Refusal of Interventions to Protect the Life of the Viable Fetus – a Case-Based Transatlantic Overview

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It is rare for a pregnant woman to refuse a recommended intervention to protect the life of her viable fetus, and few obstetricians have ever come across the problem. Nevertheless, a number of cases of such a refusal have gone to court for resolution, and some have even reached the Supreme Court of the United States. In England such disputes have always been resolved at or below the Court of Appeal.

In the United States, federal and state laws are not unanimous on whether the mother’s refusal to accept treatment should always prevail whenever there is a maternal-fetal conflict of interest. By contrast, in English law the matter is at present firmly settled in favour of a competent mother’s right to refuse, on the grounds that respecting her autonomy must always trump the protection of any fetal interest.

The question of whether a mother’s refusal to undergo a recommended treatment should be overridden in favour of her viable fetus is fundamentally one of balancing maternal rights against any fetal rights that are recognised by law, or recognised in ethics. But here it is most important to recognise that what may be required or allowed by law may not be required or allowed in an ethical context.

The question of fetal rights vis-à-vis maternal rights remains unsettled in law and ethics.

What is the Current Practice Amongst Obstetricians?

Over recent years obstetricians have undergone a considerable change of mind as to whether it may be appropriate to override a pregnant woman’s objections, and to impose treatment on her forcibly, in order to protect the life of her viable fetus.

In 1987 Kolder et al carried out a US national survey in which they asked the opinion of leading obstetricians on the enforced treatment of pregnant women against their wishes. They found that court orders had been obtained for Caesarean sections in eleven states, for hospital detention in two states, and for intra-uterine transfusion in one state. In those cases where court orders were sought, they were obtained in 86% of cases; and in these cases 88% were obtained within six hours. Of the women involved, 81% were black, Asian or Hispanic, 44% were unmarried, and 24% did not speak English as their primary language. Of the heads of fellowship programmes in maternal-fetal medicine: 46% believed that women who refused medical advice, and so endangered the life of their fetus, should be detained; 47% supported court orders for procedures such as intra-uterine transfusion; and 26% approved of state surveillance of those who remained outside the hospital system during the third trimester of pregnancy.

After an interval of 16 years, in 2003 Adams et al carried out a similar survey of heads of maternal-fetal medicine fellowship programmes. They found nine cases in which a pregnant woman’s wishes had been over-ridden. Six women had refused a Caesarean section: three had placenta praevia, one had cephalo-pelvic disproportion, and two had fetal distress requiring urgent surgical delivery. In all cases court orders were obtained, within minutes or hours for all but one case. All then underwent immediate Caesarean section, and all fetuses were born in good condition. In two other cases court orders were obtained for blood transfusion, one for maternal

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anaemia and one for Rhesus isoimmunisation, although neither was actually given. The first fetus was delivered in good condition, but the second fetus died. As for the attitudes of heads of fellowship programmes: only 8% approved of the detention of women who substance-abused during pregnancy; and only 4% approved of the detention of non-compliant diabetics, or of coercive maternal-fetal surgery, including intra-uterine transfusion. Thus, in the 16 years since Kolder et al’s survey, there has been a considerable shift towards obstetricians accepting the standpoint of pregnant women in their care.

From the numbers in these surveys, it seems that such maternal-fetal conflict is rare. Nevertheless, it is clear that such cases do occur from time to time, and so obstetricians and lawyers need to be aware of the relevant case law.

The cases of maternal-fetal conflict that have come before the courts fall into four principal categories:

1. Caesarean sections.
2. Blood transfusions.
4. Drug and alcohol abuse.

In this paper I shall not address the question of maternal-fetal conflict concerning drug and alcohol abuse, as this was covered by the author of a previous paper.4

Caesarean Sections

Both in the United States and in England, the common law that determines whether a competent pregnant woman should have control over her own body when she is carrying a viable fetus has its origin in the 1913 New York (non-pregnant) case of Schloendorff,5 in which Cardozo J said:

“Every 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 …”

US Court Decisions

The 1964 case of Anderson,6 which will be discussed again below, is one of the earliest US cases where a pregnant woman’s refusal to accept medical treatment was over-ridden. Despite her refusal, she was given a blood transfusion in order to protect the life and health of her 32 week fetus.

