SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION
DOCKET NO. A-04627-06T4

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

Appealed from Superior Court
Chancery Division, Family Part
Essex County
Civil Docket No. FN-07-572-06

Sat Below:
Hon. James S. Rothschild, J.S.C.

BRIEF OF *AMICI CURIAE* EXPERTS IN MATERNAL AND NEONATAL HEALTH, BIRTH, AND CHILD WELFARE

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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 use of New Jersey's child welfare laws to judge, and then penalize, a pregnant woman for her medical decision. Although amici's particular areas of expertise vary, they are united in their belief that women's medical decisions during pregnancy and labor, including the decision not to consent to cesarean surgery, should never be considered in determining "abuse and neglect" under New Jersey's child welfare laws. Amici are disturbed by the avoidable injustice suffered by the appellant and her family in this case, and deeply concerned about the serious repercussions of the trial court's decision in matters of informed consent and public health.

The trial court's consideration of a pregnant woman's refusal to consent to cesarean surgery was contrary to the plain language of the abuse and neglect statute, 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 abuse and neglect proceedings because New Jersey's abuse and

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

neglect law does not apply to fetuses. Moreover, penalizing a woman 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.

In addition, the trial court's conclusion that appellant's refusal to consent to cesarean surgery constituted abuse and neglect was based on unfounded assumptions regarding cesarean surgery. The trial court failed to appreciate that cesarean surgery is a major surgical intervention with serious risks and that leading health institutions regard cesarean surgery as dangerously over-prescribed. In fact, cesarean surgery rates in the United States have reached levels far beyond those recommended by health experts, with the number of surgeries recently doubling in just a ten-year period. New Jersey's rates are among the highest in the country, and the percentage of cesarean surgeries at St. Barnabas Medical Center, where appellant gave birth, is even higher than the statewide figure.

Moreover, in dismissing the appellant's medical choice as "negligent" or a product of mental illness, the trial court also failed to recognize that increasing numbers of informed,

rational women oppose cesarean surgeries for good reasons. Thus, the right of all women to weigh the risks associated with childbirth should be honored.

For all of these reasons, as discussed in further detail below, affirming the trial court's decision would sanction the unwarranted expansion of the child welfare law to fetuses, and would open the door for family courts to make uninformed and inappropriate judgments about pregnant women's medical decisions. Moreover, penalizing women through child welfare proceedings when they choose not to consent to certain medical interventions or healthcare advice would create a basis upon which medical personnel could coerce women to accede to doctors' advice. Coerced treatment and interventions would likely deter women from seeking care altogether, or at the very least chill open communication between women and their health care providers at the expense of maternal and fetal health.

Accordingly, amici curiae respectfully submit that the Court should reverse the decision of the court below.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

On April 16, 2006, V.M. arrived at Saint Barnabas Hospital Center to give birth to her first child. Brief of Division of Youth and Family Services [hereinafter "DYFS"], at 1. V.M.'s husband, B.G., was present at the hospital during the delivery.

After V.M.'s arrival, a nurse presented her with a consent form for cesarean surgery and an episiotomy.[1] V.M. consented to the episiotomy, but chose not to consent to the more invasive cesarean surgery. Law Guardian Br. at 8 (citing 3T114-13 to 115-3)[2]. After hospital personnel explained the potential consequences of not performing cesarean surgery in the event of fetal distress, V.M. did not change her mind —— a decision that DYFS describes as "non-compliant." Law Guardian Br. at 3-4 (citing 3T44-9 to 11; 3T44-13 to 16); DYFS Br. at 1. According to DYFS, hospital personnel repeatedly tried to convince V.M. to give her consent, "stress[ing] multiple times . . . the need to sign a consent in the event of an emergency." DYFS Br. at 2 (citing Pa67, Pa77). B.G. informed a nurse that he was also aware of the risks, but deferred to V.M.'s decision. Law Guardian Br. at 4 (citing 3T46-23 to 47-9).

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[1] Episiotomy is a surgical cut in the skin and muscle of the vagina during childbirth.

[2] The transcript and appendix designations are those used in the parties' briefs.

