STATE OF NEW JERSEY, Division of Youth and Family Services v. V.M. and B.G., In the Matter of the Guardianship of J.M.G.	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NOS. A-2649-08T4/A-3024-08T4 A-2226-08T4/A-3334-08T4 Appealed from Superior Court Chancery Division, Family Part Essex County Civil Docket No. FG-07-190-07 Sat Below: Hon. John J. Callahan, J.S.C.

BRIEF OF EXPERTS IN MATERNAL AND NEONATAL HEALTH, BIRTH, AND CHILD WELFARE, AMICI CURIAE, IN SUPPORT OF REVERSAL OF THE JUDGMENT OF THE TRIAL COURT

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PRELIMINARY STATEMENT

Amici, Experts in Maternal and Neonatal Health, Birth, and Child Welfare,[*] respectfully submit this brief to explain the profound legal and policy implications of the trial court's erroneous consideration of a pregnant woman's medical choices during labor in terminating her and her husband's parental rights. Amici include physicians, nurses, midwives, counselors, advocates, and policy and research professionals in the fields of reproductive, maternal, fetal and child health. Although amici's expertise varies, they are united in their belief that the misapplication of the child welfare laws in this case has resulted in a profound injustice.

Amici submit that the termination of parental rights in this case cannot be divorced from the circumstances that tragically and improperly led to the intervention of New Jersey's child welfare system and the immediate removal of a newborn from her parents. The record is clear that hospital staff referred V.M.'s case to the Division of Youth and Family Services ("the Division" or "DYFS") at least in part because of concerns regarding V.M.'s decisions during labor, including her decision not to preauthorize consent to cesarean surgery. As this Court has noted, a Family Part judge then relied on V.M.'s medical decision-making in finding abuse and neglect under New

[*] A list of all amici is included as an Appendix.

Jersey's child welfare laws, thereby leading to the continued separation of the parents from their daughter. N.J. Division of Youth and Family Services v. V.M. and B.G.; In the Matter of J.M.G., -- A.2d --, *1 2009 WL 2044826 (App. Div. Jul. 16, 2009).[1] And now, more than three years after the inappropriate separation of this family, the initial injustice and misuse of the child welfare laws has culminated in one of the most profound deprivations that our legal system can inflict upon a family: the termination of parental rights under N.J.S.A. 30:4C-15.1a. Amici submit that but for V.M.'s exercise of her constitutionally-protected decision to refuse consent to cesarean surgery during labor, her parental rights, and those of her husband B.G., would not have been terminated.

While it is true that the trial court, in terminating parental rights, analyzed expert testimony and evidence other than the parents' conduct during the birth of their child, it is equally indisputable that the court repeatedly considered V.M.'s decisions during pregnancy and delivery in its analysis under N.J.S.A. 30:4C-15.1a. Because amici submit that the law forecloses such considerations from playing any role whatsoever

[1] This court ruled, however, that other evidence supported the finding of abuse and neglect as to the mother, but reversed the trial court's finding as to the father. Id. The mother is currently seeking review of that determination before the New Jersey Supreme Court, an effort which amici support because of their belief that the law does not allow a pregnant woman's medical choices to be a "substantial" factor in a finding of abuse and neglect. See Notice of Petition for Certification, filed by V.M. in Docket No. 1-4627-06T4 (July 17, 2009).

in a court's decision to terminate parental rights, amici respectfully submit that the trial court's decision must be reversed.

The trial court's consideration of a pregnant woman's decision not to preauthorize cesarean surgery was contrary to the plain language of the termination statute, N.J.S.A. 30:4C-15.1a, the legislative goals in enacting that law, and well-settled standards protecting patients' rights. Specifically, as a matter of law, family court judges may not consider pregnant women's medical decisions in terminating parental rights because that law does not apply to pregnant women or their fetuses. Moreover, penalizing women through the child welfare regime for refusing to consent to cesarean surgery is a dramatic departure from well-established law protecting patients' rights to make their own medical decisions and to refuse medical interventions. That law, which is consistent with prevailing medical, public health, and bio-ethical standards, applies equally to women, including pregnant women who carry to term.

Moreover, as a matter of policy, allowing the trial court's decision to stand would have serious public health repercussions in New Jersey, and possibly beyond. Indeed, allowing the consideration of a pregnant woman's medical choices in child welfare decisions would create a basis upon which medical personnel could coerce women to accede to doctors' advice,

deterring women from seeking care altogether, or, at the very least, chilling open communication between women and their health care providers at the expense of maternal and fetal health.

For all of these reasons, and as set forth more fully below, amici respectfully submit that this Court should reverse the trial court's termination decision and affirm that women's medical choices during pregnancy and labor may play no role in analyzing the fitness of parents or in determinations to terminate parental rights.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

This case began with a hospital's report to child welfare authorities that a woman would not consent to cesarean surgery. T6:3-5; 6:10-14.[2] In Matter of J.M.G., supra, 2009 WL 2044826 (Carchman, J., concurring),[3] this Court set forth in detail the "circumstances which led to the placement of the child outside of the" biological parents' home and ultimately to these termination proceedings.

On April 16, 2006, V.M. and B.G., the married biological parents of J.M.G., arrived at Saint Barnabas hospital when V.M.,

[2] Transcript of Oral Decision, June 11, 2008 [hereinafter "T"]. The transcript of the December 19, 2008 oral decision is hereinafter cited as "2T."

[3] The majority's per curiam opinion explicitly "adopt[ed] the facts as set forth in the concurring opinion . . . ." Id. at *1. Amici highlight those facts bearing on the improper role that V.M.'s decision not to preauthorize cesarean surgery played in the initial removal of the child from her parents' custody at the hospital and throughout this child welfare proceeding.

who had a fever, went into labor. Id. Upon admission at the hospital, a staff person presented V.M. with a blanket consent form seeking her authorization for a number of medical interventions, including the administration of intravenous fluids, antibiotics, oxygen, fetal heart rate monitoring, episiotomy,[4] and an epidural anesthetic. Id. at *2. V.M. consented to each of those procedures, but exercised her right to informed consent by choosing not to sign the consent form preauthorizing cesarean surgery. Id. at *3.[5]

A doctor described to V.M. and B.G. the complications that could potentially occur in the event that the fetus later went into distress and a c-section was not performed. Id. B.G. said that he understood the risks and V.M. continued to exercise her right to informed consent, deciding not to preauthorize the procedure before it became medically necessary. Id. at *3. The medical personnel, however, were unsure whether a pregnant woman had the right to refuse such consent. Letter Brief of Respondent Minor Child, Docket No. A-04627-06t4, at 4 (filed in related Abuse and Neglect proceeding).[6] Accordingly, they "consulted Dr. Rokosz, a hospital administrator," who informed

[4] An episiotomy is a surgical cut in the skin and muscle of the vagina during child-birth.

[5] V.M. also chose not to consent to fetal scalp stimulation.

[6] Amici cite the Law Guardian's brief because they do not have access to the record; As the Court is aware, amici's motion to unseal the record was denied.

"the nurse, 'that the patient's rights supersede [the] rights of [the] unborn child.'" Id. at 4.

The hospital staff then requested a psychiatric evaluation to determine V.M.'s competency to exercise her right to informed consent. Matter of J.M.G., supra, at *3. Dr. Devendra Kurani spoke to V.M. for approximately one hour and determined that, although V.M. was very anxious, she "was not psychotic and had the capacity for informed consent with regard to the c-section." Id. at *3. V.M. informed Dr. Kurani that she had a psychiatric history and that she had been on medication prior to becoming pregnant. Id. B.G. confirmed that V.M. had been treated by a psychiatrist for post-traumatic stress disorder and had been prescribed Zoloft, Prozac and Seroquel. Id.

The OB-GYN on duty, Dr. Mansuria, again "stressed the need for V.M. to consent to a c-section." Id. at *3. V.M. repeated that she understood the risks, but stood by her decision.

Still unconvinced of V.M.'s competency to make her own medical choices, after Dr. Kurani left, "the staff requested a second psychiatric opinion from Dr. Jacob Jacoby." Id. at *3. V.M. also disclosed her psychiatric history to Dr. Jacoby, including that she had been treated by Dr. Ronnie Seltzer for many years. Id. Prior to Dr. Jacoby completing his evaluation, however, V.M. gave birth naturally and "without incident" to a healthy baby girl. Id. at *3-4.

On April 18, 2006, a social worker at Saint Barnabas Hospital contacted DYFS to voice the hospital's concerns over releasing J.M.G. to her parents' care. Id. at *4. As a DYFS worker later testified, the report from the hospital was regarding "a birth of a child" and that the hospital "had recommended certain procedures to assist during delivery." T6:6-8. DYFS caseworker Heather Frommer immediately went to the hospital and interviewed the hospital staff and parents. Id. Although V.M. and B.G. had disclosed V.M.'s psychiatric history to Drs. Kurani and Jacoby during labor, once it became clear that the Division was investigating them, they were not forth-coming about V.M.'s mental health history with Ms. Frommer. Id. Frommer soon informed V.M. and B.G. that the Division was taking custody of J.M.G., and their newborn daughter would not be going home with them from the hospital. Id. V.M. was understandably upset and called the police, desperate to prevent her separation from her baby. Id.

The Division later commenced Title 9 abuse and neglect proceedings pursuant to N.J.S.A. 9:6-8.21 to -8.106 [hereinafter "FN proceedings"], and placed J.M.G. in its custody. At the fact-finding hearing, the trial judge found that V.M. "was 'negligent' in not acceding to the doctors' requests and found that J.M.G. was an abused or neglected child under N.J.S.A. 9:6-8.21(c)(4)." Id. As Judge Carchman noted in a concurring

opinion in the appeal of that matter, V.M.'s refusal to consent to cesarean surgery "factored heavily into this decision." Id. at *2.

