hands of the medical and judicial establishments.

NORTHWEST WOMEN'S LAW CENTER is a private non-profit organization in Seattle, Washington, that works to advance the legal rights of women through litigation, education, and providing information and referrals. Protecting women's freedom of reproductive choice is one of the Law Center's priority issue areas. The Law Center has participated in numerous cases involving reproductive rights before the U.S. Supreme Court and other courts both within and outside Washington State.

THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (NAACOG) is the professional nursing organization for obstetrics, gynecology and neonatal nurses. Established in 1969, NAACOG has a membership of 21,000 OG nurses and allied health care professionals who are practicing throughout the United States and its territories, Canada, Germany and Korea. NAACOG represents the interests of its members whose common concern centers around quality care of women and infants and their families.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. (PPFA) is a not-for-profit corporation organized in 1922. PPFA is the leading national voluntary public health organization in the field of family planning, with 182 affiliates in 44 states and the District of Columbia operating approximately 800 family planning clinics. PPFA supports the right of all patients to make decisions regarding pregnancy and childbearing free of state coercion, and believes that patients have the right to receive fertility-related services in a manner respecting personal privacy and individual dignity.

PLANNED PARENTHOOD OF NEW YORK CITY (PPNYC), the New York City affiliate of amicus, Planned Parenthood Federation of America, is one of the largest voluntary providers of comprehensive reproductive health services in the United States. Its three clinics in the boroughs of Brooklyn, Manhattan and the Bronx provide a full range of reproductive health services to more than 27,000 patients annually. PPNYC has a long history of commitment to a woman's constitutional right of privacy regarding her reproductive health and bodily integrity.

THE PROJECT ON WOMEN AND DISABILITY IN MASSACHUSETTS (PWDM) is an organization co-sponsored by the Massachusetts State Office of Handicapped Affairs and the Boston Women's Health Book Collective. The goal of PWDM is to organize people in Massachusetts around issues involving disability rights. A priority of PWDM is to address the moral and ethical issues around prenatal and reproductive technologies and their affect on women with chronic illnesses and disabilities.

THE RAINBOW COALITON, WOMEN'S COMMISSION, is a multi-racial women's organization that is concerned with the health of all women, particularly women of color. We understand the complexities involved in the case In re A.C., and are deeply concerned about the impact which legal intervention in private medical decisions (such as forced cesarean sections) will have on poor women and women of color.

T.H.E. CLINIC for women is a non-profit community clinic providing prenatal and post-natal care, family planning and gynecological services to low income Black, Hispanic and Asian women in Los Angeles County. It is a recognized advocate throughout the State of California for the rights of women to access quality and affordable care.

UNION OF AMERICAN HEBREW CONGREGATIONS (UAHC) represents over one million Jews throughout the United States. UAHC is deeply committed to the preservation of individual and religious liberties and the freedom of choice of all people. UAHC believes people have the right to make their own choices in the area of family planning based on their own moral and religious conscience.

THE UNITARIAN UNIVERSALIST ASSOCIATION (UUA) is a denomination consisting of over 1,000 congregations with over 176,000 members. It is the policy of the UUA to support on an amicus basis the fullest consideration of First Amendment and associational claims to ensure their full protection.

THE UNITED CHURCH BOARD FOR HOMELAND MINISTRIES is a church related organization and has a long history of supporting reproductive freedom.

THE UNITED CHURCH OF CHRIST, COORDINATING CENTER FOR WOMEN IN CHURCH AND SOCIETY is the national body created by the United Church of Christ to address the concerns of women and to work toward the elimination of sexism in church and society. We are advocates for justice for women. We support and extend our advocacy to the right of women to make choices about their lives including choices about their reproductive lives.

THE UNITED CHURCH OF CHRIST, THE OFFICE FOR CHURCH IN SOCIETY greatly believe in freedom of choice, and was appalled at the decision of In re A.C. We believe that a woman should never be forced to undergo a caesarean section because it deprives her of her inherent freedom to choose.

THE WASHINGTON ETHICAL ACTION OFFICE, a division of the American Ethical Union (AEU), is a humanistic, religious and educational movement inspired by the ideal that the supreme aim of human life

is working to create a more humane society. AEU members join together in ethical societies in the common belief in the capacity and responsibility of human beings to act in their personal relationships and in the larger community to help create a better world, for this and future generations.