Although V.M. chose not to consent to invasive surgery, in addition to the episiotomy, she did consent to several other interventions during her labor, including intravenous fluids, antibiotics, fetal heart rate monitoring, and an epidural. Law Guardian Br. at 3 (citing 3T40-21 to 25). Hospital personnel, however, contended that V.M. became "very combative and upset because she did not want to sign a consent for a c-section" and "continued to refuse to sign." DYFS Br. at 1-2 (citing Pa77).

Unclear whether V.M. had the right to refuse consent to cesarean surgery, hospital personnel consulted with an administrator, who informed them "that the patient's rights supersede rights of unborn child." Law Guardian Br. at 4 (citing Da78-79; Pa62-63). Another doctor then conducted an examination of V.M. to ensure that she had the mental capacity to make her own medical decisions. Law Guardian Br. at 4. The doctor concluded that she did. Law Guardian Br. at 4 (citing Da83-84; Pa71-72).

During V.M.'s stay at Saint Barnabus, hospital staff learned that she suffered from psychiatric illnesses. DYFS Br at 3; Law Guardian Br. at 5 (3T17-16 to 18; 3T18-24 to 25). They also learned that she had been under the care of a doctor for over a decade and that she had taken medication for her illnesses. DYFS Br at 3; Law Guardian Br. at 5 (3T17-16 to 18; 3T18-24 to 25).

On April 16, 2006, V.M. gave birth vaginally to a healthy baby girl. Law Guardian Br. at 5. Her delivery was "normal," DYFS Br. at 4, and she described it as "a very easy delivery." Law Guardian Br. at 9 (citing 3T118-13 to 16). Nonetheless, the hospital made a report to DYFS, which began an investigation based on the appellant's decision not to sign a general consent to a cesarean section and/or her informed refusal to submit to such surgery. Law Guardian Br. at 3 (citing 3T9-23 to 10-16; 3T17-10 to 21).

After the child's birth, V.M. and B.G. added their daughter to their health care policy and purchased a crib for their one bedroom apartment. Law Guardian Br. at 9 (citing 3T128-2 to 129-23), at 7 citing (3T105-14 to 22). V.M. became very upset when a hospital social worker told her that "the baby would not be coming home" with her and her husband because DYFS would be seeking custody. DYFS Br. at 5.

In referring the case to DYFS, hospital staff explained that they perceived V.M. as combative and noncompliant, noting her refusal to consent to cesarean surgery. Law Guardian Br. at 3 (citing 3T42-7 to 13). Prior to her discharge from the hospital, however, two doctors evaluated V.M. and found no evidence that she was a danger to herself or others. Law Guardian Br. at 6 (citing 3T96-2 to 98-16).

On April 20, 2006, DYFS filed an order to show cause and verified complaint pursuant to N.J.S.A. 9:6-8.21 requesting custody, care and supervision of V.M.'s daughter. Law Guardian Br., at 1. The Division sought "to prove that the child was abused and neglected and the child was 'in imminent danger of becoming impaired as a result of the failure of the parent or guardian as herein defined, exercising a minimum degree of care in supplying the child with . . . surgical care.'" Law Guardian Br. at 1 (citing 3T1666-15 to 21). According to DYFS, the "surgical care" denied to the "child" was a cesarean surgery that would have required the appellant to undergo an invasive procedure that later proved to be unnecessary. The same day, the Honorable James S. Rothschild, J.S.C., signed an order to show cause granting DYFS's request. Law Guardian Br. at 1. (Da12).