On April 25, 2007, the Division commenced Title 30 proceedings (hereinafter "FG proceedings"), by filing a guardianship complaint for J.M.G. On May 19, 20, 21, and 28, 2008, the Honorable John J. Callahan, J.S.C., presided over a termination of parental rights proceeding. Br. of Appellant V.M., at 3. Judge Callahan issued a decision on June 11, 2008, concluding that DYFS had failed to meet prongs two and four of the test for terminating parental rights under N.J.S.A. 30:4C-15.1a. Id. The court therefore entered an order terminating the guardianship proceeding on June 16, 2008, and reverted the case back to an FN proceeding. Id. DYFS and the Law Guardian filed motions for reconsideration. Id.

On August 11, 2008, the court appointed Dr. Ronald Crampton to examine the parties, and reverted the case back to a FG status. Id. On October 29, 2008, Judge Callahan reopened the guardianship case to receive Dr. Crampton's report. Id.

On December 19, 2008, the court revisited the prongs of N.J.S.A. 30:4C-15.1a, which it had previously found DYFS had failed to meet, and entered a judgment of guardianship terminating V.M. and B.G.'s parental rights. Id. As set forth more fully below, the transcript of the trial court's June and

December 2008 decisions makes clear that V.M.'s exercise of her right to informed consent not only was the impetus for the intervention of the child welfare authorities in this family's life in the first place, but that it also impermissibly factored into the court's analysis of whether termination was warranted under the statute.

On June 26, 2009, amici, Experts in Maternal and Neonatal Health, Birth, and Child Welfare moved for an order permitting them to participate in this matter and to participate in oral argument. On July 20, 2009 this Court issued an order granting amici's motion and directing them to file a brief within 30 days.

ARGUMENT

I. THE TRIAL COURT IMPROPERLY CONSIDERED V.M.'S MEDICAL DECISIONS DURING PREGNANCY AND LABOR CONTRARY TO THE PLAIN LANGUAGE AND PURPOSES OF N.J.S.A. 30:4C-15.1A, AND IN CONTRAVENTION OF V.M.'S STATUTORY AND CONSTITUTIONAL RIGHTS TO MAKE HER OWN MEDICAL DECISIONS.

The United States Supreme Court has held that because parents possess a fundamental constitutional right to a relationship with their children, the Fourteenth Amendment requires that courts impose "'strict standards for the termination of parental rights.'" In re Guardianship of M.A.M., 189 N.J. 261, 347 (2007) (quoting In re Guardianship Of K.H.O., 161 N.J. 337, 346 (1999), citing Stanley V. Illinois, 405 U.S.

645, 651 (1972)); Santosky v. Kramer, 455 U.S. 745, 768-69 (1982). Accordingly, before parental rights may be terminated in New Jersey, each of the four prongs of the "best interests of the child" standard must be met by clear and convincing proof. See N.J.S.A. 30:4C-15.1a; N.J. Div. of Youth & Fam. Servs. v. A.W., 103 N.J. 591, 612 (1986). Thus, under the statute, a court may only terminate parental rights when the Division establishes the following requirements by clear and convincing evidence:

> (1) The child's safety, health or development has been or will continue to be endangered by the parental relationship;
>
> (2) The parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the delay of permanent placement will add to the harm. Such harm may include evidence that separating the child from his resource family parents would cause serious and enduring emotional or psychological harm to the child;
>
> (3) The [D]ivision has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home and the court has considered alternatives to termination of parental rights; and
>
> (4) Termination of parental rights will not do more harm than good.
>
> [N.J.S.A. 30:4C-15.1a.]

Here, V.M.'s refusal to preauthorize cesarean surgery erroneously served as the starting point for intervention of the

child welfare authorities in this family's life and was the "but for" event that led to the trial court's ultimate decision denying V.M. and B.G. their fundamental right to parent. As the New Jersey Supreme Court has noted, where a child "should never have been removed from [her parents'] custody" in the first place, "[i]t follows that . . . parental rights should not have been terminated." N.J. Division of Youth and Family Servs., v. G.L., In the Matter of the Guardianship of M.J.C., 191 N.J. 596, 609 (2007). That precept is significant here where the immediate removal of a newborn from her parents was erroneous given that it was "substantially" influenced by a pregnant women's exercise of her constitutionally and statutorily protected right to make her own medical decisions.

Moreover, with regard to the trial court's specific termination analysis, the trial judge improperly considered the mother's medical decisions during pregnancy and labor in determining whether the child's safety was or would be in danger in the future under prong 1 of N.J.S.A. 30:4C-15.1a. That consideration was categorically impermissible because the statute does not apply to pregnant woman and their fetuses. Accordingly, the trial court's decision must be reversed.

A. The Trial Court Impermissibly Considered V.M.'s Medical Decisions During Labor In Evaluating Prong One of the Best Interests of the Child Test.

The record reveals that V.M.'s decision not to preauthorize cesarean surgery was the defining event leading to the termination of her and her husband's parental rights. The birth, in fact, continued to serve as a recurring and critical reference point for the trial court in reaching its conclusion regarding V.M.'s "problems" with "authority" figures, from which it based its predictions about her ability to parent safely. Amici recognize that the record before the trial court addressed certain other conduct and evidence in addition to V.M.'s medical decisions during labor. But that other evidence does not justify or excuse the court's impermissible consideration of V.M.'s medical decisions during labor under prong one of the statute, nor obscure the fact that V.M.'s decisions during labor certainly played a substantial role in the court's decision.

As the New Jersey Supreme Court has recognized, a trial court's consideration of improper factors in reaching a termination decision may warrant reversal when the remaining evidence no longer supports the trial court's decision by the demanding standard of clear and convincing evidence. G.L., 191 N.J. at 607. Reversal because of a trial court's consideration of improper factors is particularly warranted in cases like this

one, where the trial court itself viewed the matter as a close case, finding in June 2008 that DYFS had not met its burden by clear and convincing evidence with respect to all four prongs of the best-interest-of-the-child standard, only to revisit those prongs six months later in a reopened and revised decision.

Here, the record makes clear that the trial court improperly considered evidence of V.M.'s medical decisions during pregnancy and labor in terminating parental rights. For example, the court characterized V.M.'s medical decision-making as a "lack of cooperation during the delivery procedure," T6:13, and then cited this "lack of cooperation" as a basis for its determination that "[t]he child's safety, health or development has been or will continue to be endangered by the parental relationship" under prong 1 of N.J.S.A. 30:4C-15.1a.

Moreover, in summarizing what it viewed as the relevant facts and testimony, the court noted that "the events take us back, of course, . . . back to the hospital admission of [J.M.G.'s] mother at Saint Barnabas for the actual birth and, of course, the Court notes the difficulties to the put the term nicely, by the failure of parents to provide certain necessary information to the hospital staff. . . ." 2T4:8-15. The court noted that the referral from the hospital to DYFS referenced "the birth of a child to [V.M.] and that [the hospital] had recommended certain procedures to assist during her

delivery. . ..” T6:6-8. The Court also acknowledged caseworker Heather Frommer’s testimony that two psychiatrists were called in “for consultation by the hospital, . . . due to the lack of cooperation during the delivery procedure.” T6:3-5; 6:10-14; see also T9:2-5 (noting psychiatric consult was ‘because of . . . refusal to sign consent for the C-section”). Ultimately, the Court explicitly cited V.M.’s “difficulties” with regard to her “hospital birth” as “sufficient for the satisfaction of the first prong” of N.J.S.A. 30:4C-15.1a. 2T7:21-25.

The court further cited the fact that B.G. “totally support[ed] [V.M.] and her conduct while in the hospital” as an additional factor leading the court to conclude that the child “might well be placed in harm if released to the parents.” T53:16-25. It later repeated its conclusion that it was “satisfied” by clear and convincing evidence under prong one “that the newborn infant’s safety was compromised by the conduct that was displayed” at the hospital. 2T4:18-21.

Moreover, the court’s reasoning as to the future harm posed by the parents to their child was also impermissibly tainted by the court’s consideration of V.M.’s decisions during pregnancy. Specifically, the Court questioned whether “the parents [would] apply the same attitude or approach” apparently evidenced by their conduct in the hospital “toward the selected pediatrician

. . . and take their direction and assistance without difficulty." T59:14-20.

That the court deemed V.M.'s medical decisions during pregnancy and labor relevant to the termination of parental rights is further confirmed by the court's discussion of V.M.'s credibility. For example, the court noted that V.M. maintained that she was not "ever against considering a c-section for delivery of [J.M.G.]." T8:4-6; see also T37:16-21 (noting "there was a claim that the parents also agreed to a separate release for the C-section procedure, if it was needed. Unfortunately, no other -- additional releases signed that they claim they did, for the C-section was retained and provided to the Court"); T47:13-14 (citing B.G.'s testimony that the parents reported signing "another form for consent, but . . . did not retain a copy of this"). The court further noted that "the accounts of the hospital and the parents" differed with respect to "other delivery procedures, steps such as the epidural." T37:24-38:2.

All of this evidence demonstrates that V.M.'s decisions during pregnancy and labor played a substantial role in the court's decision evaluating danger to the child under prong one of N.J.S.A. 30:4C-15.1a. As demonstrated further below, because N.J.S.A. 30:4C-15.1a(1) does not permit courts to consider such

information, the trial court's decision is not supported by clear and convincing evidence and must be reversed.

B. N.J.S.A. 30:4C-15.1a Does Not Apply to Pregnant Women and Their Fetuses.

Under the first prong of the statute, the Division must demonstrate that the "child's safety, health or development has been or will continue to be endangered by the parental relationship." N.J.S.A. 30:4C-15.1a(1). In interpreting this statutory provision, we begin, of course, with its text. State v. Bunch, 180 N.J. 534, 543 (2004). If that text "lends itself to only one interpretation and that interpretation is consistent with the overall legislative scheme," then the Court must "apply the statute as written." Ibid. That rule of construction recognizes that if the terms in a statute are unambiguous, they provide the clearest evidence of legislative intent. Ibid.

Here, the plain terms of New Jersey's termination of parental rights statute do not permit trial courts to consider pregnant women's medical choices in terminating parental rights because the statute only applies to parents and their children and says nothing about "pregnant women" or their "fetuses." N.J.S.A. 30:4C-15.1a(1); see N.J. Div. of Youth and Family Servs. v. L.V. and C.M., 382 N.J. Super. 582, 590 (Ch. Div. 2005) (analyzing analogous references to N.J.S.A. 9:6-8.21, governing abuse and neglect proceedings, and concluding that the

statute "clearly does not expressly include a fetus in its definition of a child, its protection does not extend to the child before birth").

