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Commentary on *Burton v. State*

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Abstract:

In March of 2009, Samantha Burton went into labor only 25 weeks into her pregnancy. This is a very serious pregnancy complication that not only risks the pregnant woman's health, but also greatly reduces her potential child's chance of survival despite the most aggressive care. Ms. Burton's doctor prescribed, among other things, inpatient bed rest for the duration of her pregnancy, which would have required her to be separated from her two minor children at home. Ms. Burton found that recommendation unacceptable, and as a competent adult, asked to be discharged or to obtain a second opinion from another hospital. Instead of abiding by Ms. Burton's request, a court order was obtained that required Ms. Burton to submit to any and all care the doctor believed was "necessary to preserve the life and health of [Ms. Burton's] unborn child." Ms. Burton was eventually coerced into a cesarean section, during which the doctor discovered that her child had already died in utero.

Ms. Burton's case is tragic—she not only endured the trauma of losing her child, but the state's invasion into her basic autonomy. On appeal, the court overruled the decision, finding that the trial court had used the wrong legal standard in compelling Ms. Burton's care. As part of the Feminist Judgment Series, Nadia Sawicki adds a vital concurrence to that appellate decision, which would have also overturned the trial court's decision as unsupported by substantial evidence. Her contribution highlights the need to hold lower courts accountable for avoidable evidentiary errors in addition to legal ones. This commentary provides additional support and context to explain why the trial court's evidentiary missteps are so important to correct.

*****This is a draft of my forthcoming chapter in FEMINIST JUDGMENTS: REWRITTEN HEALTH LAW OPINIONS (Seema Mohapatra and Lindsay F. Wiley, eds.) (Cambridge University Press, expected publication 2021). Feedback is welcome.*****

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I. Background

In *Burton v. State*, Samantha Burton appealed a Florida trial court's Order Authorizing Medical Treatment that compelled her to submit to any "medical care and treatment" that a doctor believed was "necessary to preserve the life and health of [Ms. Burton's] unborn child."[1] This included "restricting Samantha Burton to bed rest, administering appropriate medication, postponing labor, taking appropriate steps to prevent and/or treat infection, and/or eventually performing a caesarian section delivery of the child at the appropriate time."[2] The order also denied Ms. Burton's request to seek care at a different hospital—and presumably, with a different doctor—as it was "not in the child's best interest at this time."[3] The order was not time-limited and was expected to stay in place until after her potential child[4] was born.[5]

As Sawicki's concurrence highlights, Ms. Burton's story is completely absent from both the trial court's order and the appellate court's opinion. This omission is reprehensible. Though our information is limited, we know that at twenty-five weeks pregnant, Ms. Burton started experiencing complications: her water broke and contractions began.[6] It is worth noting the seriousness of this complication at twenty-five weeks into a pregnancy. A twenty-five-week-old fetus is at the "limit of viability."[7] Around the time of Ms. Burton's diagnosis, roughly half of these extremely premature babies (56%) would die in utero, during labor, or in the hospital before discharge,[8] although the survival statistics have improved over the past decade.[9] The lucky babies that survived typically required an average of three and a half months in the NICU.[10] And at least a quarter of the surviving children would have experienced serious disability throughout their life, including cerebral palsy, blindness, profound hearing loss, or serious intellectual and