On May 24, 2006, the trial court conducted a fact-finding hearing and found that V.M. did not consent to cesarean surgery in the event of fetal distress. Law Guardian Br. at 1 (citing 3T166-15 to 213T168-16 to 169-6). The court concluded that by refusing consent, V.M. committed abuse or neglect under New Jersey's child welfare laws. Law Guardian Br. at 2 (3T172-12 to 173-2). The court reasoned that "with the mother's life and baby's life in balance, I think it was negligent . . . not to accede to what the doctors requested." Law Guardian Br. at 2

(citing 3T172-12 to 173-2). The court suggested that V.M.'s medical choices were indicative of her mental illness, stating that her decision not to accede to the doctors' recommendation may have been "caused by her not taking [her] medication...." DYFS Br. At 10 (citing 3T172:16-20). Noting that the case was "not that strong" given the presence of a number of mitigating factors, the court nevertheless concluded that "it is my decision by a preponderance of the evidence that she refused to cooperate with the medical professionals at St. Barnabas Hospital during childbirth." Law Guardian Br. at 2 (citing 3T172-12 to 173-2); DYFS Br. at 10.[3]

The parents' attorney moved to dismiss the case for failing to make out a prima facie case of abuse. Law Guardian Br. at 7 (citing 3T107-23 to 108-4). The trial court denied the motion, concluding that the parents failed to supply the child with adequate medical care and placed the child in imminent danger of becoming impaired. Law Guardian Br. at 7 (citing 3T109-7 to 12).

This appeal followed. DYFS Br. at 16 (citing Da27). Significantly, the Law Guardian assigned to represent the interests of the minor child in these proceedings filed a brief

[3] The court's order reflected a finding of abuse and neglect as to both parents, even though the court never made an oral finding of abuse and neglect with respect to the father, B.G., and noted at the hearing "the Division has not proved its case against [him]." Law Guardian Br. at 2-3 (citing 3T174-19 to 21; 3T176-13 to 22).

on appeal to this Court in opposition to the trial court's ruling. See Law Guardian Br. at 17 (arguing that "there was no sufficient basis" for the trial court's finding of abuse and neglect, which wrongly deprived the child of her right "to be in the care of her parent").

On October 3, 2008, amici, experts in maternal and neonatal health, birth, and child welfare, moved for leave to participate as amici curiae in this matter to assist the Court in resolving numerous issues of public importance implicated by this case. On October 9, 2008, appellee DYFS filed an opposition to that motion. All other parties filed written submissions to the Court noting that they did not oppose amici's motion, apparently agreeing that significant issues of public importance are raised by this case. In contrast, DYFS's opposition argued that amici's participation would not be helpful to the Court because the trial court did not base its finding of abuse and neglect "solely" on the pregnant woman's refusal to consent to cesarean surgery. DYFS Brief in Opposition to Amicus Participation, at 3. According to DYFS, that medical decision was only one factor considered in a "totality" of factors by the trial court.

DYFS maintains that V.M.'s lack of "mental stability," evidenced by her "highly disruptive behavior" was the overarching concern in evaluating abuse and neglect. DYFS Amicus Opp. Br. at 4. In describing that allegedly erratic

behavior, DYFS noted that V.M. "refused to cooperate with staff (which included signing consents)." DYFS Amicus Opp. Br. at 4. DYFS further asserted that "the trial judge definitively made the connection of V.M.'s failure to sign the consent with V.M. not taking her prescribed medication." DYFS Amicus Opp. Br. at 5 (citing 3T169:1-25, Pa78). Thus, DYFS's descriptions of V.M.'s mental fitness are intertwined with its description of her exercising her right to informed consent. DYFS Amicus Opp. Br. at 5 (citing 3T172:17-20).

On October 10, 2008, this Court granted amici's motion to participate as amicus, but denied their related motion to unseal the Family Part record. In light of the Court's order denying access to the Family Part record, amici rely on the transcript references cited by the parties. Significantly, amici note the parties' agreement that the trial court considered, to at least a certain extent, a pregnant woman's "refusal to sign consents" to cesarean surgery in finding abuse or neglect in this case. (Brief in Opposition to Amicus Participation, at 3). It is that undisputed fact to which amici address this brief.

ARGUMENT

I. THE TRIAL COURT'S RADICAL EXPANSION OF NEW JERSEY'S CHILD WELFARE LAW TO REGULATE PREGNANT WOMEN'S MEDICAL DECISION-MAKING IS CONTRARY TO THE STATUTE AND LEGISLATIVE INTENT.