Moreover, the terms "parent" and "child" are not ambiguous. Title 30 specifically defines "child" as "any *person* under the age of 18 years." N.J.S.A. 30:4C-2(b) (emphasis added). But it does not require a statutory definition to know that one does not become a parent until the birth of a child and a fetus does not become a person until birth. See Ohio v. Gray, 584 N.E.2d 710, 711 (Ohio 1992) (concluding common usage of "parent" and "child" did not include pregnant women or their fetuses). For that reason, New Jersey courts have consistently refused to consider fetuses "persons" or "children" without explicit legislative direction to do so.

For example, in Matter of D.K., 204 N.J. Super. 205, 212-14 (Ch. Div. 1985), the court refused to interpret New Jersey's civil commitment rules as authorizing the appointment of guardians to fetuses. In that case, a judge appointed a guardian ad litem for a fetus and entered an order restraining hospital personnel from "treating the mother with any medication potentially harmful to the fetus." Id. at 210. Reversing that order, the court held that the appointment of the guardian was unlawful because R. 4:74-7, which governs civil commitment procedures, does not apply to fetuses. Id. at 214. The court

reasoned that the plain language of the rule only permitted guardians ad litem for "an infant or alleged incompetent person" and a "fetus is not a person." Ibid.

Similarly, in Giardina v. Bennett, 111 N.J. 412, 428 (1988), the New Jersey Supreme Court refused to stretch the plain meaning of New Jersey's Wrongful Death Act, N.J.S.A. 2A:31-1, to provide a cause of action for a couple whose child was stillborn. The Court concluded that the language of the statute, which provides a cause of action "[w]hen the death of a person is caused by a wrongful act, neglect or default," by its terms applied only to living persons, and not to fetuses. Id. at 420-21. The Court noted that when the Legislature intends to address "the status and interests of an unborn child," it makes its intent clear. Id. at 421-22 (noting that the workers' compensation statute in 1911 defined dependents as including both "children" and a "child in esse"; that "decedent" in the Uniform Anatomical Gift Act was explicitly defined as a deceased person and a "stillborn infant or fetus;" and that the criminal homicide laws rejected the opportunity to classify a fetus as a "person").

Given the demonstrated ability of the Legislature to enact laws addressing the status of fetuses, had it intended to allow for the termination of parental rights based on harm or danger to fetuses, it would have done so. See State v. Ikerd, 369 N.J.

Super. 610, 623 (App. Div. 2004) (reversing trial court decision sentencing a pregnant woman with a drug problem to prison in order to protect her fetus because it was "contrary to the statute" and "usurped the powers of the legislature").[7]

Given the Legislature's explicit definition of "child" under N.J.S.A. 30:4C-2(b) as limited to living persons under age 18, and New Jersey courts' unwillingness to expand the meaning of legislative terms to include fetuses, a women's medical decisions during pregnancy and labor may not be considered in determining whether a "child's safety, health or development has been or will continue to be endangered by the parental relationship" under N.J.S.A. 30:4C-15.1a(1). By its terms, the statute only applies to parents and children, and not to pregnant women and their fetuses.

[7] Other jurisdictions have embraced similar reasoning when interpreting the meaning of criminal child abuse and neglect statutes. See, e.g., State v. Geiser, 763 N.W.2d 469, 473 (N.D. 2009) (reversing child endangerment conviction of woman who tested positive for methamphetamines and suffered a stillbirth because the plain meaning of the word "child" does not include a fetus); Kilmon v. State, 905 A.2d 306, 315 (Md. 2006) (noting that "it was not the legislature's intent" in Maryland that the child abuse statute "apply to prenatal drug ingestion by a pregnant women" and citing nearly universal agreement on that point by other jurisdictions); Reinesto v. Superior Court, 894 P.2d 733 (Ariz. Ct. App. 1995) (holding that ordinary meaning of "child" in child abuse law excluded fetuses and dismissing charges filed against woman for drug use during pregnancy); Sheriff, Washoe County v. Encoe, 885 P.2d 596 (Nev. 1994) (holding that application of child endangerment statute to a pregnant woman who used illegal substances would violate plain meaning of statute, deprive woman of constitutionally mandated due process notice and render statute unconstitutionally vague); People v. Morabito, 580 N.Y.S.2d 843, 846 (N.Y. City Ct. 1992) (holding mother could not be charged with endangering welfare of child based upon acts endangering unborn noting that "when our Legislature enacts laws concerning unborn children, it says so explicitly").

Moreover, as the New Jersey Supreme Court has recognized, courts may only judge the fitness of parents by evaluating whether they have "conducted [themselves] in a way that secured [the child's] safety." G.L., 191 N.J. at 608 (concluding that statutory standard for terminating parental rights was not met because "no proof was offered to suggest" that defendant ever acted in a way that would not secure her daughter's safety). Thus, courts may not consider evidence of a parents' life choices, personal shortcomings, or even bad behavior unless it is proven by clear and convincing evidence that such conduct bears on the safety of their child. The evidence in the record does not demonstrate harm or a threat of harm to the child by clear and convincing evidence, therefore, the trial court's determination under prong one must be reversed.

Furthermore, as the New Jersey Supreme Court noted in Guardianship of K.H.O., 161 N.J. 337, 348 (1999), "[a]lthough a particularly egregious single harm" may be relevant to prong 1 of N.J.S.A. 30:4C-15.1a, "the focus is usually on the effect of harms arising from the parent-child relationship over time on the child's health and development." But here it bears emphasis that V.M. and B.G. have never been given the opportunity to parent, and thus the court's analysis of "danger" under prong one was not based on the "parent-child relationship over time;" Rather, the court's analysis was entirely speculative and based

in part on V.M.'s medical decision-making at the hospital. The trial court, however, failed to explain how V.M.'s medical decision-making could ever qualify as a "particularly egregious single harm" under prong one of the best-interest-of-the-child standard. Id. For this reason too, the court's consideration of V.M.'s medical decisions during labor was improper, and the court's conclusion with respect to prong one is unsupported by clear and convincing evidence. Accordingly, the trial court's decision should be reversed.

C. The Trial Court's Consideration of a Pregnant Woman's Medical Choices During Labor Under the Best Interest of the Child Statute Is Contrary to the Legislature's Purpose.

Even if this Court were to conclude that either of the statutory terms "parent" or "child" in the termination statute was ambiguous, the trial court still erred because there is no evidence that the Legislature intended for the actions of pregnant woman to constitute "danger" to a "child" under N.J.S.A. 30:4C-15.1a. See Reyes v. Superior Court, 141 Cal.Rptr. 912 (Cal. Ct. App. 1977) (concluding that even if reference to "child" in California's child welfare law were deemed ambiguous, it was not intended to reach "prenatal conduct" because the law "presupposed the existence of a living child susceptible to care or custody").[8] When interpreting the

[8] See also People ex rel. H., 74 P.3d 494 (Colo. App. 2003) (holding that the civil dependency and neglect statute does not include the unborn child within

text of a statute, a court's "essential task is to understand and give effect to the intent of the Legislature." Pizzullo v. New Jersey Mfrs. Ins. Co., 196 N.J. 251, 263-64 (2008). Here, the Legislature made its intent explicitly clear. N.J.S.A. 30:4C-1 states:

> This act is to be administered strictly in accordance with the general principles laid down in this section, which are declared to be the public policy of this State, whereby the safety of children shall be of paramount concern:
>
> (a) That the preservation and strengthening of family life is a matter of public concern as being in the interests of the general welfare, but the health and safety of the child shall be the State's paramount concern when making a decision on whether or not it is in the child's best interest to preserve the family unit;

That provision makes evident that the Legislature intended to protect living children; it never contemplated policing the medical decisions of pregnant women where the "safety" and "general welfare" of children are not at issue. See ibid.; N.J.S.A. 30:4C-1.1. The legislative report that reformed New Jersey's Child Welfare Law only strengthens that interpretation.

The Interim Report of the Commission to Study Child Abuse and Other Aspects of Child Welfare Laws, released in 1971,

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its protection); Cox v. Court of Common Pleas, 537 N.E.2d 721, 722 (Ohio Ct. App. 1988) (holding that the juvenile court "has no jurisdiction to regulate the conduct of a pregnant adult for the purpose of protecting the health of her unborn child"); State ex. rel. Angela M.W. v. Kruzicki, 561 N.W.2d 729 (Wis. 1997) (holding that the Wisconsin Legislature did not intend to reach fetuses through the Children's Code).

declared that New Jersey "must assume responsibility for the welfare of children in trouble -- for children whose family situation endangers their welfare or who are endangering themselves or others." Concurrent Res. No. 86 at 1 (Nov. 15, 1971). And in discussing the need for the Commission to "carefully review [] laws regarding termination of parental rights" the Court emphasized the need to protect children, but never suggested pregnant women's actions should be considered in evaluating the "danger" posed by parents under prong (1) of N.J.S.A. 30:4C-15.1a. Id. at 20. Indeed, the Legislature spoke only about the need for "legal and social responses to children in trouble," ibid., and the need for the State to assume responsibility for "children whose family situation endangers their welfare." Clearly the Legislature never contemplated application of Title 30 to protect fetuses, which are not children and do not have a "family situation." Ibid. In fact, the Commission's report never mentions "fetuses" or "pregnant women" at all.

Moreover, the Commission cautioned that the child welfare system should only "intervene in family situations under laws and procedure that are based primarily on the condition of the child and not focused on assessing or assigning the guilt or responsibility for the child's plight." Id. at 15. Accordingly, the child welfare laws were never intended "to

punish the parent for past transgressions against the child in utero or in esse." Guardianship of A.A.M., 268 N.J. Super. 533, 549 (App. Div. 1993) (Kestin, J., concurring) (citing A.W., 103 N.J. at 591). Here, the trial court violated that fundamental tenet of New Jersey's Child Welfare regime, by penalizing both parents for V.M.'s decision not to preauthorize consent to cesarean surgery during labor, even though such surgery was never necessary and she gave birth naturally to a healthy baby girl.