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[1] Order Authorizing Medical Treatment at 2, No. 2009CA1167 (Fla. Cir. Ct. March 2009) [Hereinafter Order].
[2] *Id.* at 3.
[3] *Id.*
[4] As Sawicki notes in footnote 3 of her concurrence, it is very difficult to choose a neutral word to refer to the subject of Ms. Burton's pregnancy. In the context of an unwanted pregnancy, especially if that pregnancy is terminated, reproductive rights advocates unequivocally use the word "fetus" for a variety of important reasons. But Ms. Burton's pregnancy was desired—or, at least, there is no reason to think the pregnancy was unwanted. In desired pregnancies, women often see their fetus as a baby, and in the case of stillbirth, mourn the baby's death as a child. For that reason, I sought to avoid the term "fetus" as much as possible, which to me suggests a maternal-fetal conflict that I don't believe exists here. However, I respect the rationale behind Sawicki's terminology, and agree that regardless of the chosen term, the word is incredibly loaded.
[5] Order at 2-3.
[6] *Id.* at 2; Brief of Petitioner-Appellant at 1, *Burton v. State*, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) [Hereinafter Burton Brief]; Brief of Respondent-Appellee at 1, *Burton v. State*, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) [Hereinafter State Brief].
[7] AM. COLLEGE OF OBSTETRICS & GYNECOLOGISTS, OBSTETRIC CARE CONSENSUS, https://www.acog.org/-/media/Obstetric-Care-Consensus-Series/occ006.pdf?dmc=1&ts=20180129T0128313960.
[8] *See* Nicholas S. Wood et al., *Neurologic and Developmental Disability After Extremely Preterm Birth*, 343 NEW ENGLAND J. MEDICINE 378, 379 (2000). Of course, survival rates are greatly influenced by the quality of the hospital and the technological advances of the time period. I attempted to use data that would capture what doctors knew and were conveying to their patients in 2009.
[9] More recent estimates suggest higher survival statistics, but still show that a quarter to a third of babies born before 26 weeks will not survive. AM. COLLEGE OF OBSTETRICS & GYNECOLOGISTS, *supra* note 7 at e188.
[10] Sarah E. Seaton et al., *Estimating Neonatal Length Of Stay For Babies Born Very Preterm*, 104 ARCHIVES OF DISEASE IN CHILDHOOD - FETAL AND NEONATAL EDITION F182, F184 (2019 ("Babies born at 24 and 25 weeks of gestational age who survive to discharge have the longest median length of stay, staying around 123 and 107 days, respectively.").

developmental delays.[11] When you combine disability and mortality statistics at the time, only 23% of babies born alive at 25 weeks would have been alive without a significant disability at 30 months old.[12]

Though additional weeks in the womb would have offered the potential child a better prognosis, frequently labor cannot be stopped for more than a few days. Bed rest, for instance, is now believed to be ineffective at helping almost all pregnancy complications.[13] And even for women like Ms. Burton with preterm premature rupture of membranes (PPROM), there is no evidence that bed rest improves maternal or fetal outcomes or significantly delays labor.[14] Unfortunately, the median latency period from rupture to birth before twenty-six weeks is only four to eight days.[15] One reason for this is that once the membranes have ruptured, doctors must balance the desire to delay labor with the risk of infection that can severely harm both the mother and her child.[16] The longer delivery is delayed, the higher the risk of infection, and thus, the higher the risk of maternal morbidity and mortality.[17]

In other words, once Ms. Burton's water broke at twenty-five weeks, there was no simple solution to save Ms. Burton's child, and aggressive intervention risked her health. Ms. Burton's child faced a dire prognosis no matter how aggressively the doctors treated her. When serious

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[11] AM. COLLEGE OF OBSTETRICS & GYNECOLOGISTS, *supra* note 7 at e188.

[12] Wood et al., *supra* note 8 at 379.

[13] *See e.g.*, *Bed Rest During Pregnancy: Get the Facts*, MAYO CLINIC (March 31, 2017), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20048007 ("Bed rest during pregnancy is no longer recommended for most conditions."); Cristina McCall, David Grimes & Anne Drapkin Lyerly, *"Therapeutic" Bed Rest in Pregnancy: Unethical and Unsupported by Data*, 121 OBSTETRICS & GYNECOLOGY 1305 (2013) (Exploring "[s]ix Cochrane systematic reviews of bed rest in pregnancy," finding that they "do not support [bed rest as treatment for various conditions]," and concluding that "[b]ecause 'therapeutic' bed rest has no known benefit yet established harms, its continued use is inconsistent with the ethical principles that govern medical practice."); Catherine Bigelow & Joanne Stone, *Bed Rest in Pregnancy*, 78 MOUNT SINAI JOURNAL OF MEDICINE 291 (2011) ("Bed rest is prescribed for a variety of complications of pregnancy, from threatened abortion and multiple gestations to preeclampsia and preterm labor. Although the use of bed rest is pervasive, there is a paucity of data to support its use.").

[14] *See e.*g., Catherine Bigelow et al., *780: Pilot Randomized Clinical Trial To Evaluate The Impact of Bed Rest On Maternal And Fetal Outcomes In Women With Preterm Premature Rupture of Membranes (PPROM)*, 212 AM. J. OBSTETRICS AND GYNECOLOGY S378 (2015) ("There were no statistically significant differences in maternal and fetal outcomes after FDR correction."); Nathan Fox et al., *The Recommendation For Bed Rest In The Setting Of Arrested Preterm Labor And Premature Rupture Of Membranes*, 200 AM. J. OBSTETRICS & GYNECOLOGY 165.e1 (2009).