A. Under a Plain Reading of the Statute, The Abuse and Neglect Law Does Not Apply to Pregnant Women and Their Fetuses.

It is axiomatic that interpreting the scope of a statute begins with its text. State v. Bunch, 180 N.J. 534, 543 (2004) If the statutory text "lends itself to only one interpretation and that interpretation is consistent with the overall legislative scheme," courts 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 abuse and neglect law are not susceptible to varied interpretation: it is inescapable that the Legislature never intended to regulate pregnant women or privilege doctors' opinions about what is best for their fetuses.

Title 9 of the New Jersey Statutes governs the adjudication of abuse and neglect proceedings, in which the paramount concern is the protection of vulnerable children. N.J.S.A. 9:6-8.21 to 8.73. When the Division has reason to believe that a child is in danger, it may seek to remove the child from the custody of her parents. In order to place the child in the custody of

DYFS, a Superior Court judge must find by a preponderance of the evidence that the child "is an abused or neglected" child as defined by New Jersey law. N.J.S.A. 9:6-8.46b. Under N.J.S.A. 9:6-8.21 a child is abused or neglected when she is under 18 years of age and her parent or guardian has caused her serious injury or poses a future risk to her well-being in a number of specified ways. Pursuant to subsection (d)(1) of the statute —— the provision upon which the trial court relied in this case —— an "abused or neglected child" is one "whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian . . . to exercise a minimum degree of care . . . in supplying the child with adequate food, clothing, shelter, education, medical or surgical care. . . .." N.J.S.A. 9:6-8.21(d)(1). The plain text of that statute makes reference only to a "parent or guardian" and their children; it says nothing about "pregnant women" or their "fetuses." See N.J.S.A. 9:6-8.21; see also N.J. Div. of Youth and Family Servs. v. L.V. and C.M., 382 N.J. Super. 582, 590 (Ch. Div. 2005) (concluding that "since [N.J.S.A. 9:6-8.21] clearly does not expressly include a fetus in its definition of a child, its protection does not extend to the child before birth").

The terms "parent" and "child" are not ambiguous. One does not become a parent until the birth of a child and a fetus does

not become a child 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). Moreover, subsection (d) describes child abuse as the denial of necessities needed by living persons —— "food, clothing, shelter, education, medical or surgical care." N.J.S.A. 9:6-8.21(d). Those terms collectively make clear that the Legislature only intended to protect living persons. Accordingly, by applying the abuse and neglect law to pregnant women and their fetuses, the trial court drastically expanded the scope of the statute beyond its terms and intended reach.

That expansive interpretation is a departure from precedent. Historically, 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 Chancery Division 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. The Chancery Court judge reviewing those proceedings 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 the "appoint[ment] of a guardian ad litem for an infant or alleged incompetent person" and "[a] fetus is not a person." Ibid. (citing Roe v. Wade, 410 U.S. 113, 158 (1973) ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn.")).

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. In reaching that result, the Court noted that when the Legislature intended to address "the status and interests of an unborn child," it made its intent clear. Id. at 421. The Court explained that when the Legislature first enacted the workers' compensation statute in 1911, the Legislature defined dependents as including both the "children" and a "child in esse." Ibid. According to the Court, when the Legislature intended to include fetuses within the definition of "decedent" in the Uniform Anatomical Gift Act, it explicitly defined that

term to include both a deceased person and a "stillborn infant or fetus." Ibid. The Court further noted that in the context of the criminal homicide laws, the Legislature considered and rejected the opportunity to classify a fetus as a "person." Id. at 422 (citing 2 Final Report of the New Jersey Criminal Law Revision Commission: Commentary 150 (1971) (noting that at common-law homicide could be committed only against a "human being," which did not include fetuses)). Given the demonstrated ability of the Legislature to enact laws addressing the status of fetuses, had it intended to include fetuses within the abuse and neglect law, it would have done so. See State v. Ikerd, 369 N.J. Super. 610, 623 (App. Div. 2004) (reversing trial court decision sentencing a drug-addicted pregnant woman to prison to protect her fetus because it was "contrary to the statute" and "usurped the powers of the legislature").[4]

[4] Other jurisdictions have embraced similar reasoning when interpreting the meaning of child abuse and neglect statutes. See, e.g., 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); Kentucky v. Welch, 864 S.W.2d 280, 284 (Ky. 1993) (reviewing legislative history and concluding criminal child abuse statute did not apply to defendant's use of controlled substance during pregnancy and had the legislature intended to include the unborn within the statute, "it would have done so expressly"); Sheriff, Washoe County, Nev. 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 "when our Legislature enacts laws concerning unborn children, it says so explicitly").