In sum, the trial court's consideration of a pregnant woman's medical decision during labor was contrary to the purpose of the termination statute, and its decision should therefore be reversed.

II. THE TRIAL COURT ERRED BY FAILING TO HONOR PREGNANT WOMEN'S RIGHT TO MAKE THEIR OWN MEDICAL DECISIONS AND TO REFUSE MEDICAL INTERVENTIONS WITHOUT LEGAL PENALTY.

By considering V.M.'s medical decisions during pregnancy, including decisions regarding what information to disclose to her doctor, the trial court disregarded established law protecting the rights of pregnant women to make their own medical decisions and to refuse medical interventions. Those rights are rooted in well-settled constitutional, statutory, and common law governing informed consent and patients' rights.

As the New Jersey Supreme Court has recognized, "the right of a person to control his own body is a basic societal concept,

long recognized in the common law." Matter of Conroy, 98 N.J. 321, 346 (1985). Specifically, a patient's right to direct her own medical treatment is "[e]mbraced within the common-law right to self-determination." Matter of Quinlan, 70 N.J. 10, 41 (1976). That right, described in modern terms as the doctrine of informed consent, recognizes that "no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies." Conroy, supra, 98 N.J. at 346.

An inseparable element of the right to informed consent is the "right to informed refusal." Id. at 347 (citation omitted). Thus, the law has long recognized the rights of competent adults "to decline to have any medical treatment initiated or continued." Ibid. (citing Bennan v. Parsonnet, 83 N.J.L. 20, 22-23, 26-27 (Sup. Ct. 1912) (acknowledging "common-law rule that patient is 'the final arbiter as to whether he shall take his chances with the operation or take his chances of living without it'")); see also Schloendorff v. Society of New York Hosp., 105 N.E. 92, 129 (N.Y. 1914). In keeping with this age-old tradition, the Legislature, in 1989, enacted a patient "bill of rights," which codified the informed consent doctrine and explicitly protects the right of patients to refuse medical treatment. See N.J.S.A. 26:2H-12.8e; see also Liguori v. Elmann, 191 N.J. 527, 546 (2007).

In addition, both the United States and New Jersey Constitutions protect individuals' right to make decisions concerning their bodies, including medical decisions. See Quinlan, supra, 70 N.J. at 40. Specifically, the Fourteenth Amendment of the Constitution of the United States and Art. I, par. 1. of the New Jersey Constitution of 1947 protect an individual right to privacy, which encompasses the right to consent to or decline medical treatment and surgical procedures. Ibid.; see also Winston v. Lee, 470 U.S. 753, 759 (1985)(noting "compelled surgical intrusion into an individual's body . . . implicates expectations of privacy and security of such magnitude" that court could not order suspect to submit to surgery in order to recover evidence of crime). This right to privacy and self-determination generally outweighs any countervailing state interests, such that competent persons may "refuse medical treatment, even at the risk of death." Conroy, supra, 98 N.J. at 353. These rights are possessed equally by women, including those who become pregnant and carry to term. In re A.C., 573 A.2d 1235, 1243-44 (D.C. 1960) (overturning lower court's order authorizing hospital to perform cesarean surgery without first determining whether terminally ill woman consented, reasoning that "a fetus cannot have rights in this respect superior to those of a person who has already been born"); see also Right to Choose v. Byrne, 91 N.J. 287, 310

(1982) (recognizing pregnant women's medical interests as superior to their fetuses).

By considering a woman's refusal to consent to cesarean surgery in analyzing whether termination of parental rights was warranted, the trial court ignored those fundamental principles. It also departed in a dramatic and alarming way from New Jersey precedent condemning the use of child welfare laws to interfere with pregnant women's medical decisions, or penalize women as a result of those decisions. Indeed, until now, New Jersey courts have never permitted the State to interfere with pregnant women's medical decisions through the child welfare regime.

For example, in L.V. and C.M., supra, 382 N.J. Super. at 590, the court held that New Jersey's abuse and neglect law "does not and cannot be construed to permit government interference with a woman's protected right to control her body and her future during her pregnancy." In that case, DYFS sought to remove a child from the custody of her mother based solely on the mother's refusal to take certain HIV medications during her pregnancy. Id. at 585. DYFS argued, mirroring its argument in the previous abuse and neglect proceeding in this matter, that the woman's refusal to submit to treatment constituted abuse and neglect of a child because the medications could have "reduce[d] the risk that the baby would be born HIV positive." Ibid. The trial court rejected that argument, holding that the mother's

choices during pregnancy "related solely to recommended medical treatment" and decisions about treatment are "protected from any interference" from the child welfare system. Id. at 591.

Recognizing the coercion that would result if women face sanctions through the child welfare regime for refusing to consent to medical procedures or recommendations, the court reasoned that the Division cannot hold "the Act's provisions over her head as a 'Sword of Damocles.'" Ibid. According to the court:

> [t]he decisions she makes as to what medications she will take during her pregnancy . . . are left solely to her discretion after consultation with her treating physicians. The right to make that decision is part of her constitutional right to privacy, which includes her right to control her own body and destiny. Those rights include the ability to refuse medical treatment, even at the risk of her death or the termination of her pregnancy.
>
> [Id. at 591.]

Similarly, in Matter of D.K., supra, 204 N.J. Super. at 212-214, the court recognized that the State may not infringe upon the right of pregnant women to direct their own medical decisions. The court ruled that the appointment of a guardian ad litem for a fetus and a court order restraining the pregnant woman from freely taking medication impermissibly invaded her "medical province" and unconstitutionally "made a choice between [her], a person, and her fetus, a nonperson, favoring the

latter." Id. at 217. Other courts have similarly rejected the elevation of a fetus's interests over those of a pregnant woman. See In re Fetus Brown, 689 N.E.2d 397, 400 (Ill. App. Ct. 1997) (holding that "State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus"); In re Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994) ("[A] woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus.").

Even if this Court were to depart from this precedent and deem the interest of a fetus to be that of a person, the law would still preclude the State from applying its child welfare laws to this context. As other jurisdictions have recognized, courts may not "compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person's health." In re A.C., supra, 573 A.2d at 1243-44 (citing McFall v. Shimp, 10 Pa.D. & C.3d 90 (Allegheny County Ct. 1978) (refusing to order man to donate bone marrow necessary to save life of his cousin)). Those decisions "reject any notion that pregnancy somehow deprives a woman of legal protection from compelled physical sacrifice." S.F. Adams et

al., Refusal of Treatment During Pregnancy, 30 Clinics in Perinatology 127, 128 (2003).

Here, in contravention of those principles, the trial court, in terminating parental rights, improperly considered V.M.'s refusal to preauthorize cesarean surgery, as well as what information she chose to share with her OB-GYN. The court's error began with its inappropriate suggestion that patients must "take direction" from doctors "without difficulty." T59:19-20. Because of patients' statutory and constitutional right to informed consent, there was no basis in law for the court to view such facts as a measure of parental fitness. This is particularly salient given that V.M.'s decision not to reflexively "take direction" from doctors proved to be the correct one for her and her family, as she gave birth vaginally to a healthy baby girl. Given the risks of cesarean surgery and the positive outcome of the natural birth here, it arguably would have been more appropriate for the court to have viewed V.M.'s medical decision as a predictor of safe and appropriate parenting decisions in the future, rather than drawing the opposite inference, as it did here. T53:23-25.

Moreover, the court also reasoned that "it's important to note that, admittedly [V.M.] and [B.G.] never did advise" V.M.'s original OB-GYN or the one who was on-call during the delivery "of the previous or prior mental health treatment of an

extended period through Dr. Seltzer," which the court deemed necessary for the hospital to know "in dealing with the concerns and situation of the delivery itself." T38:12-21. But the court never explained why V.M. or her husband were compelled to reveal her mental health history given that the hospital was required to respect the medical choices of a competent pregnant woman, which two hospital psychiatrists unquestionably found V.M. to be, notwithstanding any psychiatric issues. Nor did the court explain how the parents, by not volunteering this information until asked by the evaluating psychiatrists, in any way put a "child" in danger or indicated that they would endanger the child in the future.

Similarly, the court's consideration of V.M.'s failure to advise her OB-GYN of her mental health history as a "compounding failure" that was revealing of how she would "deal[] with other authority figures into the future," T71:20-72:4, was also a totally inappropriate consideration under the statute. A pregnant woman's decisions about her relationship with her doctor and what information to share with her OB-GYN are hers alone to make, and simply have no connection with whether a "child's safety, health or development has been or will continue to be endangered" on account of conduct by the parents. N.J.S.A. 30:4C-15.1a(1).

If allowed to stand, the trial court's decision will not only sanction a profound injustice for V.M. and her family, it will also set a dangerous precedent, suggesting to doctors and others that pregnant women do not have the same common law, statutory, and constitutional rights to medical decision-making, including the right to refuse invasive surgery, as all other persons. Such a holding would run afoul of equal protection guarantees and women's due process rights to privacy protected under the state and federal constitutions. See Quinlan, supra, 70 N.J. at 40; Byrne, supra, 91 N.J. 287 at 305-06. It would also impermissibly infringe on the child's constitutional right not to be unnecessarily separated from the "love and comfort" of her natural parents, N.J. Div. of Youth and Family Servs. v. G.M., 398 N.J. Super. 21, 48 (App. Div. 2008); see also N.J. Div. of Youth and Family Servs. v. A.R.G., 179 N.J. 264, 286 (2004), undermining the State policy that "[c]hildren should be raised by their own families whenever possible," N.J.S.A. 30:4C-74. Accordingly, the trial court's decision should be reversed.

III. THE TRIAL COURT'S FAILURE TO HONOR PREGNANT WOMEN'S RIGHT TO REFUSE MEDICAL INTERVENTIONS WAS INCONSISTENT WITH PREVAILING MEDICAL, PUBLIC HEALTH, AND BIO-ETHICAL STANDARDS.