[15] *See* Julie E. Robertson et al., *Fetal, Infant and Maternal Outcomes among Women with Prolapsed Membranes Admitted before 29 Weeks Gestation*, 11 PLOS ONE 1, 4 (2016); Elsa Lorthe, et al., *Preterm Premature Rupture Of Membranes At 22e25 Weeks' Gestation: Perinatal And 2-Year Outcomes Within A National Population-Based Study (EPIPAGE-2)*, 219 AM. J. OF OBSTETRICS & GYNECOLOGY 298.e1, 298.e4 (2018). Later in the pregnancy, latency to birth can be extended to almost two weeks with active management. Mara J. Dinsmoor, *Outcomes After Expectant Management of Extremely Preterm Premature Rupture of The Membranes*, 190 AM. J. OF OBSTETRICS AND GYNECOLOGY 183 (2004).

[16] Dinsmoor, *supra* note 15 at 31 (Noting that "PPROM management has two main goals: reducing fetal immaturity at birth and avoiding chorioamnionitis" and "[e]xtension of the latency period nonetheless exposes the fetus to complications such as chorioamnionitis, retroplacental hematoma and fetal distress.").

[17] AM. COLLEGE OF OBSTETRICS & GYNECOLOGISTS, *supra* note 7 at e191 ("Maternal morbidity and mortality may arise not just with interventions surrounding periviable pregnancy management but also with decisions not to intervene. For example, decisions to delay delivery (so-called "expectant management") in the setting of preterm premature rupture of membranes (PROM) may result in maternal infection . . .").

health complications arise in a desired pregnancy, women are faced with some of the most difficult decisions of their lives. In these tragic situations, doctors should strive to support patient autonomy, not create additional trauma by stripping patients of their rights. The American College of Obstetrics & Gynecology (ACOG), for instance, has long urged doctors to "present the option of nonintervention" as a reasonable choice before twenty-six weeks.[18] And after adequate counseling, doctors should respect whatever choice is made. Accordingly, the American Academy of Pediatrics has said:

> When the fetus' prognosis is uncertain, decisions regarding obstetric management must be made by the parents and their physicians . . . . Counseling may result in the family choosing not to have active intervention for the delivery and care of the infant. Because the relative benefits of different types of obstetric management are not always known, families should be supported in these often difficult and sometimes controversial decisions.[19]

It is with this background in mind that we review what is known of Ms. Burton's story. After voluntarily presenting at Tallahassee Memorial Hospital, Ms. Burton was examined by Dr. Bures-Forsthoefel.[20] We must assume that Dr. Bures-Forsthoefel explained the seriousness of her situation before recommending that Ms. Burton remain on bedrest at the hospital and immediately quit smoking to give her child the best (albeit not promising) chance at life.[21] Forced bedrest at the hospital would have required Ms. Burton to be separated from her two children for the duration of her pregnancy—potentially months—which she found unacceptable.[22] As a rational and competent adult, Ms. Burton refused to follow Dr. Bures-Forsthoefel's orders and asked to be discharged.[23]

Instead of allowing Ms. Burton to leave, the hospital involved the state attorney general's office, which inserted itself into this private medical decision.[24] After litigation ensued, Ms. Burton requested transfer to another hospital, in all likelihood to obtain a second opinion from other doctors.[25] Of course, many responsible mothers would seek a second opinion for such an important medical decision—the life and health of her child and herself were on the line. Yet the court denied this request, and Ms. Burton's rights with it, under the false assumption that "a change is not in

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[18] ACOG, *Periviable Birth: Interim Update*, 215 AM. J. OBSTETRICS & GYNECOLOGY B2, B6 (2016); *see also ACOG Practice Bulletin, Perinatal care at the threshold of viability*, 79 INT'L J. GYNECOLOGY & OBSTETRICS 181 (2002).

[19] Hugh MacDonald, *Perinatal Care at The Threshold of Viability*, 110 PEDIATRICS 1024, 1025-26 (2002); *see also* Karen Kavanaugh et al., *Supporting Parents' Decision Making Surrounding the Anticipated Birth of Extremely Premature Infant*, 23 J. PERINATAL & NEONATAL NURSING 159 (2009).

