MALPRACTICE LIABILITY VERSUS PATIENT'S RIGHTS IN OBSTETRICAL CARE: THE PHYSICIAN'S DILEMMA

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INTRODUCTION

Physicians practicing today need to be aware of their legal rights and obligations as well as those of their patients. As changes are made in both medical technology and legal thought, the legal system seems to be sending conflicting messages to physicians in the area of maternal and fetal care. Malpractice is a very real threat for practicing obstetricians. Results of malpractice cases indicate to physicians that they must take every available precaution to effectuate a favorable outcome for both the mother and fetus. Yet, at the same time, abortion cases indicate that they must respect the autonomy of the pregnant patient. This dichotomy has resulted in many doctors seeking court orders to perform procedures which they feel are medically necessary, but to which the patient refuses her consent. Apparently, many physicians feel that this is the best way to protect themselves and to comply with the conflicting demands of the law. Such orders, however, represent an apparent regression in the field of women's rights while taking advantage of medical advances in the area of fetal survival.

In 1987 the *New England Journal of Medicine* published a study undertaken by two physicians and an attorney of the prevailing attitudes within the medical profession (specifically obstetrics and gynecology) regarding court-ordered obstetrical care.[1] The authors sent a questionnaire to the heads of fellowship programs in maternal-fetal medicine and to the directors of residency programs in maternal-fetal medicine in the states which do not have a fellowship program. A total of 45 states was represented in the survey.[2]

Part of the questionnaire was designed to elicit opinions on various nonconsensual interventions into the life of a pregnant woman on behalf of the developing fetus. These questions were tabulated only for the heads of the fellowship programs.[3] The authors found that only 24% of those responding "consistently upheld a competent woman's right to refuse medical advice."[4]

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[1] Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 N. ENG. J. MED. 1192 (1987).

[2] *Id.*

[3] *Id.*

[4] *Id.* at 1194.

Specifically, 46% of the respondents indicated that they felt that pregnant women who refuse to follow medical advice should be confined to hospitals or similar facilities where compliance could be assured.[5] Forty-seven percent favored issuance of emergency court orders not only for cesarean sections, but also for other accepted procedures that could potentially save the life of the fetus.[6] Twenty-six percent advocated third-trimester surveillance of all pregnant women not already being monitored within the hospital system.[7]

These answers reflect a very paternalistic attitude and a willingness on the part of a large and respected segment of the medical community to subordinate the autonomy of pregnant women to the judgment of the attending physicians. They prompt one to wonder why such a group would hold such attitudes. Many possible answers exist.

Physicians are trained to save lives; a decision not to take advantage of every possible means of maintaining life may be contrary to their professional thinking. Often, doctors may believe that they understand better than a lay person the implications of the person's decision, and are thus more qualified to make such decisions. Additionally, many physicians fear legal liability if they do not utilize every means at their disposal to effectuate a favorable outcome.

This paper will explore the relationship between malpractice law and the emergent phenomenon of court-ordered obstetrical interventions. It will discuss the impact of the fear of malpractice on the practice of obstetrics and gynecology, as well as the demands apparently placed upon doctors by the abortion decisions. The conclusion is that the malpractice cases and the abortion cases communicate conflicting messages to physicians, thus backing them into a corner from which their only means of escape seems to be a court order sanctioning their course of action.

PHYSICIAN'S SOURCES OF INFORMATION: REPORTING ON MEDICAL MALPRACTICE

Medical malpractice is a topic which receives a great deal of attention now. The general public is aware of the problems faced by physicians in attempting to deal with malpractice suits and insurance premiums. Physicians themselves are even more acutely aware of the problem. An examination of the sources of their information provides some insight into how the attitudes toward the malpractice problem and its impact on delivery of care are fostered.

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[5] *Id.* at 1193.

[6] *Id.*

[7] *Id.* at 1194.

The *American Medical News* (AMN), a weekly publication for the members of the American Medical Association, periodically includes a feature entitled Medico-Legal Decisions. This feature summarizes recent cases which the editors feel are of interest to the readership of AMN. An examination of the 1988 issues of AMN[8] reveals that summaries of fifty-nine cases appeared in the Medico-Legal Decisions column during the year. Of these, twenty-seven reported outcomes which can be considered favorable to physicians. Twelve reported outcomes unfavorable to physicians. Twenty reported cases which were seemingly neutral in their effect upon the medical profession.[9] Of the fifty-nine total cases reported in Medico-Legal Decisions in 1988, twelve dealt directly with issues affecting obstetricians. Five of these were favorable to the doctor, five were favorable to the plaintiff, and two were neutral. These figures lead to the conclusion that AMN is not reporting these court decisions with the intent to cause alarm among members of the medical profession.