The trial court's holding that a doctors need not respect pregnant women's medical decision-making and may instead view a woman's refusal to consent to cesarean surgery as a form of

parental unfitness or an act that endangers the "safety" of a child not only lacks a basis in law, but is also contrary to prevailing standards of medical ethics and public health. Indeed, leading authorities in those fields agree that the use of punitive policies to coerce pregnant women to follow particular treatment recommendations is both inappropriate and detrimental to maternal and fetal health.

A. Leading Medical Institutions Recognize Pregnant Women's Right to Informed Consent.

A range of government agencies and independent health experts have embraced policies that protect and advance the rights of patients —— including pregnant women —— to make their own medical decisions and to refuse treatment and interventions. Those experts agree that "in all but the most extreme circumstances, it is impermissible to infringe upon the pregnant woman's autonomy rights." Michelle Oberman, Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts, 94 Nw. U.L. Rev. 451, 452-53 (2000). For example, the Joint Commission, an independent organization that accredits and certifies health care organizations and programs nationwide, requires hospitals to inform their patients that they "have the right to make decisions about [their] care, including refusing care" and have "the right to be listened to."

Joint Commission, Speak Up: Know Your Rights 4 (2008).[9] Similarly, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry has adopted a "consumer bill of rights and responsibilities" that requires hospitals to "give patients the opportunity to refuse treatment." Advisory Commission On Consumer Protection and Quality in the Health Care Industry, Consumer Bill Of Rights And Responsibilities, Ch. 4 (1997).[10] The Commission reminds providers that they must "abide" by patients' decisions. Ibid. And the United States Department of Health and Human Services, which outlines standards of care for hospitals participating in Medicaid or Medicare, also requires providers to recognize the rights of patients to "request or refuse treatment." See 42 C.F.R. 482.13(b)(2) (2007). None of these standards exempts pregnant women.

As the American Medical Association ("AMA") and the American College of Obstetricians and Gynecologists ("ACOG") have noted, the standard of informed consent applies equally to women at all stages of their pregnancies. The ACOG Committee on Ethics has explained that "[p]regnancy does not obviate or limit the requirement to obtain informed consent." ACOG Committee on Ethics, Maternal Decision Making, Ethics, and the Law: ACOG

[9] available at http://www.jointcommission.org/PatientSafety/SpeakUp/sp_rights.pdf.

[10] available at http://www.opm.gov/insure/health/cbrr.htm#exec

Committee Opinion No. 321 (2005) [hereinafter "ACOG Ethics Opinion No. 321"]. The AMA has similarly made clear that, because most medical interventions aimed at benefiting the fetus often pose significant risks to pregnant woman's health, the physician's duty is to provide information to enable an informed decision, "not to dictate" her choice. Helene M. Cole, M.D., Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663 (1990) [hereinafter Legal Interventions During Pregnancy].

Here, the trial court ignored this fundamental tenet by questioning whether "the parents [would] apply the same attitude or approach toward the selected pediatrician" as they had in their interactions with hospital staff and others "and take their direction and assistance without difficulty." T59:14-20. As these authorities make clear, the trial court's reasoning not only ignored the law of informed consent, but also provided a legal basis for medical coercion directly at odds with the best professional, medical and public health practices. As such, this Court should not permit the decision to stand.

B. Leading Medical Institutions Denounce Practices that Coerce Pregnant Women to Consent to Medical Advice As Unethical and Damaging to Maternal and Fetal Health.

Beyond issues of informed consent, both the AMA and ACOG specifically discourage measures that would coerce pregnant women to follow their doctors' medical recommendations, recognizing that overriding patient choice through threats of any kind is unethical and undermines maternal and fetal health. As a matter of ethics, the AMA has made clear that "decisions that would result in health risks are properly made only by the individual who must bear the risk." Legal Interventions During Pregnancy, supra, at 2665.

In particular, the AMA has concluded that doctors should not "deprive[] a pregnant woman of her right to reject personal risk and replace[] it with the physician's evaluation of the amount of risk that is properly acceptable." Ibid. Similarly, the ACOG Ethics Committee has condemned "actions of coercion to obtain consent or force a course of action" because it limits a patient's right to self-determination and undermines the principle of informed consent. ACOG Committee on Ethics, ACOG, Patient Choice: Maternal-Fetal Conflict: ACOG Committee Opinion No. 55 (1987) [hereinafter "ACOG Ethics Opinion No. 55"].

These opinions recognize that coercing pregnant women to accede to medical advice is unethical because doctors cannot

always accurately predict birth outcomes or know what is best for a patient. ACOG Ethics Opinion No. 321, supra, at 1131; see also Veronica E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 New Eng. J. Med. 1192, 1195 (1987) [hereinafter "Court-Ordered Interventions"] (describing study of court-ordered obstetric interventions which found that in almost one third of cases in which court orders were sought to force pregnant women to undergo medical procedures, the medical judgment proved to be unnecessary or incorrect).

Indeed, courts risk grave consequences when they interfere with women's medical choices based on the invariably uncertain judgments of medical providers. For example, in a decision now widely repudiated and considered unconstitutional, Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981)(denying motion for stay of order on appeal), a court ordered a woman to submit to cesarean surgery based on a physician's claim during an "emergency" proceeding, in which the pregnant woman did not appear, that without the surgery there was a 99 to 100 percent chance of fetal death. Before the surgery could be performed, the pregnant woman fled and, despite the dire prediction, had a safe vaginal delivery. See Legal Interventions During Pregnancy, supra, at 2664; see also Robert N. Berg, Georgia Supreme Court Orders Cesarean Section – Mother Nature Reverses on Appeal, 70 J. Med. Ass'n Ga. 451 (1981).

Because it is impossible for doctors to guarantee that a pregnant woman will not be harmed by a given medical intervention, ACOG has cautioned doctors to carefully present "a balanced evaluation of expected outcomes" and honor pregnant women's right "to weigh the risks and benefits." ACOG Ethics Opinion No. 321, supra, at 1133.

More fundamentally, medical and public health authorities agree that departing from those standards and treating pregnant women's informed refusal of medical advice as relevant to their fitness as a parent drastically transform the doctor-patient relationship at the expense of maternal and fetal health. Interpreting a pregnant woman's medical decision as "danger" to her child would suggest an obligation on the part of physicians to report pregnant women who do not consent to cesarean surgery to child welfare authorities. See N.J.S.A. 9:6-8.10 (stating "any person" with "reasonable cause to believe a child has been subjected to child abuse . . . shall" report the abuse to DYFS) (emphasis added). As a result, the role of obstetricians would be transformed from "independent patient counselor[s]" to "agent[s] of the state," rendering the hospital setting for pregnant women adversarial, rather than supportive. Legal Interventions During Pregnancy, supra, at 2665.

That transformation would fundamentally run counter to the purpose of the medical profession. As the AMA has explained,

"[a] physician's role is as a medical adviser and counselor. Physicians should not be responsible for policing the decisions that a pregnant woman makes that affect the health of herself and her fetus." Ibid. Moreover, judicial intervention in this context could render nearly every decision a pregnant woman makes subject to scrutiny by her doctors and the courts. See Court-Ordered Interventions, supra, at 1195. It would open the door to other court-ordered interventions in pregnant women's medical decision-making and could lead to forced prenatal care and health restrictions. Ibid. (describing how a precedent sanctioning forced cesareans could later permit courts to dictate pregnant women's diet, work, and athletic activities).

Moreover, as both the AMA and ACOG have recognized, adversarial or coercive doctor-patient relationships risk harm to the health of both pregnant women and their future children by "precipitat[ing] general distrust of physicians on the part of pregnant women." Legal Interventions During Pregnancy, supra, at 2665. Women may withhold information from their doctors if they believe it could lead to judicial intervention or may avoid medical care altogether. Ibid. As a result, doctors' ability to provide effective prenatal care would be undermined. Ibid. A public policy that foments pregnant women's distrust of doctors is counterproductive, particularly where experts recognize that "[e]ncouraging prenatal care and

treatment in a supportive environment" is most likely to advance maternal and child health. ACOG Ethics Opinion No. 321, supra, at 1134.

Here, the court's reliance upon of the "lack of cooperation during the delivery procedure" T6:13-14, reveals an alarming failure to acknowledge V.M.'s right to refuse treatment, implying that hospitals may use coercive measures such as requiring multiple psychiatric evaluations to respond to a pregnant patient's "refusal to sign a consent for [a] C-section." T9:4-5. The court also inappropriately blamed V.M. for the hospital's insistence that she consent to the surgery. T88:9-13. ("Why then cannot this Court attribute a certain degree of responsibility to [V.M.'s] failure to alert Dr. Cohen or – and/or admitting hospital staff of the long standing PTSD problems that she was quite aware of. . ."). But the fact that hospital staff were unaware of V.M.'s right to refuse cesarean surgery until they consulted with an administrator is revealing of the coercive environment in which V.M. gave labor. As a result of her firm decision not to preauthorize all possible interventions and the doctors' relentless efforts to get her to do so, V.M. grew increasingly angry and frustrated, on top of the typical pain, emotion, and fear that generally accompanies labor and childbirth. Rather than accept her steadfast refusal to sign the consent, hospital staff repeatedly pressured her to

consent, and characterized her consequent behavior as "erratic," "non-compliant," "uncooperative," "inappropriate," and "combative."[11]

Moreover, in addition to V.M.'s refusal to preauthorize cesarean surgery, both parents' subsequent refusal to agree with hospital personnel that her decision was inappropriate may also have influenced the Court's decision. Sociologist Jennifer Reich has observed that social workers and judges typically do not trust parents to regain custody of their children unless they demonstrate that they "explicitly accept responsibility for the event or lifestyle that brought the family into the [child welfare] system." Jennifer A. Reich, Fixing Families: Parents, Power, and the Child Welfare System 225 (2005). Here, V.M. and B.G. were unwilling to do so because they correctly viewed V.M.'s decisions during labor as irrelevant to their fitness as parents, and for that matter, protected from interference by the state as a matter of statutory and constitutional law.