[20] Burton Brief at 1.

[21] *Id.* at 1; State Brief at 1.

[22] *Id.* at 2; Brief for ACLU at 7, *Burton v. State*, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) [Hereinafter ACLU Brief].

[23] Burton Brief at 1; State Brief at 1.

[24] In Florida, "a health care provider wishing to override a patient's decision to refuse medical treatment must immediately provide notice to the State Attorney presiding in the circuit where the controversy arises, and to interested third parties known to the health care provider. The extent to which the State Attorney chooses to engage in a legal action, if any, is discretionary based on the law and facts of each case." State Brief at 19-20 (quoting *In Re Dubreuil*, 629 So. 2d 819, 824 (Fla. 1993)).

[25] Sawicki Concurrence at 5.

the child's best interest at the time."[26] Instead, the court compelled Ms. Burton to submit to any treatment Dr. Bures-Forsthoefel recommended "to preserve the life and health of [her] unborn child," ignoring Ms. Burton's interests entirely.[27] The result was that Ms. Burton was forced to follow medical recommendations that we know in retrospect were both ineffective and outside of the standard of care. In the process, she was stripped of her right to make healthcare decisions for herself and end-of-life decisions for her child. A second medical opinion could have revealed Dr. Bures-Forsthoefel's errors and biases. But more importantly, it would have allowed Ms. Burton to exercise autonomy over her medical decisions amidst a devastating situation.

Unfortunately, this terrible story has a worse ending. After days of forced treatment, confinement, and separation from her two living children, "doctors performed an emergency cesarean section on Ms. Burton and discovered that her fetus had already died in utero."[28] In other words, the deprivation of Ms. Burton's right to bodily autonomy did not protect her child, and Ms. Burton was still left a grieving mother of a stillborn baby. This reality is shockingly absent from the case history, which remarkably paints Ms. Burton as the villain, not the victim, of a profound loss. Without question, the loss of her child was compounded by the trauma of compelled, futile medical treatment.

Once the trial court learned that Ms. Burton was no longer pregnant, it lifted the Order Authorizing Medical Treatment.[29] Nevertheless, Ms. Burton bravely appealed the trial court's prior order even though it had dissolved. And she won. All three appellate judges agreed that the district court had applied the wrong legal standard in evaluating the state's infringement of Ms. Burton's rights[30] (although one of them would have dismissed the appeal on mootness grounds).[31]

II. Original Opinion

The first issue before the appellate court was mootness. Judge Clark, writing for the court, held that the case was not moot because the issue was "capable of repetition yet evading review."[32] The court next examined the substantive issue of whether the trial court had applied the correct legal standard in evaluating whether to compel medical treatment on a competent adult. Judge Clark found that the standard applied by the trial court—best interest of the child (BIC)—was incorrect.[33] The court rightly noted that the BIC standard applies only when the state seeks to compel treatment for children over the objections of physically independent parents.[34] It does not, however, apply when the state seeks to compel treatment for developing fetuses over a mother's objection, which would necessarily infringe on her right to privacy and bodily autonomy.[35]

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[26] Order at 3.
[27] Burton Brief at 1.
[28] ACLU Brief at 2.
[29] Burton Brief at 2; State Brief at 2.
[30] *Burton v. State*, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) (Clark, J.) (Van Nortwick, J., concurring) (Berger, J. dissenting).
[31] *Id.* (Berger, J. dissenting).
[32] *Id.* at 264 (citing, *inter alia*, *Roe v. Wade*, 410 U.S. 113 (1973)).
[33] *Id.* at 265.
[34] *Id.* at 266.
[35] *Id.*

Instead, the court held that the proper test for evaluating compelled treatment in pregnancy has three parts. First, the trial court must make a finding of fetal viability: "Only after the threshold determination of viability has been made may the court weigh the state's compelling interest to preserve the life of the fetus against the patient's fundamental constitutional right to refuse medical treatment."[36] Second, the trial court must determine whether "the state's compelling state interest is sufficient to override the pregnant woman's constitutional right to protect her person, including her right to refuse medical treatment."[37] Third and finally, "the state must then show that the method for pursuing that compelling state interest is 'narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual.'"[38] This legal standard is much more protective of pregnant women.