From the fetal perspective, the two principal cases that have shaped US law regarding the legal status of the viable fetus have been the 1973 Supreme Court cases of Roe v Wade7 and Doe v Bolton.8

In Roe, the Supreme Court made a number of important declarations:

1. A fetus is not to be classed as a person under the Fourteenth Amendment, and it has no independent right to life.
2. A woman’s right to abortion during the first trimester is protected by the right to privacy.
3. After the first trimester, the state may regulate abortion in the interests of maternal health.
4. When the fetus becomes viable, the state has an “important and legitimate interest in protecting the potentiality of human life”, and it may then proscribe abortion, except when abortion is considered necessary “to preserve the life or health of the mother”.

In Doe, the Supreme Court held that “medical judgment may be exercised in the light of all the factors – physical, emotional, psychological, familial, and the woman’s age – relevant to the
mother’s wellbeing”; and that this judgment should “operate for the benefit, not the disadvantage of the pregnant woman”.

There is now a view in some quarters that Roe should be overturned, but this issue is well outside the scope of this paper.

Roe was concerned only with the problem of abortion. However in 1981 it was cited in support by the Supreme Court of Georgia when it rejected an appeal in the case of Jefferson, a pregnant woman with placenta praevia at 39 weeks gestation. For religious reasons, Mrs Jefferson had refused to undergo Caesarean section for the benefit of her fetus. However the trial court held that “as a matter of law … this child is a viable human being and it is entitled to the protection of the Juvenile Court Code of Georgia”. It also held that any invasion of her privacy and bodily integrity was “outweighed by the duty of the State to protect a living, unborn being from meeting his or her death before being given the opportunity to live”. The trial court’s original view was upheld on appeal, and so she was ordered to undergo Caesarean section against her wishes.

In the 1986 District of Columbia case of Maydun, a 19 year old student at 37 weeks gestation was in prolonged labour and she had membranes ruptured for 48 hours. Fearing infection, her obstetrician recommended delivery by Caesarean section but she refused, partly for religious reasons. He requested a court order, and this was granted. She was delivered by Caesarean section, but no sign of infection was found. This case was never appealed, but in the later case of re AC (see below) the DC Court of Appeal was to criticise this decision.

The Maydun case well illustrates the fact that an obstetrician may be wrong in his diagnosis and his reasoning as to why a Caesarean section should be carried out.

Although the maternal refusal of Caesarean section had been overridden for fetal reasons in both Jefferson and Maydun, in that same year of 1986 the Supreme Court considered in Thornburgh whether pregnant women should be allowed to make unwise decisions regarding treatment pathways. Stevens J held that:

“In the final analysis, the holding in Roe v Wade presumes that it is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect on their destiny.”

As regards fetal rights after viability, these were denied in the 1988 Illinois case of Stallman v Youngquist. Here a child sued his mother for prenatal injuries that he suffered when his mother was injured crossing the road, allegedly in a careless fashion. The Illinois Supreme Court dismissed his claim, holding that “a fetus cannot have rights superior to those of its mother” and that “a pregnant woman owes no legally recognised duty to her developing fetus”.

Nevertheless, the Supreme Court has leant somewhat further towards protecting fetal rights in the cases of Webster (1989) and Casey (1992).

In Webster the use of viability as a critical time was itself questioned, and the appropriateness of an earlier time was mooted. It held that:

“We do not see why the State’s interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation before viability but prohibiting it after viability.”

In Casey, the Supreme Court leant even further towards protecting the fetus, when it held that the state had an interest:

“… from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.”

Although not a Supreme Court case, the case of Re AC was to prove historic. In 1987 Angela Carder was 28 years old and pregnant. She had earlier had a teenage cancer treated, but now she was found to have a secondary tumour in her lung. At 25 weeks gestation her condition became
terminal. She was advised to have a Caesarean section to save the fetus, even though it would be of no benefit to her; in fact it would probably hasten her demise. She refused consent to the operation, but she expressed some hesitation. Hospital lawyers then sought a court order for Caesarean section. A single judge heard the case in the hospital, but Mrs Carder was neither heard nor represented at the hearing. The order was given for Caesarean section, on the grounds that her competence was uncertain. The case went to immediate appeal, but the three judges of appeal refused to block the operation. The operation went ahead, but the baby died within a couple of hours, and the mother died within a couple of days. This case was reheard in 1990 by all the judges of the DC Court of Appeals. The appeal court criticised the trial judge for not assessing the mother’s wishes for herself. It held that a mother’s wishes should generally prevail, and that any exceptions would be:

“… extremely rare and truly exceptional … Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person’s body, such as Caesarean section, against that person’s will.”