In addition, the court impermissibly considered V.M.'s reaction to having her newborn taken away from her at the hospital, an improper consideration under N.J.S.A. 30:4C-15.1a. The court concluded that V.M.'s decision to "call the Livingston police," after she learned that DYFS was taking her newborn went

[11] Brief of Plaintiff-Respondent Department of Youth And Family Services, filed in DOCKET NO. A-04627-06T4, at 1-2.

"beyond the usual bounds of conduct within a hospital setting." T38:5-11. While V.M.'s decision to call the police may seem extreme in hindsight, it bears emphasis that this was the response of a mother, who while still depleted and recovering from child birth after having to resist the pressure of the hospital staff to consent to a surgery she ultimately did not need, had just been informed that the Division would be taking away her newborn. V.M. believed that her fundamental rights had been violated and sought help from the police. The fact that the court considered this information at all is telling, given that V.M.'s reaction to losing her daughter has no relevance whatsoever to whether V.M. put her "child's safety" at risk. As the New Jersey Supreme Court has noted, "[t]he primary focus of the court should be upon harm for which there is unambiguous and universal social condemnation." A.W., supra, 103 N.J. at 604 (internal citation and quotation marks omitted) (citing physical and sexual abuse as examples). V.M.'s behavior, even if unpleasant or inconvenient for the hospital staff, is not "harm for which there is 'unambiguous and universal social condemnation.'" Id. She was upset about losing her child; certainly, this emotion ought not be condemned at all, let alone subject to universal social condemnation.

Moreover, as this Court noted in N.J. Division of Youth and Family Servs. v. R.L., 388 N.J. Super. 81, 102 (App. Div. 2006),

while a parent's "hostility toward DYFS and hospital personnel [may be] of concern," that fact does not reflect on his or her "ability to parent his child" unless there is evidence that the child's safety has been or will be compromised. Here, the record is devoid of any evidence that V.M. or B.G. ever acted violently or neglectfully toward their child or that they would ever place the child in harm's way. Purported threats to a child's safety or welfare that are "based on speculation and not on clear and convincing evidence" are unquestionably insufficient under the clear and convincing rubric of N.J.S.A. 30:4C-15.1a(1). G.L., 191 N.J. at 608 ("[P]resumptions have no place in a termination analysis."). These precepts are particularly relevant in the instant matter given that the parents have never had any opportunity to parent their child. Thus, there is absolutely no evidence in the record that V.M. and B.G. ever did anything to put their child at risk and the trial court's predictions about harm to the child are, therefore, entirely speculative and rooted in assumptions based upon V.M.'s choices during labor, and her reaction to having her newborn taken from her at birth.

In sum, the trial court's assessment of the danger posed by the parents based on the mother's refusal "cooperate" with hospital staff during delivery is contrary to the best practices of medical and public health experts. Those authorities

recognize that coercive medical interventions do not promote the interest of pregnant women or their fetuses. Rather, the threat of child welfare penalties sends an unfortunate and even perilous message to pregnant women not to seek prenatal care, and to give birth without the assistance of health professionals. In short, coercive treatment undermines maternal and fetal health.

IV. A WOMAN'S REFUSAL TO CONSENT TO CESAREAN SURGERY IS NOT IRRATIONAL OR NEGLIGENT BECAUSE CESAREAN SURGERY IS AN INVASIVE AND RISKY INTERVENTION THAT IS OFTEN UNNECESSARILY PRESCRIBED.

A. Cesarean Surgery Is a Major Surgical Intervention That Poses Serious Risks.

In deeming a pregnant woman's decision not to consent to cesarean surgery "negligent," Matter of J.M.G., supra, 2009 WL 2044826 at *4 (Carchman, J., concurring), the trial court in the abuse and neglect proceeding failed to appreciate that cesarean surgery is a major surgical intervention with serious risks for both the pregnant woman and her fetus. By suggesting that V.M.'s choices during birth reflected a "problem with authority figures" or a likelihood to put her child at risk in the future, the trial court in this proceeding similarly embraced a fundamental misconception regarding the risks and benefits of cesarean surgery. Specifically, the court failed to appreciate that cesarean surgery is a major surgical intervention with

serious risks, which, a person may rationally decide, is in her —— and her fetus's —— best interest to avoid.

In particular, medical research suggests that cesarean delivery is often more dangerous than vaginal delivery. See Williams Obstetrics, 592 (22nd ed. 2005) (noting that with cesarean surgeries "[m]aternal morbidity is increased dramatically" and "rehospitalization in the 60 days following cesarean delivery was nearly twice as common as after vaginal delivery"). For pregnant women, the many risks of cesarean surgeries under the most rigorous medical supervision include infection, hemorrhage, thromboembolism, bladder and uterine lacerations, and even death. Id.

In fact, a recent, comprehensive, nationwide analysis of modern maternity care released by the Milbank Memorial Fund and others found that "cesarean section has potential for great harm when overused." Carol Sakala & Maureen P. Corry, Evidence-Based Maternity Care: What It Is and What It Can Achieve 44 (2008) [hereinafter "Milbank Report"]. That report noted that "maternal death, emergency hysterectomy, blood clots and stroke . . . poor birth experience, less early contact with babies, intense and prolonged postpartum pain, poor overall mental health and self-esteem, poor overall functioning" were more likely to occur with cesarean surgeries than vaginal birth. Ibid. Cesarean surgery also poses risks for a woman's future

reproductive life, increasing the risk of involuntary fertility and future deliveries marked by low birth weights, preterm births, and stillbirths. Id. at 46.

Other life-threatening complications arising in future pregnancies include rupture of the uterus along the scar, premature separation of the placenta from the uterine wall and abnormal attachment of the placenta. Peter S. Bernstein, Complications of Cesarean Deliveries, Medscape, Sept. 19, 2005 (internal citations omitted). Any of those complications can cause hemorrhage, require emergency hysterectomy, or result in the death of the mother. Cesarean surgery presents significant risks to fetuses as well: babies delivered via cesarean surgery are four times more likely to die before discharge, three times more likely to have respiratory difficulties, including asthma, and may suffer scalpel lacerations during the surgery. Id.

Apart from the numerous risks to a woman's physical health posed by cesarean surgery, there are also mental health risks that have largely gone unrecognized by the medical and public health community until recently. Poor birth experience, whether vaginal or surgical, may lead to feelings of confusion, distress, and anger. But a recent survey found that mothers who underwent cesarean surgery were even more likely to feel frightened, helpless, and overwhelmed while giving birth. Nicette Jukelevics, Understanding the Dangers of Cesarean Birth:

Making Informed Decisions 60 (2008). In addition to Post-Partum Depression (PPD) and temporary dysphoria, current research indicates that up to 6 percent of women meet clinical criteria for Post-Traumatic Stress Disorder ("PTSD") as a result of their experiences during birth, which is often precipitated by increased obstetrical interventions such as cesarean surgery and feelings of powerlessness in her birthing experience. Cheryl Tatano Beck, Post-Traumatic Stress Due to Childbirth: the Aftermath, 53 Nursing Res. 216 at 223-224 (July/Aug 2004); Jukelevics, Understanding the Dangers of Cesarean Birth, supra, at 62-63 (noting that how a woman is treated by healthcare personnel or perceives her experience during birth can bear upon the trauma and strain mother-infant bonding). Significantly, the PTSD effects of birth trauma are similar to the symptoms experienced by persons who have undergone other frightening or overwhelming medical procedures such as open-heart surgery or cancer treatment. Id. at 63.

In light of the serious risks associated with cesarean surgery to both the mother and fetus, appellant's decision to withhold her consent to surgery simply cannot be considered a basis to terminate her parental rights, particularly where she correctly judged that the procedure was unnecessary. Mere disagreement —— no matter how vociferous —— with hospital personnel evinces not a disregard for the safety of her child,

but rather a conscious assessment of the associated risks. It bears reiteration that the record never indicated that a cesarean surgery was necessary, nor did V.M. indicate that she would refuse the surgery if it became necessary: the request for her consent was made as a matter of efficiency for hospital personnel, who sought blanket consent to all possible interventions in advance. V.M.'s desire to avoid unnecessary and possibly traumatizing surgical intervention was neither dangerous nor irrational. It was reasonable to protect her own physical and mental health and her ability to bond with her daughter in the immediate postpartum period.

In short, nothing about a woman's opposition to unnecessary medical interventions should create an inference that she will endanger her child in the future. And, to the extent that the trial court presumed that a doctor would not recommend cesarean surgery unless its benefits outweighed its risks, ample evidence-based research undermines that assumption as well.

B. Evidence-Based Research Suggests that Many Cesarean Surgeries Are Not Medically Necessary Or Advisable, Particularly in New Jersey.

In suggesting that V.M. should "take direction" from doctors "without difficulty," and that her conduct evidenced an inability to safely parent her child, the trial court assumed that doctors only seek consent to cesarean surgeries in urgent, life-threatening circumstances. While amici agree that cesarean

surgery can be a beneficial and life-saving procedure in certain circumstances, evidence-based research makes clear that cesarean surgery is often performed in many non-emergent situations and is often unnecessary. See Milbank Report, supra, at 41-48.

In fact, cesarean surgery rates in the United States have reached levels far beyond those recommended by national and international health organizations. See World Health Organization, United Nations Children's Fund, United Nations Population Fund, Guidelines for Monitoring the Availability and Use of Obstetric Services 25 (1997); see also Milbank Report, supra, at 42 ("Recent analyses substantiate the World Health Organization's recommendation that optimal national cesarean rates are in the range of 5 percent to 10 percent of all births and that rates above 15 percent are likely to do more harm than good.") (internal citations omitted). The number of cesarean surgeries in the United States increased by 50 percent between 1996 and 2006, Nat'l Ctr. for Health Statistics, U.S. Dep't of Health and Human Serv., Health United States 2008 70 (2009), and according to the most recent data by the CDC, 31.8 percent of babies in America were delivered surgically in 2007. Brady E. Hamilton et al., Births: Preliminary Data for 2007 Nat'l Vital Statistics Rep., March 18, 2009 at 3.[12] This record-breaking cesarean rate marks the eleventh consecutive year of increase,

[12] available at http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf

with no signs of abatement. Id. Indeed, the U.S. Department of Health and Human Services notes "total cesarean rates are likely to rise further[.]" Health United States 2008, supra at 70.