The cases which are reported in AMN represent twenty-four states and one federal circuit. They appear to be very ordinary cases; there is no apparent reason for selection of these cases over any others decided within the same time period. A reading of the reported obstetric cases reveals a great variety of types of cases and dispositions chosen. They address such topics as fetal abuse by a pregnant woman,[10] potential agency liability on the part of a hospital in a conspiracy to conceal a tubal ligation performed without consent,[11] Good Samaritan Laws,[12] and statutes of limitation.[13]

Several of the cases provide good explanations of the applicable law to those who seek out and read the entire text.[14] It is unlikely, however, that practicing physicians regularly read judicial

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[8] Figures include every issue in 1988 with the exception of December 16, which was unavailable.

[9] Several of the seemingly neutral reports do not represent final disposition of the case.

[10] *In re* Ruiz, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (Ohio C.P. 1986), *reported in* AM. MED. NEWS, Sept. 16, 1988, at 26.

[11] Barbour v. South Chicago Community Hosp., 156 Ill. App. 3d 324, 509 N.E.2d 558 (1987), *reported in* AM. MED. NEWS, Nov. 11, 1988, at 24.

[12] Burciaga v. Saint John's Hosp., 187 Cal. App. 3d 712, 232 Cal. Rptr. 75 (1986), *reported in* AM. MED. NEWS, Oct. 14, 1988, at 42.

[13] Mendez v. United States, 655 F. Supp. 701 (S.D.N.Y. 1987), *reported in* AM. MED. NEWS, Oct. 21, 1988, at 28; Gaines v. Preterm-Cleveland, Inc., 33 Ohio St. 3d 54, 514 N.E.2d 709 (Ohio 1987), *reported in* AM. MED. NEWS, Dec. 2, 1988, at 23.

[14] *See, e.g.,* Burciaga, 187 Cal. App. 3d. at ___, 232 Cal. Rptr. at 78 (explaining the existence of duty); Witherell v. Weimer, 148 Ill. App. 3d 32, 499 N.E.2d 46 (1986) (explaining qualification of expert and use of expert testimony to establish standard of care); Mariano v. Tanner, 497 So.2d 1066 (La. Ct. App. 1986) (explaining standard of care).

opinions to keep themselves informed of recent legal developments. They are therefore left to rely on the reporting of these decisions in periodicals which they read. The Medico-Legal Decisions feature of AMN seems to report the cases fairly, yet the summaries are often confusing because they are incomplete or made before the cases have reached final disposition.

Elsewhere within AMN, many articles have appeared which address the issue of malpractice. Many of these deal with the issue of tort reforms and alternatives to the current system of settling medical malpractice complaints. Some of these articles, as well as many editorial comments, are hostile to the legal system.[15] The tone of these articles may serve to foster a distrust of the law which may counteract the beneficial effects of the fair reporting within the Medico-Legal Decisions feature.

The general reporting in AMN on medical malpractice is not particularly encouraging to physicians. Those reading AMN on a regular basis are likely to be left with the impression (correct or incorrect) that the threat of medical malpractice is both real and severe and that it is in their best interest to seek the protection of the law and the sanction of the courts before undertaking treatment of pregnant women which may later be questioned.

LAW AND MEDICINE: IMPOSITION OF DUTIES UPON PHYSICIANS

Medical malpractice is a part of tort law, designed to compensate those who have been injured as a result of poor care on the part of a doctor.[16] Negligence is the most common theory used in malpractice suits.[17] Four elements are necessary for a successful malpractice suit:

1) Duty. The plaintiff must show that the physician owed a duty to the plaintiff. This duty, to act within the standards established by the profession, arises from the relationship which exists between the doctor and the patient. The physician is required to exercise the necessary knowledge

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[15] *See, e.g., Lawyers beam over lack of malpractice caps*, AM. MED. NEWS, Aug. 19, 1988, at 9; *'Go ahead and sue' seems to be prevailing attitude*, AM. MED. NEWS, Mar. 18, 1988, at 28.