Judge Van Nortwick agreed with Judge Clark's opinion, but wrote a separate concurrence to add that he also believed Ms. Burton's Sixth Amendment right to appointed counsel was violated.[39] Even though this case involved a civil, not criminal, proceeding, Judge Van Nortwick relied on the United States Supreme Court's precedent finding that "an indigent litigant has a right to appointed counsel only when, if [s]he loses, [s]he may be deprived of [her] physical liberty."[40] His concurrence argued that Ms. Burton was entitled to representation by counsel before being "involuntarily admitted to the hospital and, ultimately, required to undergo a caesarian section against her will."[41] Finally, in dissent, Judge Berger concluded that even though "the trial judge applied the wrong legal standard," the case was moot.[42]

This appellate decision was a victory. And because of that, it would be easy to conclude that the case should not be included in this volume. But Sawicki's concurrence perfectly highlights the omissions that speak loudly even in cases where women successfully assert their rights—the exclusion of women's stories, the undervaluing of their interests, the creation or exaggeration of fetal-maternal conflicts, and the failure to recognize the impact of gender bias. I explore below how Sawicki's concurrence fills in these gaps and models how judges can better promote feminist ideals.

III. Feminist Judgment

The main contribution of Sawicki's concurrence is to highlight the various evidentiary failures of the trial court. This addition is vital. The record lacks any evidence corroborating Dr. Bures-Forsthoefel's assertion that the compelled treatment would help Ms. Burton's child; it also fails entirely to consider Ms. Burton's reasons for refusal or whether the compelled treatment would be non-invasive or pose low risks to her. Instead, the trial court accepted as fact the medical opinion of one doctor and seemed to ignore Ms. Burton completely. Though the appellate opinion corrects the trial court's legal errors, it fails to discuss these important factual omissions or consider whether the evidence was sufficiently supported by "competent, substantial evidence."[43]

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[36] *Id.*
[37] *Id.*
[38] *Id.* (quoting *In re Guardianship of Browning*, 568 So.2d 4 (Fla.1990)).
[39] *Id.* (Van Nortwick, J., concurring) (quoting *Lassiter v. Department of Social Services*, 452 U.S. 18, 26-27 (1981)).
[40] *Id.*
[41] *Id.* at 267.
[42] *Id.* at 267-68.
[43] *Id.* at 2-4.

a. Lack of Evidence that the Compelled Treatment Would Benefit Ms. Burton's Child

First, Sawicki's concurrence notes that there is no evidence or testimony corroborating Dr. Bures-Forsthoefel's medical opinion that bed rest and other medical interventions were in the best interests of Ms. Burton's child.[44] This is troubling for many reasons. For one, medical advice is inherently fallible. Sawicki explains in her concurrence that nearly a third of court ordered interventions against pregnant women are futile or harmful in retrospect.[45] This case falls within that category. Dr. Bures-Forsthoefel ordered inpatient bed rest at great personal cost to Ms. Burton even though it is ineffective at treating PPROM, from which Ms. Burton suffered, and is associated with serious medical risks.[46] Dr. Bures-Forsthoefel also completed a caesarian section without Ms. Burton's consent for a child that had already died in utero, further jeopardizing Ms. Burton's health and future fertility with no corresponding benefit to her child.[47] As the medical literature suggested, Dr. Bures-Forsthoefel's aggressive and rights-depriving approach was not guaranteed (or even more likely than not) to save Ms. Burton's child.

Without question, Ms. Burton could have opted to pursue this course of treatment had she desired, but it is outrageous that she was forced to receive risky and futile care against her will. Had the court required any corroborating evidence or permitted Ms. Burton to pursue a second medical opinion, it could have realized that the accepted medical standard of care in this situation is deference to parental choice and that Dr. Bures-Forsthoefel's recommendations were likely grounded in an ideological objection to Ms. Burton's decision. Anti-choice doctors can bring their belief that fetal life should be protected at all costs into their medical judgments even outside of the abortion context.[48]

It is worth noting that the trial court's Order Authorizing Medical Treatment may not have been justified even under the BIC standard that the court incorrectly utilized. Under common law and the U.S. Constitution, parents are given broad authority to make healthcare decisions for their children.[49] These parental rights can be overridden in certain cases where the parental choice is clearly not in the child's best interest—for instance, if parents refuse a life-saving blood transfusion for their child on religious grounds.[50] But when there is no obviously correct medical decision to be made for the child, courts often defer to parental choice even if it involves refusing medical