Moreover, the increase in New Jersey's cesarean surgery rate outpaces the national trend. Over 20 years ago, well before the spike in cesarean rates of the last decade, New Jersey's rates were sharply on the rise. See Sandra S. Friedland, Rise In Caesarean Births Stirs Dispute, N.Y. Times, (Dec. 31, 1981) (noting that steep rise in New Jersey led many to question whether cesareans are performed too frequently). Today, New Jersey's rates are among the highest in the country. Shannon Mullen, Caesareans Rising: C-section Rates Have Been Steadily Increasing — and There's No Change In Sight, Asbury Park Press (Jan. 17, 2006) (noting that New Jersey's rate "perennially leads the nation"). The Star Ledger, which maintains a database on its website analyzing rates of cesareans surgeries in New Jersey, has noted that hospitals in the state "are performing Caesarean section deliveries at an ever-increasing rate." The Star Ledger, Giving Birth in New Jersey (2006).[13] Compared to national figures, which show that cesarean surgeries account for 30.3 percent of all births, New Jersey's rate of cesarean surgery is higher, at 36.3 percent of all

[13] available at http://www.starledger.com/str/indexpage/environment/hospitals.asp.

births in the state. Milbank Report, supra, at 18. Only Louisiana has a higher rate of 36.8 percent. Ibid.

Significantly, the percentage of births that are cesarean surgeries at St. Barnabas Medical Center —— the hospital where appellant gave birth —— is even higher than the state's percentage. The most recent data puts the New Jersey cesarean rate for 2008 at 39.4 percent and, significantly, St. Barnabas Medical Center at a staggering rate of 49.3 percent. New Jersey Center for Health Statistics, Births by Facility and Prior Cesarean Status, Breech Status, Method of Delivery, and Attendant, New Jersey Occurrences, 2008 (2009)(on file with counsel); see also, Giving Birth in New Jersey (2006) (noting 2006 figure that 43 percent of all births at St. Barnabas were performed by cesarean surgery). Those rates suggest that cesarean surgeries are performed in New Jersey, and specifically at St. Barnabas, in situations where they may not be medically necessary or even advisable. See, e.g., Oberman, supra, 94 Nw. U.L. Rev. at 451-501; Milbank Report, supra, at 41 ("The absolute indications for cesarean section apply to a small proportion of births, yet rates of cesarean section are steadily increasing in the United States."); Howard Minkoff & Frank A. Chervenak, Elective Primary Cesarean Delivery, 348 New Eng. J. Med. 946 (2003) (describing risks and benefits of "elective" cesarean delivery).

Indeed, some experts have suggested that increased rates of cesarean surgery are the result of a belief among hospitals and medical professionals that the procedure is "efficient and lucrative." Milbank Report, supra, at 44 (internal citations omitted). For example, New Jersey Medicaid reimburses providers at a higher rate for a cesarean delivery than for a vaginal delivery, creating a disincentive for doctors to attend vaginal births, which may be prolonged or unpredictable or may occur at inconvenient times. New Jersey Dep't of Human Serv., Div. of Medical Assistance and Health Serv., Medicaid Eligibility and Services Manuals, Chapter 10-54, Physician's Services, at 359, 361 (2006) (showing reimbursement of $465 for a vaginal delivery, but $595 for a surgical delivery, exclusive of all the other costs attendant to a cesarean surgery that do not accompany vaginal delivery).[14]

Others note that cesarean surgeries are "widely viewed as reducing risk for malpractice claims and suits" even if such practices are not in the interests of pregnant women and their children. Ibid. (citing C.J. Lockwood, Why the CD Rate Is on the Rise (Part 1), 49 Contemporary Ob/Gyn 8 (2004)). In

[14] available at http://www.state.nj.us/humanservices/dmahs/info/resources/manuals/10-54_Manual.pdf This practice is being discontinued in some states both to reduce healthcare costs and to improve maternity services by realigning incentives. Caroyln McConnell, Take Away the Incentives for Too Many C-Sections, http://crosscut.com/2009/08/06/health-medicine/19144 (August 10, 2009).

addition, the increased rate of cesarean surgery among younger women, who are more likely to have subsequent pregnancies, exacerbates the overall increase in cesarean surgery because "the overwhelming majority of women who have a first cesarean go on to have repeat cesareans with subsequent births." Health United States 2008, supra, at 70. Although the American College of Obstetricians and Gynecologists recommends that most women be offered vaginal birth after cesarean section (VBAC), Am. Coll. Obstetricians & Gynecologists, Vaginal Birth After Previous Cesarean Delivery, ACOG Practice Bulletin 54, at 6 (2004),[15] only 7.2 percent of New Jersey women with a prior cesarean delivered vaginally in 2008, Births by Facility and Prior Cesarean Status, supra, and 23 percent of hospitals either ban VBAC or do not have doctors who attend VBAC on staff. See New Jersey Center for Health Statistics, Births by Facility and Prior Cesarean Status, supra; International Cesarean Awareness Network, VBAC Policies in U.S. Hospitals, http://ican-online.org/vbac-ban-info.

Moreover, contrary to the assumptions underlying the trial court's conclusion that appellant should be compliant when it comes to the medical advice of "authority figures," T72:3-4, research reveals that increased rates of cesarean surgeries do not necessarily produce overall better birth outcomes. World

[15] available at http://www.acog.org/acog_districts/dist9/pb054.pdf.

Health Organization data indicate that the United States' maternity care performance with respect to rates of maternal and neonatal mortality, low birthweights, and perinatal mortality is "disappointing when compared with other nations." See Milbank Report, supra, at 17. Although U.S. rates of cesarean surgery "far exceed" those of other first world nations, in the United States those figures "are not accompanied by higher rates of infant survival." Oberman, supra, 94 Nw. U.L. Rev. at 451-501.

For example, the U.S. has a maternal mortality rate approximately equal to that of Slovenia, which has a cesarean rate of 12 percent. Lauren Plante, Mommy, What did you do in the Industrial Revolution: Meditations on the Rising Cesarean Rate, 2 Int'l J. of Feminist Approaches to Bioethics 140 (Spring 2009) (internal citations omitted. Indeed, "[t]here has been little progress in lowering the U.S. infant mortality rate" since 2000, whereas the cesarean delivery rate has increased by 38 percent in the same timeframe. Health United States 2008, supra at 48, 136.

Cesarean surgery is also extremely costly to the U.S. healthcare system. Milbank Report, supra, at 12, (citing Agency for Healthcare Research and Quality 2008). Today, about 21 percent of all hospital discharges among females ages 18-44 listed cesarean surgery as a procedure experienced during the hospital stay. Health United States 2008, supra at 387. Because

maternity practices that were developed solely to address particular problems during birth are now "used liberally and even routinely in healthy women," the U.S. healthcare system has been saddled with staggering costs associated with unnecessary maternal interventions. Milbank Report, at 4, 12.[16] This has been described as the "perinatal paradox: doing more and accomplishing less." Id. at 3.

While there is much debate within the medical and public health community about the reason for the high rate of cesarean surgery in the United States, there is no disagreement that cesarean surgery is a costly, major surgical intervention with significant consequences for pregnant woman and their fetuses. Given that such surgery is an invasive procedure with a host of potential risks and negative consequences, the trial court erred by considering appellant's decision to refuse to preauthorize such surgery, and by viewing her exercise of informed consent, as indicative of a problem with authority figures. The court failed to recognize that it is entirely rational for a pregnant

[16] For example, six of the ten most common procedures billed to Medicaid and to private insurers in 2005 were maternity-related interventions, with cesarean surgery being the most common operation billed for both Medicaid and private payers. Milbank Report, supra, at 12, (citing Agency for Healthcare Research and Quality 2008). These interventions are costly because they often require additional "co-interventions to monitor, prevent, or treat side effects" and are "associated with risk of maternal and newborn harm" which greatly adds to costs. Id. at 35. One analysis concluded that if the U.S. cesarean rate reflected actual medical need there would be savings of more than $2.5 billion to the health care system. Id. at 47 A legal precedent that reinforces existing cesarean surgery rates or encourages even more surgeries would have significant financial consequences for the U.S. healthcare system.

woman to decide that she should only agree to cesarean surgery as a last resort.

C. A Woman's Refusal to Consent to Cesarean Surgery Is In No Way Indicative of Parental Unfitness.

By considering V.M.'s medical decisions during labor in assessing parental fitness, the trial court erroneously dismissed the many rational reasons described in this brief that a woman would choose not to consent to cesarean surgery. In fact, in making the medical decision that she did, appellant became a member of an increasingly vocal group of rational women and mothers in New Jersey and across the U.S. who are concerned about the risks of cesarean surgery and resolute in their determination not to be pressured into unnecessary surgery.

The New Jersey chapter of the National Organization for Women recently launched the "Worst to First 2010" campaign to educate women about the consequences of cesarean surgery and to work with hospitals to reduce the number of unnecessary cesareans. See National Organization for Women of New Jersey, http://nownj.org; N.J. Maternity Care Worst to First 2010, http://www.njmaternitycare.com. Indeed, many women believe that they face great pressure when it comes to cesarean surgery. See Childbirth Connection, Listening to Mothers II Survey and Report 59 (2006) (noting that 25 percent of responding mothers who underwent a cesarean surgery felt pressure to submit to the

procedure).[17] Accordingly, "[p]atients are more likely than in the past to question or disagree with their physicians" about birthing decisions because they are more informed about their health care options. S.F. Adams et al., supra, 30 Clinics in Perinatology at 128. In light of books, documentaries, coverage in the popular press, and the knowledge-building work of non-profit organizations (including several amici), more women are aware about the risks of unnecessary cesarean surgery and empowered to safeguard their rights, autonomy, and choices in childbirth.[18]

These advocates make one thing clear: though there may be differences of opinion in any one case, it is entirely reasonable for a woman not to sign a blanket consent for cesarean surgery before there is any evidence of its need. They further make clear that it is also entirely rational for her to desire a vaginal birth, to decline recommendations for cesarean surgery, and to challenge hospital staff who may be pressuring or attempting to coerce her to accede to their recommendations.