THE WOMEN'S EQUITY ACTION LEAGUE (WEAL) is a national membership organization committed to the economic development and advancement of all women. WEAL supports reproductive freedom as a right for all women, and recognizes that right as intimately tied to the capacity of women to gain economic security.

THE WOMEN'S LAW PROJECT (WLP) is a non-profit, public interest law firm which seeks to advance the legal status of women through litigation, public education, and individual counseling. During the past fifteen years its activities both in Pennsylvania and nationally have included work in the fields of health, reproductive freedom, employment, domestic relations, housing, insurance, credit, education, and constitutional privacy.

THE WOMEN'S LEGAL DEFENSE FUND (WLDF) is a tax-exempt non-profit membership organization founded in 1971 to challenge sex-based discrimination and to advance women's concerns through the legal system. WLDF has worked extensively on issues of reproductive freedom.

APPENDIX B

NETTIE STONER'S STATEMENT
(Mother of A. C.)

We were having a really hard time anyway without this court business. It was so unfair to Angie and to us.

We were there with Angie. Angie was in a lot of pain - but she knew we were there. On Tuesday morning they called us early to tell us that Angie was not doing very good. We called a priest to come immediately - he gave her her last rights and then only a few minutes later the hospital staff told us we were needed at a "short meeting". They did not tell us it was a court hearing. It took all day. They didn't tell us it would take us away from her.

Poor Angie, first she's told she's dying and the next thing everybody abandons her and leaves her alone in her room. She must have been just lying there wondering where everyone was. Then even before the hearing was over they started prepping her for surgery -- she was already in so much pain.

We told the judge she didn't want the surgery, that we didn't want her to suffer anymore, that we didn't think the baby would live. But they didn't listen. After the surgery and after they told her her baby was dead, I think Angie just gave up.

My daughter Angie was outgoing, and warm -- she had a special talent for making everyone around her feel good. Even though she was fighting cancer she helped other people. She worked with senior citizen groups and she helped other patients at the National Institute for Health where she was being treated. Because she was so optimistic -- she would give other

patients courage and hope. She would talk to people who had surgery and help them through it. She never let things stop her. She'd probably get up and talk in a minute - she sang and danced whether on her feet or later in her wheel chair after her leg was removed because of the cancer.

Angie knew what she wanted. She tried to get involved with rights for the handicapped. She knew people were prejudiced against her, not letting her into certain establishments, not hiring her. That girl - she taught me that you can't discriminate against handicapped people. Because people discriminate against me also - she would say why don't you get out of here and do something about it.

I know if Angie had lived she would have pursued her rights - to fight against the hospital and the court that forced her to have that senseless surgery. I am here today, speaking out - fighting this decision for Angie. I hope this kind of thing never happens again -- so that other families, yours and mine, won't suffer like we did.

DANIEL STONER'S STATEMENT
(Father of A. C.)

I am here today because what happened to my daughter was wrong. And what people assumed about her was wrong. Angie got sick when she was 13. It was a rare form of cancer. And we were told she was going to die. As far as we are concerned, for 14 years our daughter was considered "terminally" ill, and what right did the court have to decide that her life was over. If we gave up on Angie 14 years ago she would not have been here to give joy to so many people, to laugh, to work, to dance and to marry.

Terminal is when every avenue of treatment is exhausted. Yet the hospital just let her lie there, nobody was doing anything for her. They didn't even try to treat her before they decided she was going to die.

Then on top of that the court and the hospital forced her to have surgery she didn't want. It really burns me up that she said she didn't want it and they did it anyway. After they said she was going to die, she didn't want the baby, and she didn't want the pain. She'd been through an awful lot in her life. And, we were clear that we wanted what she wanted -- and we all knew this baby wasn't going to live.

We never thought there was going to be a hearing -- we can't believe anything happened that fast. We were in the room with her one minute and then in a court hearing the next. And, they kept talking about the fetus and viability. What did that have to do with my daughter's life?

The court decided that she was going to die anyway as if that justified what they did. I just don't think they should do that to anyone.

## Certificate of Service

I hereby certify that a copy of the foregoing Brief of Amici Curiae NOW LDEF, NARAL et al. in Support of Appellant was mailed on or before the 6th day of September, 1988 to:

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