For obvious reasons, coercive Caesarean section cases are usually decided in a hurry. However AC was the first judicial review of a coercive Caesarean section in which judges had benefit of written legal briefs and formal argument by attorneys on both sides of the issue, and time to reflect before formulating an opinion.

Later in 1990, the Supreme Court delivered its verdict in Cruzan. Although this was not a pregnancy case, the court’s decision is highly relevant in the context of coercive treatment to a mother in pregnancy. In Cruzan, O’Connor J held that:

“… because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause [of the Constitution].”

Despite Cruzan, in 1994 the Illinois courts were challenged with a case quite different to that of AC. This was the case of Baby Boy Doe. Mrs Doe was at 37 weeks gestation when placental insufficiency was diagnosed and delivery by Caesarean section was advised. She refused surgery on religious grounds, and a court order was requested. In support of the petition, it was argued the fetus was:

“… a real life being kept prisoner in its mother’s womb and tied to an oxygen source that is not working.”

On appeal, the District Appellate Court denied the petition, holding that:

“A woman’s right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact on the fetus is not legally relevant …”

The Illinois State Supreme Court and the US Supreme Court were asked to review the case, but they declined. Mrs Doe was then transferred to a different hospital where another obstetrician delivered her vaginally of a healthy baby two weeks later. As also with Maydun, the case of Baby Doe illustrates that an obstetrician may be wrong in his diagnosis and in his reasoning as to why a Caesarean section should be carried out.

Sometimes both the maternal and fetal lives are at risk. In the 1999 Florida case of Pemberton, a woman at the end of her pregnancy had been in labour at home for over 24 hours. She had a previous history of Caesarean section through a vertical (or classical) uterine incision, but no hospital arrangements had been made for her delivery. Moreover, she had been unable to
obtain assistance for a home delivery from any obstetrician, all of whom had warned her of the high risk of uterine rupture if she went into labour. A federal district court granted an order for Caesarean section, and this was carried out. Afterwards, she sued the hospital, alleging that several of her constitutional rights had been violated, but she lost her case. The court held that:

“Mrs Pemberton was at full term and actively in labour. It was clear that one way or the other, a baby would be born (or stillborn) very soon, certainly within hours. Whatever the scope of Mrs Pemberton’s personal constitutional rights in this situation, clearly they did not outweigh the interests of the State of Florida in preserving the life of the unborn child.”

In this case the court took the view that overriding a maternal refusal, in order to protect a viable fetal life, was supported by the Supreme Court’s view cited in Roe.

In 2004 Melissa Rowland, a Utah woman, was pregnant with twins. She had already had six children, two of whom had been delivered by Caesarean section. She was advised to deliver this baby by Caesarean section, but she refused. She went on to deliver vaginally: a baby boy who was stillborn, and a baby girl who was born alive but who tested positive for cocaine.

Rowland was at first charged with the murder of her baby boy but, after bargaining, she accepted a plea to two counts of child endangerment for using drugs in pregnancy, and she is now in jail. This is an interesting case, as her principal crime, if any, would really be of failing to rescue her stillborn baby boy.

Minkoff and Paltrow have analysed this case from the ethical viewpoint, and they have concluded that if:

“… [she] is to be judged legally culpable for the death of her fetus, then the courts must first create a new and significant exception to the doctrine of informed consent and the common law and constitutional principles upon which it is based. Such a precedent could introduce a substantial disparity between the rights of pregnant women and those of all other persons.”

**English Court Decisions**

For many years it has been well established in English law that the fetus has no legal rights until it is born. For example, in the 1979 abortion case of Paton, Sir George Baker, then President of the Family Division of the High Court, held that:

“The fetus cannot, in English law, in my view, have a right of its own until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country.”