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[17] available at http://www.childbirthconnection.org/pdf.asp?PDFDownload=LTMII_report

[18] Some of those resources include: The International Cesarean Awareness Network, www.ican-online.org; Childbirth Connection, www.childbirthconnection.org; Choices in Childbirth, www.choicesinchildbirth.org; BirthNet, www.birthnewyork.org/birthnet; and Doulas of North America, www.dona.org. Books and online guides that provide information and advice to pregnant women include: Henci Goer, The Thinking Woman's Guide to a Better Birth (Berkley ed. 1999); Five Ways to Avoid a C-Section, CNN.com, at http://www.cnn.com/2007/HEALTH/08/23/ep.csection/index.html; About.com, Five Ways to Avoid a Cesarean Section, at http://pregnancy.about.com/od/laborbirth/a/avoidcesarean.htm.

In fact, far from being irrational, voicing a choice not to consent to cesarean surgery is consistent with the recommendations of the medical and public health community and a growing number of consumer and self-help health advocates.

Here, the trial court suggested that V.M. was not credible because she claimed that she had not refused "treatment at the hospital." T19:4-6. In interpreting V.M.'s claim as reflecting negatively on her credibility, the court failed to appreciate that there is a difference between refusing advance consent to major surgery before there is evidence of the need for it, and refusing consent even in the face of an emergency, a position that, as the record reveals, V.M. never took in this case. Given the proclivity of hospitals in general, and St. Barnabas in particular, to engage in what appear to be a vast number of medically unnecessary cesarean surgeries, informed consumers are arguably wise to refuse consent before there is an actual need for the intervention.

By considering a mother's decision not to undergo cesarean surgery as relevant to parental fitness, the trial court failed to appreciate the many reasons, discussed above, why a woman would refuse cesarean surgery and, instead, penalized V.M. through the draconian remedy of the termination of her parental rights, for a decision that is not only increasingly common, but also recommended by experts. Accordingly, because the evidence

does not clearly and convincing demonstrate that J.M.G.'s "safety, health or development has been or will continue to be endangered by the parental relationship[,]" as required by N.J.S.A. 30:4C-15.1a(1), the trial court's decision was fundamentally flawed and should be reversed by this Court.

CONCLUSION

For the reasons set forth above, amici respectfully submit that the lower court's decision was in error and that this Court should reverse the termination of parental rights as to both parents.

Respectfully submitted,

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Appendix

Dr. Howard Minkoff, M.D. is the Chair of the Department of Obstetrics and Gynecology at Maimonides Medical Center in Brooklyn, New York, and a distinguished Professor of Obstetrics and Gynecology at the State University of New York Health Science Center at Brooklyn. Dr. Minkoff is a Vice Chair of the Ethics Committee of the American College of Obstetricians and Gynecologists and sits on the editorial board of several prominent medical journals. An internationally recognized expert on high risk pregnancy, Dr. Minkoff brings his wealth of knowledge to this Court to ensure that it understands that punitive and effectively punitive measures —— including the intervention of the child welfare system and the removal of infants from their mothers based on medical decision-making during pregnancy —— will harm both maternal and child health.

Henci Goer is an award-winning medical writer, internationally known speaker, and acknowledged expert on evidence-based maternity care. A former doula and Lamaze educator, she is the author of The Thinking Woman's Guide to a Better Birth and Obstetric Myths Versus Research Realities, a highly-acclaimed resource for childbirth professionals.

International Cesarean Awareness Network's (ICAN) mission is to prevent unnecessary cesareans through education, to provide support for cesarean recovery, and to promote Vaginal Birth After Cesarean. ICAN supports women exercising their right to informed consent and refusal in healthcare and strongly believes that pregnancy does not restrict or eliminate a woman's rights.

Dr. Anne Lyerly, M.D., M.A., is an Associate Professor of Obstetrics and Gynecology at Duke University and the Trent Center for Bioethics, Humanities and History of Medicine. Dr. Lyerly joins this brief on her own behalf to explain as a physician and medical ethicist that the use of child welfare laws to sanction pregnant women for their medical decisions represents a departure from the ethical and sound practice of medicine and obstetrics, which will harm women, children and families.

Dr. Lisa Harris, M.D., is a practicing obstetrician-gynecologist at University of Michigan Health System and a faculty member in their Program in Bioethics.

Dr. Marsden G. Wagner, M.D. is a physician, perinatologist and epidemiologist. She is also former Director of Women's and Children's Health for the World Health Organization, which maintains that informed consent is one of the cornerstones of good maternity care because it preserves the right of women to control their own bodies and reproduction.

Nicette Jukelevics, MA, is a childbirth educator, researcher, and author of "Understanding the Dangers of Cesarean Birth: Making Informed Decisions," published in 2008, which critically examines the increasing use of cesarean deliveries for childbirth, including their risks and outcomes.

Dr. Elizabeth M. Armstrong, Ph.D. holds a joint appointment in the Department of Sociology and the Woodrow Wilson School at Princeton University, the Office of Population Research and the Center for Health and Wellbeing. She has published articles in the scholarly literature on substance use during pregnancy, family planning, adolescent motherhood, and the sociology of pregnancy and birth. She is the author of Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder, the first book to challenge conventional wisdom about drinking during pregnancy.

American Association of Birth Centers ("AABC") is a national non-profit multi-disciplinary organization that represents the interests of women and families in advocating for improved access to birthing services. AABC promotes the rights of women and their families in all communities to birth their children in an environment which is safe, sensitive, cost-effective, and requires minimal intervention —— a right that includes informed consent and refusal of medical services.

American College of Nurse-Midwives ("ACNM") is a national trade association that represents the interests of over 11,000 Certified Nurse-Midwives and Certified Midwives in the United States. ACNM's mission is to promote the health and well-being of women and infants within their families and communities

through the development and support of the profession of midwifery as practiced by Certified Nurse-Midwives and Certified Midwives, a profession committed to the principles that every individual has the right to safe, satisfying health care that respects human dignity and cultural variations, and women's right to self-determination with regard to their bodies, including medical decision-making.

The New Jersey Chapter of the American College of Nurse Midwives is a statewide affiliate of the national organization of the same name. Like its national counterpart, the New Jersey chapter seeks to promote the health and well-being of women and infants within their families and communities through the development and support of the profession of midwifery. The New Jersey Chapter of the ACM is committed to ensuring that New Jersey's pregnant women, mothers and families have access to safe, satisfying health care and that women's right to self-determination in medical decision-making is always respected.

The Big Push for Midwives Campaign is a national coalition of consumers, midwives, and other activists that advocate for the health and well-being of childbearing women and their babies, including access by all women and families to the Midwives Model of Care. The Campaign seeks to ensure the availability of safe, evidence-based care during pregnancy, labor, birth, and postpartum. Protecting the rights of women and families to full and unfettered informed consent and informed refusal of health care services is central to the Campaign's mission and policy interests.

BirthNet, Inc. is a non-profit organization that works to educate the public about evidence-based maternity care in order to improve care for all women. Through education, community forums, workshops, and outreach, BirthNet encourages women and families to learn about their rights and about the choices and options available during pregnancy and birth.

Child Welfare Organizing Project ("CWOP") is a New York-based non-profit organization consisting of parents and professionals who seek reform of child welfare practices through the increased and meaningful involvement of parents in child welfare decision-making. CWOP works to debunk prevailing stereotypes about parents and families involved in the child-

welfare system, who are often unfairly and inaccurately demonized, and aims to brings its unique insights to local policy discussions.

Choices in Childbirth is a New York-based consumer advocacy group dedicated to educating all health care consumers about their options and rights in making decisions regarding maternity care.

Citizens for Midwifery ("CfM"), a coalition of parents, concerned citizens, doulas, childbirth educators, midwives, nurses, and physicians, is a national, consumer-based non-profit organization that promotes the Midwives Model of Care through public education. Essential to CfM's mission is respect for the rights of pregnant and laboring women to freely make informed decisions about medical tests and procedures.

The National Association of Nurse Practitioners in Women's Health ("NPWH") works to assure the provision of quality health care to women of all ages by nurse practitioners and recognizes and respects women as decision-makers for their health care. NPWH joins this case as amicus to explain to the Court that the policy of using child welfare laws to interfere with women's medical decisions violate principles of good care and will result in unnecessary damage to both women's and children's health.

The National Latina Institute for Reproductive Health ("NLIRH") works to ensure the fundamental human right to reproductive healthcare for Latinas and their families through advocacy, community mobilization and public education. NLIRH is dedicated to opposing coercive, discriminatory or punitive policies and practices related to the medical decisions of pregnant women, which differentially impact women and families of color.

National Organization for Women of New Jersey works to eliminate discrimination, harassment, and violence against women and advocates for women's equality, including their reproductive freedom. Through community organizing and public education, in collaboration with other state affiliates and the national NOW office, NOW-NJ advocates against forced, unwanted, and unnecessary reproductive procedures, including cesarean surgery.

National Women's Health Network ("NWHN") works to improve the health of all women by developing and promoting a critical analysis of health issues in order to affect policy and support consumer decision-making. The NWHN is committed to ensuring women's self-determination in all aspects of their reproductive and sexual health and aspires to a health care system that is guided by social justice and reflects the needs of diverse women. Additionally, the NWHN is concerned about the rising rates of cesarean deliveries in the United States and the negative effects this has on women's health, infant health and the quality of U.S. health care.

Statewide Parent Advocacy Network ("SPAN") of New Jersey advocates for New Jersey families on issues that impact their children. SPAN is particularly committed to families at risk, including families involved in the child welfare system.

The Tatia Oden French Memorial Foundation works to empower women with respect to pregnancy and childbirth, and advocates on issues involving informed consent, the off-label use of drugs, and maternal mortality. The Foundation works in memory of Tatia Oden French, who died of an amniotic fluid embolism after her doctors gave her an off label drug to induce labor. Her daughter, Zorah, also died during childbirth.

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