[16] Virginia's law of medical malpractice is codified at VA. CODE ANN. §§ 8.01-581.1 to 8.01-581.20 (1989 Supp.). For a general discussion of the law of medical malpractice in Virginia, *See* 14B *Michie's Jurisprudence* §§ 12 et seq. (1988).

[17] K. FINEBERG, J. PETERS, J. WILSON & D. KROLL, OBSTETRICS/GYNECOLOGY AND THE LAW § 1.20 (1984).

and skill to provide appropriate treatment to the patient. The degree of knowledge and skill mandated may be ascertained from medical texts and literature.[18]

2) Breach of duty. The plaintiff must show that due to an omission or a commission, the physician did not act within the applicable standard of care.

3) Compensable injury. The plaintiff must show that she suffered actual injury for which compensation can be made.

4) Proximate cause. The plaintiff must show that the doctor's breach of the standard of care was the proximate cause of her injury. The physician's action need not be the sole cause of the injury; it can be one of the causes of the act which set in motion a chain of occurrences which ultimately led to the injury.

Widely accepted standards for obstetricians have been promulgated by the American College of Obstetricians and Gynecologists (ACOG).[19] The ACOG standards indicate that the primary responsibility of the obstetrician is to the woman, yet they provide for many procedures and policies which are justified on the basis of fetal well-being. In its Maternal Health Policy, the ACOG indicates that the scope of gynecological and obstetrical services should include "the maintenance in so far as possible of an optimal environment for fetal development."[20] Specific policies suggested on the basis of fetal well-being include preliminary questioning regarding possible pregnancy of all women prior to x-rays,[21] electronic fetal monitoring,[22] and arrangements for the presence of a second physician to take responsibility for the newborn if significant risk factors are present.[23]

The ACOG recognizes that the right to make decisions regarding treatment belongs to the patient, stating "[t]he ACOG supports the right of the pregnant woman to informed consent while recognizing that at the same time the woman assumes responsibility for decisions which she makes in the interest of her own health and the health and welfare of her infant."[24] In addition, the ACOG criticizes the mandatory second opinion which some states have attempted to institute

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[18] Virginia has codified the standard of care and methods for its determination at VA. CODE ANN. §§ 8.01-581.20 (1989 Supp.).

[19] AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES (5th ed. 1982).

[20] *Id.* at 87.

[21] *Id.* at 79.

[22] *Id.* at 28.

[23] *Id.* at 26.

[24] *Id.* at 75.

regarding abortion.[25] The problem, according to the authors, is that such requirements fail to recognize the primary importance of the patient's well-being; the second opinion is not necessarily the correct one, and may not be in the best interest of the patient.[26]

Courts have imposed certain duties to unborn children upon doctors. An early case to do so was *Smith v. Brennan.*[27] The court allowed a cause of action for a child later born alive who was injured in an auto accident while in utero, stating that "a child has a legal right to begin life with a sound mind and body."[28] This principle has been extended to allow suits against physicians on behalf of fetuses later born alive. An illustrative case is *Shack v. Holland.*[29] There, the court allowed recovery by a fetus later born alive for lack of informed consent. Although the duty of disclosure was to the mother, the court recognized that the failure of the physician to adequately inform the pregnant woman impacted upon the fetus, and allowed the claim.[30]

The duties owed by a physician and the parties to whom they are owed are thus not always clear. Both the courts and the medical profession indicate that the physician has a duty to the pregnant woman and her fetus. The ACOG standards recognize the right of the woman to make decisions regarding her treatment, with the expectation that she will take responsibility for her decisions. The recognition of the courts of a right of action for medical malpractice on the part of the fetus, however, undermines the confidence that physicians can place in that expectation.

THE ABORTION DECISIONS: PRIMACY OF MATERNAL WELL-BEING

Obstetricians caring for pregnant women often find themselves in the position of having two patients, mother and fetus. An apparent conflict can arise for the doctor in attempting to determine which patient should be primary. The judiciary has sent a clear message on this issue.

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[25] *Id.*

[26] *Id.* at 105.

[27] 31 N.J. 353, 157 A.2d 497 (1960).

[28] *Id.* at 503.

[29] 389 N.Y.S.2d 988 (Sup. Ct. 1976).

[30] *Id.* at 993.