In short, a plain reading of the statute makes clear that pregnant women's medical decisions may not constitute abuse and neglect under N.J.S.A. 9:6-8.21 because that law does not extend to fetuses. Accordingly, the trial court's consideration of a pregnant woman's refusal to consent to a cesarean surgery in evaluating abuse and neglect constituted an erroneous expansion of the statute that should be reversed by this Court.

B. The Trial Court's Expansion of the Abuse and Neglect Law Is Contrary to the Legislature's Purpose in Enacting It.

Even if this Court were to conclude that either of the statutory terms "parent" or "child" is ambiguous, the trial court still erred because there is no evidence that the Legislature intended to apply the abuse and neglect law to pregnant women and their fetuses. 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"). When interpreting the 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. 9:6-8.8(a) states:

> The purpose of this act is to provide for the protection of children under 18 years of age who have had serious injury inflicted upon them by other than accidental means. The safety of the children served shall be of paramount concern. It is the intent of this legislation to assure that the lives of innocent children are immediately safeguarded from further injury and possible death and that the legal rights of such children are fully protected.

That provision makes evident that the Legislature intended to protect living children; it never contemplated policing the medical decisions of pregnant women where the "lives" and "legal rights" of children are not at issue. See ibid. This Court need not look any further than that statement of legislative intent. See Pizzullo, supra, 196 N.J. at 264 (noting that resort to extrinsic aids to divine intent of Legislature is only appropriate when text of a statute is unclear). However, the legislative report that formed the basis for Title 9 only strengthens that interpretation of legislative intent.

In particular, the Interim Report of the Commission to Study Child Abuse and Other Aspects of Child Welfare Laws, released in 1971, declared that New Jersey's child welfare laws "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). Clearly the Legislature never contemplated application of Title 9 to protect

fetuses, which do not have a "family situation" and can endanger neither themselves nor others. 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 abuse and neglect 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 Div. of Youth and Family Servs. v. A.W., 103 N.J. 591 (1986)).

Here, the trial court violated that fundamental tenet, which animates Title 9, by severely penalizing a pregnant woman for refusing to consent to cesarean surgery, even after she gave birth naturally to a healthy baby girl. Accordingly, the trial court's consideration of the woman's medical decision was contrary to the legislative goals in enacting the abuse and neglect statute, and its decision should 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 a pregnant woman's medical decision under the "abuse and neglect" statute, 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, competent adults have long possessed the right "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'")). As Justice Cardozo of the New York Court of Appeals summarized it, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." 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 protected 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. Right to Choose v. Byrne, 91 N.J. 287, 310 (1982) (recognizing right of pregnant women to choose medically-necessary abortions); 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 "a fetus cannot have rights in this respect superior to those of a person who has already been born").

By considering a woman's refusal to consent to cesarean surgery in analyzing whether her child was abused or neglected, the trial court ignored those principles. It also drastically departed from New Jersey precedent condemning the use of child welfare laws to interfere with pregnant women's medical decisions. Indeed, up 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, similar to its contentions here, 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.