[44] Sawicki Concurrence at 4-5.
[45] *Id.*
[46] *See supra* notes 11-12.
[47] ACLU Brief at 2.
[48] Jeffrey Blustein & Alan R. Fleischman, *The Pro-Life Maternal-Fetal Medicine Physician A Problem of Integrity*, 25 HASTINGS CENTER REPORT 22, 23-24 (1995) ("Pro-life does not just mean anti-abortion, of course, and a pro-life position can be expected to have implications for physician conduct beyond those relating to abortion. For example, in cases involving a conflict between the interests of the expectant mother and those of the unborn child, a pro-life physician may support interventions to protect the fetus that a pro-choice physician would oppose.").
[49] *See e.g.*, In Prince v. Commonwealth of Massachusetts, 321 U.S. 158, 166 (1994) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."); Newmark v. Williams, 588 A.2d 1108, 1115 (Del. 1991) ("Parental authority to make fundamental decisions for minor children is also a recognized common law principle").
[50] *See e.g., Newmark*, 588 A.2d at 1115-17.

care that might be beneficial.[51] For instance, in *Newmark v. Williams*, the Supreme Court of Delaware allowed parents to refuse treatment for their child with cancer because even with aggressive medical treatment, the child only had a 40% chance of survival and the treatment would have caused intense suffering.[52] Ms. Burton's child faced similar odds. Thus, even under this lower standard, the trial court may have errored in ordering treatment over Ms. Burton's objection.

b. Lack of Evidence that the Compelled Treatment Would Not Harm Ms. Burton

Second, Sawicki's concurrence points out that there is no evidence in the record about how this treatment would have affected Ms. Burton—the actual recipient of the treatment.[53] Though this evidence is always essential, it is especially important to consider it here given the possibility that any coerced care would have been futile for her child. Can the state ever prove the fetus's interests outweigh the mother's when the child is more likely than not to die regardless of the care she or he receives? As Sawicki notes, bed rest and caesarian sections carry serious risks, including muscle and weight loss, bone turnover, depression and anxiety, infection, hemorrhage, and death.[54] Here, the risks to Ms. Burton carried no benefit to either Ms. Burton or her child. But even had the bedrest or surgical delivery been in the fetus's best interest based on competent medical evidence, a pregnant woman's medical interests *must* be considered alongside her child's. After all, it is only when the treatment "poses an insignificant or no health risk to the woman . . . and would clearly prevent substantial and irreversible harm to her fetus" that compelled medical treatment should even be considered.[55] By excluding all evidence of the risks to Ms. Burton, the trial court dehumanized her and rendered her nothing more than a vessel.[56]

Unfortunately, even when doctors and courts consider the risks to the pregnant woman along with the risks to her child, they often exaggerate the risks to the child and undercount the risks to the woman.[57] This disparate risk valuation is based on the assumption that women should be self-sacrificing—i.e., that they should bear large risks even for a small chance of benefit for their child.[58] "[I]n dismissing the risks to the mother, the doctor treats her needs as less important than those of her child. She is supposed to be willing to sacrifice her well-being—even to risk death—for the health of her fetus."[59] When women fail to abide by this assumption, women are

[51] *See e.g., Newmark*, 588 A.2d at 1119. ("No American court, even in the most egregious case, has ever authorized the State to remove a child from the loving, nurturing care of his parents and subject him, over parental objection, to an invasive regimen of treatment which offered, as Dr. Meek defined the term, only a forty percent chance of 'survival.'").
[52] *Id.*
[53] Sawicki Concurrence at 4-6.
[54] *Id.*
[55] *Id.* at 5 (quoting the American Medical Association).
[56] *See e.g.,* April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 148 (2007) ("Detention and commitment for the benefit of fetal health reduces pregnant women from citizens to "fetal containers" and "maternal environments.").
[57] *See e.g.,* Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L. J 492, 562 (1993).
[58] *Id.* at 563 ("The physician's conclusory decision that the indeterminate risk of infection in the newborn outweighs the doubling in the risk of death to the mother (as well as the additional risk of complications to both) reveals an underlying assumption (perhaps unconscious) that women both are and should be self-sacrificing.").
[59] *Id.*

often pegged as bad mothers in need of correction.[60] But forcing women to be self-sacrificial is anomalous in the American legal tradition, where courts have historically opined that individuals have no legal obligation to save the lives of others.[61] And of course, there is nothing inherently irrational or wrong about parents neutrally balancing competing risks between the mother and fetus or even prioritizing the health of the mother, who is a fully-formed person with unequivocal moral value.