Since its 1973 decision in *Roe v. Wade*,[31] the U.S. Supreme Court has consistently indicated that the life and health of the mother must be the primary consideration of the physician.[32]

In *Roe*, the Court held that a state has an interest in both the life and health of the mother and the life of a potentially viable fetus.[33] Each of these interests becomes compelling at a different point in the course of the woman's pregnancy.[34] However, even at the point at which the interest in fetal life becomes compelling, the Court indicated that the state cannot proscribe an abortion necessary to preserve the woman's life or health.[35]

The Court reaffirmed its commitment to women's health and life in 1976 in *Planned Parenthood v. Danforth*.[36] Missouri sought to prohibit the use of saline abortion after the twelfth week of pregnancy, citing maternal health as the motivating concern for the prohibition.[37] The Court noted that saline amniocentesis was, at the time, one of the most widely used and safest methods of abortion. It therefore rejected the state's proffered rationale and struck down the statute as dangerous to maternal health, noting that the regulation had the effect of forcing women desiring abortions after the twelfth week to submit to more dangerous methods.[38]

In *Colautti v. Franklin*,[39] the Court construed a Pennsylvania statute that required physicians performing abortions to exercise the same standard of care that would be necessary if a live birth rather than an abortion were intended. The doctor was further required to utilize the abortion method most likely to result in a live birth, unless a different method was necessary to preserve the health or life of the woman. The Justices declared these provisions unconstitutional because they were ambiguous as to which interest was predominant. They indicated that it might induce the physician to attempt to "make a 'trade-off' between the woman's health and additional

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[31] 410 U.S. 113 (1973).

[32] This paper was written prior to the Supreme Court decision of *Webster v. Reproductive Health Services*, 57 U.S.L.W. 5023 (July 3, 1989). Although the Court purported to leave *Roe v. Wade* intact, a plurality seemed to indicate that maternal health may not always be primary. *Webster*, 57 U.S.L.W. at 5029-5030. Thus, it is currently unclear what direction the Court will take regarding the relative weight to be afforded the rights and health of the mother versus the fetus.

[33] 410 U.S. at 162.

[34] *Id.* at 163.

[35] *Id.* at 165.

[36] 428 U.S. 52 (1976).

[37] *Id.* at 76.

[38] *Id.* at 78-79.

[39] 439 U.S. 379 (1979).

percentage points of fetal survival" and stressed the need for more specificity before the state could impose criminal liability on physicians.[40] Pennsylvania later attempted introduction of a similar provision in another statute which the court struck down, indicating that it failed to make explicit that the woman could not be forced to bear any additional medical risk for the sake of the fetus.[41]

States have also attempted to regulate post-viability abortions by requiring the presence of a second attending physician for the fetus. In 1983 the Court upheld such a provision in *Planned Parenthood Association v. Ashcroft.*[42] Three years later, however, it invalidated a similar provision in *Thornburgh v. American College of Obstetricians and Gynecologists.*[43] These seemingly irreconcilable decisions can be explained by the Court's insistence upon the superiority of the health of the woman. The Court recognized that the state's interest in protecting fetal life after viability could justify requiring the presence of a doctor to take care of the fetus, but the health of the mother would have to remain paramount. In both cases the Court was concerned with the existence of an emergency exception for cases where the health of the mother would be endangered by waiting for the arrival of the second doctor. In *Ashcroft*, apparently enough Justices were convinced that the exception was implied within the statute to uphold it.[44] The *Thornburgh* court, on the other hand, found no such exception. Writing for the court, Justice Blackmun stated that the statute "evinces no intent to protect a woman whose life may be at risk."[45]

Taken together, these cases clearly indicate that a doctor performing an abortion should consider the life and health of the pregnant woman to be paramount to any other concerns. The Court has recognized a state interest in both the life of the mother and the potential life of the fetus, but has always considered the interest in the woman to be superior to the interest in the fetus. By analogy, it would seem that the life and health of the woman should be paramount in any situation in which the interests of the pregnant woman and the fetus are in potential conflict. Yet, when faced with suits involving such circumstances, several courts have decided differently.

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[40] *Id.* at 400-401.

[41] Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 769 (1986).

[42] 462 U.S. 476 (1983).

[43] 476 U.S. 747 (1986).

[44] 462 U.S. at 485.