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)); see also 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."). 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's articulated basis for depriving a woman of the custody of her child was her refusal to "cooperate" with hospital personnel by refusing to consent to cesarean surgery. See Law Guardian Br. at 2 (citing 3T172-12 to 173-2); DYFS Br. at 10. In doing so, the court ignored well-established law protecting women's rights to privacy and self-determination. If allowed to stand, the trial court's decision will not only cause further injustice and injury to the woman and her family, it will 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 women's due process rights to privacy protected under the state and federal constitutions and equal protection guarantees. 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) (noting that in light of "constitutional protections surrounding family rights . . . the court's authority to remove children from the custody of their parents must be exercised with scrupulous adherence to procedural safeguards"). 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 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

child abuse or neglect not only lacks a basis in law, it 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).[5] 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).[6] The Commission reminds providers that they must "abide" by patients' decisions. Ibid. And the 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 Committee Opinion No. 321 (2005) [hereinafter "ACOG Ethics

[5] available at http://www.jointcommission.org/PatientSafety/SpeakUp/sp_rights.pdf.
[6] available at http://www.opm.gov/insure/health/cbrr.htm#exec

Opinion No. 321"]. The American Medical Association ("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].

These authorities make clear that the trial court not only ignored the law of informed consent, but also provided a legal basis for medical coercion directly at odd with best medical and public health practices. As such, the trial court's decision is unsound, and this Court should not permit it 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 stated, "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 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 now widely repudiated decision, Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (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 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 child abuse or neglect would drastically transform the doctor-patient relationship at the expense of maternal and fetal health.

Interpreting a woman's medical decision as abuse and neglect 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 run counter to the fundamental role and 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. Accepting forced cesareans 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 "[e]ncouraging prenatal care and treatment in a supportive environment" is most likely to advance maternal and child health. Maternal Decision Making, supra, at 1134.

As medical and public health experts recognize, 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, or not to give birth with the assistance of health professionals. In short, as

experts recognize, 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," Law Guardian Br. at 7 (citing 3T109-7 to 12), the trial court failed to appreciate that cesarean surgery is a major surgical intervention with serious risks. For pregnant women those risks include infection, hemorrhage, thromboembolism, bladder and uterine lacerations, and even death. Williams Obstetrics, 592 (22nd ed. 2005). Evidence suggests that cesarean delivery is more dangerous than vaginal delivery. See ibid. (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").

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. And cesarean surgery presents significant risks to fetuses as well: babies born after cesarean surgery are more likely than vaginally born babies to experience respiratory problems, surgical injuries, and problems with breastfeeding. Id. at 44.

The New Jersey Supreme Court interprets the "minimum degree of care" required under subsection (d)(1) of the abuse and neglect statute N.J.S.A. 9:6-8.21 — the provision upon which the trial court relied in this case — to mean "conduct that is grossly negligent because it is willful or wanton." G.S. v. Div. of Youth and Family Servs., 157 N.J. 161, 178-79 (1999) (noting that "the concept of willful and wanton misconduct implies that a person has acted with reckless disregard for the safety of others"). 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 cannot be considered "grossly negligent" under the law, particularly where she correctly judged that the procedure was unnecessary.[7] 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 concluding that it was negligent for appellant not to consent to cesarean surgery, the trial court assumed that doctors only seek consent to cesarean surgeries in urgent, life-threatening circumstances. Law Guardian Br. at 2 (citing 3T172-12 to 173-2) (concluding that "with the mother's life and baby's life in balance, I think . . . it was negligent not to accede to what the doctors requested"). 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

[7] As described earlier, nor does this provision suggest that parents would be "grossly negligent" if they chose not to subject themselves to a risky surgical procedure for the benefit of their child. See 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)).

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 and a "new record level has been reached every year in the present century" —— with the trend only continuing. Milbank Report, supra, at 41. Currently, in 2008, approximately one in every three mothers gives birth by cesarean surgery in the United States. Ibid.

New Jersey's cesarean surgery rates are consistent with those trends. 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 a ever-increasing rate." The Star Ledger, Giving Birth in New Jersey (2006).[8] Compared to national figures, for which 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 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. According to the Star Ledger's analysis, 43 percent of all births at St. Barnabas are performed by cesarean surgery. The Start Ledger, Giving Birth in New Jersey (2006).

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

Those rates suggest that cesarean surgeries are likely being performed in New Jersey and specifically at St. Barnabas in circumstances under which 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, MD & Frank A. Chervenak, M.D., 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). 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)).