In 1992 in the Court of Appeal case of Re T (a blood transfusion case that will be discussed below), Lord Donaldson held that there was only one hypothetical exception to the right of a competent pregnant patient to refuse treatment:

“The only possible qualification is a case in which the choice may lead to the death of the fetus … If and when it arises, the courts will be faced with a novel problem of considerable legal and ethical complexity.”

England’s first court-authorised Caesarean section was carried out in 1992. Mrs S was in labour at term: her membranes were ruptured, her fetus was in transverse lie, and an elbow was projecting through the dilating cervix. Her obstetrician advised a Caesarean section, as there was a high risk of uterine rupture, which would put both lives in great danger. However Mrs S refused surgery for religious reasons, and she was supported in this by her husband. The hospital asked the court to intervene. After an ex parte hearing lasting 18 minutes, at which Mrs S was not represented, Sir Stephen Brown, then President of the Family Division of the High Court, declared that a Caesarean section could lawfully be performed despite the patient’s refusal, as it
was necessary in the interests of both the mother and her unborn child. The only legal authorities
that he quoted were as follows:

“The fundamental question appears to have been left open by Lord Donaldson in Re T (Adult:
Refusal of Medical Treatment) and there is no legal authority that is directly in point.”

And:

“There is some American authority [here he cited Re AC] which suggests that if this case were
being heard in the American courts the answer would likely be in favour of granting a
declaration in these circumstances.”

Clearly Sir Stephen had cited Re AC incorrectly here, as in Re AC on appeal it was in fact held
that the forced Caesarean section had been unlawful.

Although Re S has never been appealed, in English legal circles it is generally believed that
this decision was discordant with previous case law, and also with the Congenital Disabilities
(Civil Liabilities) Act 1976 which gives a child after birth the right to sue anyone who has caused
it pre-birth injury, except for its own mother. (The single exception to this is where a child may
sue his own mother if she negligently caused him harm whilst driving a car, for which she would
have been insured.) Nevertheless, following on from the 1976 Act there is also case law to
support a common law duty of care on the part of others towards the unborn child, but space
precludes discussion of this here.23

The 1997 case of MB24 involved a pregnant woman who had consented to an elective
Caesarean section, but who had a pathological fear of needles such that she refused permission
for the anaesthetic. The case went to court, and eventually to the Court of Appeal. This held that
her fear of needles rendered her temporarily incompetent to make the necessary decision, and so
it declared that overpowering her in order to give her the anaesthetic injection would not be
unlawful. The operation then went ahead. In giving the court’s judgment Dame Elizabeth Butler-
Sloss, then President of the Family Division, made a number of landmark declarations in terms of
English law. These included the following:

“A competent woman, who has the capacity to decide, may, for religious reasons, other reasons,
for rational or irrational reasons or for no reason at all, choose not to have medical intervention,
even though the consequence may be the death or serious handicap of the child she bears, or her
own death. In that event the courts do not have the jurisdiction to declare medical intervention
lawful and the question of her own best interests, objectively considered, does not arise.”

And:

“A fetus, up to the moment of birth, does not have any separate interests capable of being taken
into account by a court considering an application in respect of the performance of a Caesarean
section on the pregnant woman carrying the fetus. A court does not have jurisdiction to declare
medical intervention lawful to protect the interests of an unborn child, even at the point of its
birth.”

And:

“If Parliament were to think it appropriate that a pregnant woman should be subject to controls
for the benefit of her unborn child, then doubtless it will stipulate the circumstances in which
such controls may be applied and the safeguards appropriate for the mother’s protection. In
such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary
to extend the law.”