c. Refusal to Consider Ms. Burton's Non-Medical Interests

Finally, Sawicki highlights that there is no evidence of Ms. Burton's motives for refusing treatment.[62] We know at a minimum that Ms. Burton had two children at home for whom she was responsible. Understandably, she did not want to be separated from them, especially for an indeterminate amount of time. Though the trial court painted Ms. Burton as a bad mother for refusing treatment that might save her baby, she was in all likelihood acting out of love and care for her two living children as any good mother would. The trial court paradoxically demanded that Ms. Burton entirely ignore the needs of her two kids, but also be willing to sacrifice everything for her fetus. It would have been reasonable for Ms. Burton to prioritize the needs of her living children, especially given that the forced separation and bed rest were never likely to save her baby.

It is also possible that Ms. Burton's refusal of care was at least partially related to her child's poor prognosis. Even if that were the case, it would not make Ms. Burton a bad mother to the child inside of her. Many women find it more compassionate to save their child from suffering in this world than to force the child to endure months of pain that might nevertheless end in death.[63] Sometimes, "a blanket and an embrace is the highest quality care [mothers] can give [their] bab[ies]."[64] The optimal response in this situation is not determined by objective medical facts alone, but by the parents' values. Joseph Goldstein has argued that "no one can be presumed to be in a better position, and thus better equipped, than a child's parents to decide what course to pursue if the medical experts cannot agree or, assuming their agreement, if there is no general agreement in society that the outcome of treatment is clearly preferred to the outcome of no treatment."[65] There is no "right" answer for Ms. Burton, which is why all relevant professional organizations

[60] *Id.* at 565 ("This delegation [to doctors] is the final critical step in a process that, through medical and legal discourse, defines mothers as "good" or "bad" depending on whether or not they accept 'medically necessary' procedures."); April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 740 (2004) ("Only when pregnant women make altruistic choices on behalf of their fetuses, are their choices assured of state protection. When pregnant women wish to make themselves, their lives, their desires, or their values primary, courts have instead restricted women's autonomy by compelling unwanted, nonconsensual treatment on behalf of the fetus.").

[61] *See* Julie D. Cantor, *Court-Ordered Care: A Complication of Pregnancy to Avoid*, 366 NEW ENG. J. MED. 2237, 2240 (2012).

[62] Ehrenreich, *supra* note 57 at 11-15.

[63] *See generally*, Greer Donley, Parental Autonomy Rights for Prenatal End-of-Life Decisions (Working Paper, 2019).

[64] Jen Gutner, *I Didn't Kill My Baby*, N.Y. TIMES (Feb. 26, 2019), https://www.nytimes.com/2019/02/26/opinion/born-alive-abortion.html (describing the loss of her son after her water broke at twenty-two weeks).

[65] Joseph Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645, 651 (1977).

recognize that parents are entitled to make the choice that they feel is best for their child.[66] It might not have been the decision that Dr. Bures-Forsthoefel would make if she were unlucky enough to face the same experience, but she was never the relevant decision maker.

By ignoring Ms. Burton's motives entirely, the court whitewashed her out of her own child's death, as if Dr. Bures-Forsthoefel cared more about her child than she did. But only Ms. Burton, not the doctor or the judge, would have to deal with the anxiety of watching her child experience pain and fight for life. Only Ms. Burton would have to suffer for months while her child was in the NICU, not knowing if she would ever take her baby home. Only Ms. Burton would have to nurse the child if she or he survived with serious disabilities. And only Ms. Burton would ultimately mourn her child's death. Other than her refusal to unquestionably accept Dr. Bures-Forsthoefel's treatment plan—a decision that was medically correct in hindsight—there was no reason to suspect Ms. Burton was anything but a loving mother. It is therefore anomalous that the trial court concluded that Dr. Bures-Forsthoelfel was more credibly acting in the child's best interests than the child's mother.