Moreover, contrary to the assumptions underlying the trial court's conclusion that appellant should have "accede[d] to what the doctors requested" Law Guardian Br. at 2 (citing 3T172-12 to 173-2), research reveals that increased rates of cesarean

surgeries do not necessarily produce overall better birth outcomes. For example, World Health Organization data indicates 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.

Some experts also argue that cesarean surgery is extremely costly to the U.S. healthcare system. Milbank Report, supra, at 12, (citing Agency for Healthcare Research and Quality 2008). 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. Id. at 4, 12.[9] This has

[9] 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.

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 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 forego such surgery against her. The court failed to recognize that it is entirely rational for a pregnant woman to decide that she should only agree to cesarean surgery as a last resort.

C. The Trial Court Erred by Suggesting A Woman's Refusal to Consent to Cesarean Surgery is Negligent and Indicative of Mental Illness.

The court inappropriately suggested that the appellant's medical decision in this case was not only irrational and negligent, it was the likely product of mental illness. See DYFS Br. at 10 (citing 3T172:16-20) (noting court's statement that appellant's decision not to accede to the doctors' recommendation may have been "caused by her not taking [her] medication"). DYFS similarly considers the appellant's exercise of informed consent as synonymous with mental illness,

describing her as "non-compliant," Law Guardian Br. at 3-4 (citing 3T44-9 to 11; 3T44-13 to 16), and describing her "erratic behavior" as her refusal "to cooperate with staff (which included signing consents)." See DYFS Amicus. Opp. Br. at 5 (citing 3T172:17-20). By characterizing the appellant's medical decision to refuse cesarean surgery as irrational and attributing her choice to mental illness, 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 who are concerned about the risks of cesarean surgery and resolute in their determination not to be pressured into unnecessary surgery. 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).[10] 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

[10] available at http://www.childbirthconnection.org/pdf.asp?PDFDownload=LTMII report

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 perils of unnecessary cesarean surgery and empowered to safeguard their rights, autonomy, and choices in childbirth.[11]

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. 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.

By punishing —— through the removal of her child —— the

[11] 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.

mother's decision not to undergo cesarean surgery, the trial court failed to appreciate the many rational reasons a woman would refuse cesarean surgery. Accordingly, its decision was fundamentally flawed and should be reversed by this Court.

V. PUNITIVE AND COERCIVE CHILD WELFARE POLICIES LIKE THE ONE ADOPTED IN THIS CASE UNFAIRLY BURDEN THE RIGHTS OF THE MOST VULNERABLE WOMEN.

Finally, adopting the trial court's position in this case could increase the potential for discriminatory application of the child welfare laws and the unnecessary separation of children from poor, minority parents. Evidence suggests that a regime that permits doctors and the courts to police the medical decisions of pregnant women is most likely to be applied against vulnerable women. See Maternal Decision Making, supra, at 1134.

In fact, "[i]n cases of court-ordered cesarean deliveries, the vast majority of court orders have been obtained against poor women of color...." Maternal Decision Making, supra, at 1134. As the AMA has explained, doctors may be more likely to misunderstand women's reasons for refusing care and more likely to seek to override their medical decisions when the patient has a different racial or socioeconomic background than her health care provider. Legal Interventions During Pregnancy, supra, at 2665. Accordingly, low-income, minority women are more

susceptible to the use of the child-welfare regime to police and punish their medical decisions.

The New Jersey Supreme Court has previously noted the grave concern that "society has traditionally protected the rights of parents if those parents are affluent or middle class . . . [but has] discounted the cultural backgrounds and solid parenting skills of low-income parents." See A.W. supra, 103 N.J. at 601 (quoting Stack, Cultural Perspectives on Child Welfare, 12 N.Y.U. Rev. L. & Soc. Change 539, 547 (1983-84)). This Court should be vigilant regarding that concern when evaluating the impact of the precedent set by this case.

Here, the court's radical interpretation of the state's child welfare law increases the potential for discriminatory application of the law and the unnecessary separation of children from poor, minority parents. For this reason, too, the trial court's decision should be reversed.

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 finding of abuse and neglect.

Respectfully submitted,

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