In 1998 the Court of Appeal considered the case of St George’s v S,25 which may well prove to be
the last English case of a Caesarean section carried out on a woman against her consent. Mrs S
was suffering from pre-eclampsia, and so she was admitted under order to a mental hospital, from whence she was transferred to a maternity hospital. Delivery by Caesarean section was recommended, but she refused. The court was asked to intervene. The court of first instance declared that a Caesarean section would not be unlawful, and so this was carried out. After delivery she appealed the decision. The Court of Appeal upheld its earlier decision in *Re MB*, and so it held that the operation on Mrs S had been unlawful and a trespass. The court laid down a number of helpful procedural guidelines as to how such cases should be avoided in the future. These included: a stricture on the use of the mental health legislation to detain a pregnant woman suffering from no more than a physical disorder; and requirements that in future hearings should be heard with both parties present or represented, particularly if the patient is incompetent; and that the case be fully argued based on appropriate information and documentation. Importantly, the Court of Appeal held that in future:

“An application to the High Court for a declaration will be pointless if the patient is competent and refuses consent to the treatment.”

So it seems that this will probably be the last coercive English Caesarean section.

**Blood Transfusions**

**US Court Decisions**

There have been several cases of court-ordered blood transfusion that have been quoted in support of petitions for court-ordered interventions in pregnancy. Best known is the 1964 case of *Georgetown* where the court ordered a blood transfusion in a Jehovah’s Witness who objected for religious reasons. It took the view that the state had an interest in protecting her children from abandonment if she died. But, as will be seen below, this view is no longer shared unanimously.

In the 1964 case of *Anderson*, the New Jersey Supreme Court ordered that blood may be given to a woman 32 weeks pregnant who refused for religious reasons. It held:

“We are satisfied that the unborn child is entitled to the law’s protection and that an appropriate order should be made to insure [sic] blood transfusions to the mother in the event that they are necessary in the opinion of the physician in charge at the time.”

In a 1985 case, *re Jamaica Hospital*, a New York court ordered blood transfusion in a woman at 18 weeks gestation, that is, below the age of viability. It was said:

“While I recognise that the fetus in this case is not yet viable … the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient’s right to refuse a blood transfusion on religious grounds.”

But this coercive approach was soon to change. In the 1990 case of *Fosmire* a New York court authorised a blood transfusion in a Jehovah’s Witness who lost a lot of blood at Caesarean section and had a haemoglobin level of only 4 g/dl. The blood was transfused, but she appealed after the event. Although the matter at issue was by then technically moot, in order to provide future guidance the New York Court of Appeals vacated the lower court’s order. It held that:

“… the state’s concern with maintaining family unity and parental ties is not an interest which it enforces at the expense of all personal rights or conflicting interests.”

In 1996 the Court of Appeal of Florida considered the case of *Harrell*, a Jehovah’s Witness. She needed a blood transfusion at 26 weeks gestation as she had an (unspecified) life-threatening condition, but she refused. A court order was obtained saying that she or the child could be given a blood transfusion if it were necessary to save the child’s life, but this blood was never actually
given. She was delivered by Caesarean section, but the child died two days later. The Florida Court of Appeal specifically declined to “address the substantive issues raised as to the state’s interest in compelling a pregnant woman to undergo a blood transfusion”. It held that the trial court had erred in considering the hospital’s emergency petition for treatment, that the hospital had no standing to bring such a petition, and that the trial court should have dismissed the petition sua sponte.

In 1997 the Appeal Court of Illinois considered the case of *Fetus Brown*[^31]. Mrs Brown was 26 years old and 34 weeks pregnant. She had had an operation to remove a urethral mass, from which she bled profusely. Being a Jehovah’s Witness, she refused a blood transfusion on religious grounds, despite her haemoglobin being only 3.4 g/dl. There was concern that both she and her fetus might die, and so an application to court was made. The circuit court appointed a guardian for the fetus, with power to consent to blood transfusion. Mrs Brown was sedated and held down for the purpose. In time she delivered a healthy baby. Later, the Appeal Court considered her appeal against the decision to transfuse blood despite her refusal. After carefully balancing the interests of mother and fetus, it held that:

“… without a determination by the Illinois legislature that a fetus is a minor for the purposes of the Juvenile Court Act, we cannot separate the mother’s valid treatment refusal from the potential adverse consequences to the viable fetus … We thus determine that the circuit court erred in ordering Brown to undergo the transfusion on behalf of the viable fetus.”

Thus, as in both *Harrell* and *Fetus Brown*, the more recent court view is that a competent pregnant woman must be allowed to refuse a blood transfusion.

**English Court Decisions**

As far as I know, no cases have come before the English courts where there has been an issue about giving blood to a pregnant woman without her consent.