[45] 476 U.S. at 771.

Examination of these differing pronouncements from courts on medical malpractice and abortion rights reveals the dilemma faced by treating physicians in cases where a pregnant woman refuses to follow medical advice. If the doctor, desiring to protect himself from potential liability, treats the woman against her wishes, he violates her Constitutional rights and faces possible civil liability for battery. On the other hand, if the enlightened physician abides by her wishes and respects her right to autonomy, he faces potential liability for malpractice if the fetus suffers injury or death. It is easy to see why many frustrated physicians feel that the only way to protect themselves is to seek a court order.

Usually, such requests are made in emergency situations. Hearings are convened quickly and are often informal. Decisions are made very rapidly. A *New England Journal of Medicine* study reported that 88% of such orders were obtained in six hours or less.[46] Most of the cases, therefore, are not reported. The opinions in those that are reported are usually filed some time after the decision is actually made; thus, the decisions are made under pressure and opinions are filed after more time for reflection has passed.

The only case of a compelled cesarean section to be ultimately and finally adjudicated by a state supreme court is *Jefferson v. Griffin Spalding County Hospital Authority*.[47] Mrs. Jefferson was receiving prenatal care at the Griffin Spalding County Hospital where doctors determined that she had a placenta previa, a condition which indicates a need for a cesarean section. Her doctors estimated that if a vaginal delivery were attempted the chances of fetal mortality were 99% and the chances of maternal mortality were 50%.[48] Mrs. Jefferson refused consent to a cesarean section on religious grounds. The hospital requested an order to perform the surgery, which was granted only upon the condition that Mrs. Jefferson voluntarily come to the hospital to deliver.[49] The day after the order was granted, the Department of Social Services petitioned the Juvenile Court seeking custody of the fetus, based upon its status as a deprived child.[50] The court granted

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[46] Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 N. ENG. J. MED. 1192, 1193 (1987).

[47] 247 Ga. 86, 274 S.E.2d 457 (1981).

[48] *Id.* at 458.

[49] *Id.*

[50] *Id.* at 459.

the motion and ordered Mrs. Jefferson to submit to the necessary surgery.[51] In its order the Juvenile Court declared: "The Court finds that the intrusion into the life of Jessie Mae Jefferson and her husband John W. Jefferson, is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live."[52] The Georgia Supreme Court refused to grant a stay, thus affirming the order.[53] Mrs. Jefferson refused to return to the hospital and later vaginally delivered a healthy child.[54]

A more recent case of a compelled cesarean delivery is *In re A.C.*[55] After indicating the impropriety and undesirability of court decisions in cases of this type,[56] the appeals court affirmed an order to perform a cesarean section without the consent of the pregnant woman, who was dying of cancer. The court recognized the compelling state interests in both maternal and fetal life, and conceded that considerations of maternal life should probably be primary. However, the court then indicated that those considerations were inapplicable to this case because A.C. was dying anyway;[57] the only foreseeable consequence of the order was to shorten her life by a matter of days or hours. The court also pointed out that A.C. was sedated and seemed to indicate that her life was not of a very high quality at that point.[58]

These two cases directly contradict the balance of interests specified by the Supreme Court in the line of cases discussed above. The *Jefferson* and *A.C.* courts blatantly stated that they were weighing the rights of the fetus against the health and life of the mother, and allowing the fetus to prevail. The Supreme Court, however, has indicated that courts should not weigh the rights of the fetus more heavily than those of the mother. It is not surprising that health care professionals look at these cases and simply become more confused over what their duties and responsibilities are.

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[51] *Id.*

[52] *Id.* at 460.

[53] *Id.*

[54] Jost, *Mother versus Child*, A.B.A.J., April 1989, at 84, 86.

[55] 533 A.2d 611 (D.C. App. 1987), *reh'g en banc granted*, 539 A.2d 203 (1988).

[56] *Id.* at 612.

[57] *Id.* at 617.

[58] *Id.* at 614.