As Sawicki's concurrence points out, the trial court made a common mistake: the false assumption that Ms. Burton's interests conflicted with those of her child.[67] While this is the dominate paradigm in the case of abortion, there is no reason to see the mother and child's interests as conflicting in desired pregnancies. Parents want what is best for their children—in fact, the Supreme Court recognizes a "presumption that fit parents act in their children's best interests"—but parents may disagree with their doctors on what that is.[68] There is nothing innately wrong with a person challenging their physician's recommendations, seeking a second opinion, or pursing a different treatment plan. As discussed above, medical advice is fallible, and patients (not their doctors) are the only people who must live with the effects of their medical decisions. Ms. Burton did not agree with Dr. Bures-Forsthoefel's advice. This wasn't necessarily because of any conflict between her interests in the child's interests, but because she decided that a different approach was in the best interest of herself and her child.[69] The court should have acknowledged this.

IV. Discussion

Sawicki's concurrence clearly documents why trial courts should not rely on the testimony of one physician to compel treatment. It is not enough for appellate courts to correct a trial court's inaccurate legal standards, they must also police whether lower courts are meeting a sufficiency of the evidence standard. The correct legal standard will do little to protect women in future situations if courts routinely defer to the opinion of one doctor who may greatly exaggerate the possible benefits to the potential child and undercount the risks to the woman. Doctors motivated by their personal ideology do this with regularity and judges often accept their findings without question.[70] Though courts typically see doctors as "neutral arbiters," Michelle Oberman has argued

[66] *See supra* notes 16-17.
[67] Sawicki Concurrence at 8.
[68] Troxel v. Granville, 530 U.S. 57, 58 (2000) (internal quotations omitted).
[69] Ehrenreich, *supra* note 57 at 552-53 ("Rather than suggesting disregard for the well-being of one's offspring, those refusals might instead suggest rejection of a demeaning vision of one's self and one's body and a claiming of one's right to human dignity, respect, and autonomy.").
[70] *Id.* at 563; R. Alta Charo, *Physicians and the (Woman's) Body Politic*, NEW ENG. J. MED. (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1313499 ("it is the latest example of a disturbing pattern of legislative

that doctors are often the ones generating the conflict.[71] She suggests that the conflict is not between the women and the fetus, but between the woman and her doctor.[72] And by definition, the doctor cannot be an impartial party when he or she instigated the very action by contacting the state.[73] Sawicki's concurrence—had it been included with the original opinion—would have provided more protection to Floridan women under the care of overzealous doctors by urging trial courts to demand corroborating medical testimony and evidence before reaching their findings of fact.

These evidentiary failures are problematic for their own sake, but also for the stereotypes they promote. Nancy Ehrenreich has argued that when courts unquestioningly accept medical judgments "as 'truth' and reject[] alternative approaches as ridiculous," they "draw the inevitable conclusion that women who resist doctors' orders are irresponsible, hysterical, and/or dangerous"[74] Though law tends to defer to medicine as an objective truth, the history of birth "has highlighted the fact that medicine is a social construct."[75] Women should not be labeled as bad mothers simply for challenging the recommendations of a doctor—recommendations that may very well be wrong or not in accordance with their own values and preferences. Courts can fight this stereotype by forcing doctors to corroborate their recommendations instead of paternalistically assuming a doctor knows what is better for a woman and her child than the woman does. At the very least, courts should permit patients the small grace of a second opinion to demonstrate that their decision fits within a range of reasonable options.

Sawicki's concurrence does an excellent job of demonstrating that these crucial omissions are not just mistakes, but the result of systemic marginalization of women and gender bias in the courts.[76] Of course, this marginalization and bias affects poor women and women of color to a much greater degree than white women.[77] One study found that eighty-one percent of court ordered interventions against pregnant women involved women of color.[78] By highlighting the various ways that gender bias impacts women in the legal system, Sawicki calls on trial courts to recognize and correct their sexism. It might not impact the most ideological judges, but would certainly provide helpful language to trial court judges who may be suspicious of physician recommendations or eager to correct mistakes of the past. Overall, Sawicki's concurrence adds much needed feminist perspective and evidentiary bite to the *Burton* opinion.

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and judicial misrepresentation and misuse of medical information in the pursuit of partisan aims focused on women and pregnancy.").

[71] Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 454 (2000).

[72] *Id.*

[73] *Id.*

[74] Ehrenreich, *supra* note 57 at 565.

[75] *Id.* at 543; *Id.* at 538 ("The notion that physicians are merely engaging in an objective medical assessment when they label certain mothers as bad is sustained by the invisibility of alternative ways of thinking about reproduction, women, and their bodies.").

[76] Sawicki Concurrence at 10-12, 14-15, 18-19.

[77] Veronica E. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987).

[78] *Id.*