However, in the 1992 case of *Re T*,[^32] a 20 year old pregnant woman of 34 weeks gestation was severely injured in a road traffic accident. She had been brought up as a Jehovah’s Witness and, after discussing the current situation with her mother, she declared that she would refuse any blood transfusion. She was delivered by Caesarean section of a stillborn infant, but her condition continued to deteriorate postoperatively, and she was put on a ventilator. Her father, supported by her boyfriend, applied to the court for a declaration that it would not be unlawful for the hospital to transfuse blood despite her lack of consent. Eventually the case came before the Court of Appeal, which gave the declaration requested. It held that the general principle still applied that a competent adult patient was entitled to refuse any treatment, irrespective of the wisdom of that decision. However, in this particular case there was doubt as to whether the patient had appreciated the seriousness of her condition and the likelihood of death. There was also concern that she may have been subject to the undue influence of her mother at the time that she refused the blood. For these reasons her refusal may have been invalid.

**HIV Treatment**

Each year, 7,000 women with HIV give birth in the US, and 700 do so in the UK[^33]. Nowadays it is generally accepted that they should all be offered screening for HIV early in pregnancy because appropriate antenatal interventions can reduce the maternal-to-child (vertical) transmission of HIV infection from 30% down to 2%.[^34] Such interventions include anti-retroviral therapy given antenatally and intrapartum to the mother, and then to the neonate for the first 4–6 weeks of life; delivery by elective Caesarean section; and the avoidance of breastfeeding.[^35]

However, not all women will accept these interventions, and so the question arises as to whether they should be compelled to do so for the sake of their unborn child.

[^31]: In 1997 the Appeal Court of Illinois considered the case of *Fetus Brown*.
[^32]: In the 1992 case of *Re T*.
[^33]: Each year, 7,000 women with HIV give birth in the US, and 700 do so in the UK.
[^34]: Nowadays it is generally accepted that they should all be offered screening for HIV early in pregnancy because appropriate antenatal interventions can reduce the maternal-to-child (vertical) transmission of HIV infection from 30% down to 2%.
[^35]: Such interventions include anti-retroviral therapy given antenatally and intrapartum to the mother, and then to the neonate for the first 4–6 weeks of life; delivery by elective Caesarean section; and the avoidance of breastfeeding.
Despite a careful search on Lexis, I have been unable to find a single court case in either the US or in England in which a pregnant woman’s refusal to accept screening, antenatal treatment, or Caesarean section for HIV has been a point at issue. However there is probably little doubt that such cases relating to the refusal of interventions in HIV pregnancy will reach court before long.

As far as universal testing is concerned, the options are: (1) voluntary testing with counselling regarding risks and benefits; (2) testing with patient notification and right of refusal; and (3) mandatory testing with no right of refusal. Both the Royal College of Obstetricians and Gynaecologists and the US Centers for Disease Control have favoured the first option. Both the American Medical Association and the American College of Obstetricians and Gynecologists, have favoured the second option. In a wide-ranging review of the legal and constitutional issues involved, Eden has argued that the Supreme Court would find that mandatory HIV testing of pregnant women would not be unconstitutional, even though it may not be the most effective way of reducing perinatal transmission.

As for the imposition of antenatal anti-HIV treatment and delivery by Caesarean section of pregnant women who refuse consent, it seems the legal and ethical issues here are the same as those considered above for blood and Caesareans.

Notes
1. Presented to the American College of Legal Medicine in Chicago on 1 October 2005.
5. Schloendorff v Society of New York Hospital 211 NY 125 at 126 (1914).
18. Pemberton v Tallahassee Memorial Regional Medical Center Inc 66 F Supp 2d 1247 (ND Fla 199).
23. Burton v Islington Health Authority and De Martell v Merton and Sutton Health Authority [1992] 3 All ER 833.
26. Application of the President and Directors of Georgetown College Hospital 331 F 2d 1000 (1964).
27. Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson 201 A 2d 537 (NJ 1964).
28. In re Jamaica Hospital 491 NYS 2d 898 (Sup Ct 1985).
30. Tina Harrell v St Mary's Hospital 678 So 2d 455 (Fla 4th Dist App 1996).