PROBLEMS OF COMPELLING TREATMENT: THE SLIPPERY SLOPE

The sanction of compelled medical treatment of pregnant women by the courts may well be the first step in the serious erosion of women's rights to reproductive autonomy. One attorney has pointed out that "[i]t used to be that a woman lost her rights when she married. A current move now seeks to deprive women of their rights when they get pregnant."[59]

It is not difficult to imagine the implementation of the strictly paternalistic measures advocated by some of the respondents to the *New England Journal of Medicine* survey. The doctors participating in the survey reported two cases in which court orders were obtained for hospital detention of pregnant women who refused treatment, and two cases in which intrauterine blood transfusions were ordered against the wishes of the patient.[60] In at least one case the court not only ordered the compulsion of medical treatment, but also directed the local police to locate the woman and bring her to the hospital to undergo the treatment.[61]

"Slippery slope" problems are easy to envision with such strict surveillance of pregnant women. It could lead to imposition of civil liability on the part of pregnant women to their fetuses later born alive. One court that has considered the issue pointed out that this "would have serious ramifications for all women and their families, and for the way in which society views women and women's reproductive capabilities."[62] The court declined to allow such a cause of action which "would necessitate the recognition of a legal duty on the part of the mother; a legal duty as opposed to a moral duty, to effectuate the best prenatal environment possible."[63]

Compelling women to submit to certain procedures for the sake of their fetuses and increased surveillance of women during pregnancy may also lead to the imposition of sanctions upon pregnant women for failure to act in the best interests of the fetus at all times during the pregnancy. Increasingly, courts are using child abuse or criminal statutes to punish women for less than perfect behavior during pregnancy. Women have been prosecuted for drug offenses and child

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[59] Remarks by Martha A. Field before the American Society of Law and Medicine (Oct. 1988), *quoted in* AM. MED. NEWS, Nov. 11, 1988, at p.11.

[60] Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 N. ENG. J. MED. 1192, 1193 (1987).

[61] Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 2026 (1986), *reporting In re* Baby Jeffries, No. 14004 slip op. at 9 (Jackson County, Mich. P. Ct. May 24, 1982).

[62] Stallman v. Youngquist, 125 Ill.2d 267,___, 531 N.E. 2d 355, 359 (1988).

[63] *Id.*

abuse based upon their behavior while pregnant.[64] At least one judge has sentenced a pregnant woman who was found to be using drugs to jail for a crime that would normally bring probation, justifying his action as protecting the fetus.[65] Dr. Ira Chasnoff, President of the National Association for Perinatal Addiction, Research and Education, suggests that this approach is wrong; the goal is better served through education and treatment.[66]

Broad state intervention into the lives of pregnant women not only violates the Supreme Court's mandates of autonomy, but may serve to contravene the very goals it seeks to effectuate. Disregard of the patient's wishes places the physician and the patient in adversarial positions, which is antithetical to the concept of patient care. Court orders sanctioning treatment against the wishes of the patient interpose the state between the physician and the patient, the very situation which the court in *Roe* sought to avoid.

Physicians may anticipate that their disregard of the woman's wishes will serve the ultimate goal of fetal survival. This may well be true in the particular case presenting itself at the moment. However, beyond the scope of the particular case, the effect may be just the opposite. Women may be less likely to seek help for substance abuse if they fear that their children will be taken from them or that they will face criminal charges. Thus, the goal of increased care for fetuses may actually be undermined by these actions that may be taken in their interests.

CONCLUSION: WORKING WITHIN THE CURRENT SYSTEM

It seems impossible to solve the doctors' dilemma in any way satisfying to all. Unless changes are made in the liability compensation system which serve to alleviate fear on the part of the physicians, they will probably continue to seek some affirmation of the decisions they make in an effort to avoid liability.

It remains intolerable, however, that courts are assuming the power to deny pregnant women rights that all other citizens have, particularly the right to bodily integrity and autonomy in reproductive choice. Courts should not continue to issue orders empowering third parties to make intensely private decisions for competent women.

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[64] *Drug Abuse, Pregnancy Pose Issue*, Richmond Times-Dispatch, Jan. 9, 1989, at 1.

[65] *Id.*

[66] Jost, *Mother Versus Child*, A.B.A.J., April 1989, at 84, 88.

Ideally, physicians would be able to practice without fear of massive liability forcing them to lose their livelihood, and pregnant women would have the full rights of other citizens. Unfortunately, the two currently seem incompatible. Perhaps the best way to operate within the current system is for physicians to continue to seek court orders, but for courts to refuse to grant them. In this way, the courts will affirm the right of the woman to make her own decision, and eliminate excess liability for the physician who wants to respect his patient's wishes by providing him with a court decision on which to rely.