FORCED CESAREAN SECTION AS REPRODUCTIVE CONTROL AND VIOLENCE: A FEMINIST SOCIAL WORK PERSPECTIVE ON THE "BABY R" CASE

by

Kelly E. Maier

Bachelor of Social Work, University of Victoria (1983)

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Name: Kelly E. Maier

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Examining Committee:

Chair: Dr. Andrea Lebowitz

Dr. Arlene McLaren
Associate Professor
Department of Sociology & Anthropology
Senior Supervisor

Dr. Susan Wendell
Associate Professor
Department of Women's Studies & Philosophy
Second Reader

Dr. Kathryn McCannell
Associate Professor of Social Work
School of Social Work
University of British Columbia
External Examiner

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Author:

(signature)

Kelly Maier

(name)

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(date)

Abstract

The "Baby R" case, in which a pregnant woman's fetus was apprehended and the woman was pressured into "consenting" to cesarean surgery in a Vancouver hospital in 1987, brings into sharp focus the recent expansion, under the auspices of fetal "protection," of medical, legal and social work control over pregnant women's bodies and lives. Using the case study approach, the complex set of circumstances in "Baby R" is unravelled, focusing on the issues of informed consent and the role of child protection legislation. The growing documentation of obstetric and legal intervention in Canada and the United States is also used to provide a broader context for the discussion. Forced cesarean section, which includes court-ordered cesarean section, is one instance of a trend toward increased obstetrical, legal and social work interventions in pregnancy and birth. While the medical and legal aspects of these interventions have been discussed to some extent in the feminist and mainstream literatures, the implications of such interventions for social work remain largely unexamined.

A feminist social work perspective defines the problem of forced cesarean section as a violation of patients' rights to refuse medical treatment under conditions of informed consent, and a violation of women's equality rights. The claim that pregnant women's refusal to consent to a cesarean section constitutes "child abuse" or "child neglect" is rejected. Instead, arguments are advanced that forced cesarean section and fetal apprehension are illegal and unethical interventions that extend medical and state control over women's bodies, thwart women's struggles for reproductive rights and pose a significant risk to women's physical and mental health. Moreover, the instrinsic violence is made explicit: forced cesarean section is a form of violence--*reproductive violence*--against women that especially threatens the rights and well-being of socio-economically marginalized women.

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Preface

My decision to pursue graduate studies was a direct result of the gap in my formal knowledge of the reality of women's lives and women's oppression. As a social work practitioner and a feminist activist committed to social change, I felt a deep need to understand critically women's oppression in particular, and the ways in which social structures maintain relations of domination and subordination in general. In 1985, when I was accepted for admission to the Master of Social Work program at the University of British Columbia, it would have been difficult to study reproductive issues from a feminist perspective, since gender as a significant category of analysis was not part of the social work curriculum. Because of this, I pursued another option--graduate studies in the new, interdisciplinary Master of Arts program at Simon Fraser University in the Women's Studies Program (now Department). Within this program I was able to draw from and build upon my social work experience and education, and to examine gender and the implications of gender relations for social work policy and practice in the area of reproductive issues from a feminist social work perspective. I sought to incorporate social work ideas by discussing my work-in-progress with colleagues, presenting the arguments in programs in social work forums, translating the work into a brief for the social work professional association, as well as by selecting a social worker for my external examiner.

It is encouraging that in 1992, due to revisions to the social work curriculum at the University of British Columbia which give gender a place of some importance in social work education, social work students have more options to pursue research from a feminist social work perspective *within* a graduate social work program.

Chapter 1

FORCED CESAREAN SECTIONS: FROM DOCTORS' ORDERS TO COURT ORDERS

> The experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other in such a way as to catch one between and among them and restrict or penalize motion in any direction. It is the experience of being caged in: all avenues, in every direction, are blocked or booby trapped....whether it is deliberate or not, people can and do fail to see the oppression and hence fail to see various elements of the situation as systematically related in larger schemes. As the cageness of the birdcage is a macroscopic phenomenon, the oppressiveness of the situations in which women live our various and different lives is a macroscopic phenomenon. Neither can be *seen* from a microscopic perspective. But when you look macroscopically you can see it--a network of forces and barriers which are systematically related and which conspire to the immobilization, reduction and molding of women and the lives we lead (Frye, 1983:4,7).

In May 1987, a pregnant woman's fetus was apprehended by British Columbia child welfare authorities because the woman disagreed with the attending obstetrician on the method for delivering her baby. Accepting grounds for the apprehension as "denial of necessary medical care," the lower court allowed a fetus to be considered "a child in need of protection" under the Family & Child Services Act. What began in the hospital as a pregnant woman's refusal of a cesarean section operation, became a full blown child protection hearing in the courts. Spotlighted in the media and in the family court hearing were the pregnant woman's history of parenting and unconventional lifestyle. Although the lower court decision was overturned by the B.C. Supreme court in 1988, the child was never actually returned to the custody of his mother but remained in the permanent care of the Ministry of Social Services and Housing. This case, known as "Baby R," was the second of its kind in Canada. Unlike the first fetal apprehension case,[1] Baby R became the subject of considerable media attention and brought to public light the current debate on forced cesarean sections and other forms of unwanted medical and legal interventions in pregnancy and childbirth.

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[1] See Kirkland (1987).

The public response to Baby R came from several camps. The medical, ethical and legal communities were sharply divided on this issue. Proponents of the forced cesarean section and fetal apprehension in the Baby R case either viewed the surgery as a necessary medical "*fetal* protection" measure, or saw the case as a clear instance of "*child* protection." Feminists and human rights groups were the quickest to oppose the medical and child welfare interventions, claiming that forcing unwanted medical treatment on a pregnant woman seriously violated her fundamental legal rights (as a patient and as a female). Notably absent in the public response, however, was any comment from the profession of social work.

Significance of the Research Question

Because of my social work background in the child protection field and as an active feminist in the women's movement the Baby R case not only caught my attention but heavily preoccupied my thoughts. It was the feminist commentary on the Baby R case which alerted me to the fact that a larger debate was taking place regarding the recent trend of medical doctors, hospital administrators, social workers, lawyers and other third parties to seek court orders to force obstetrical interventions on pregnant women. The B.C. Baby R case graphically illustrates the problem of forced cesarean sections and brings into sharp focus (in part because it occurred so close to home) the ways in which women's rights are being violated by medical, social welfare and legal interventions to protect fetuses. What I found most chilling as a social worker is the fact that child protection social workers are playing a key role in these actions.

I decided that the complex issues embedded in the Baby R case as recorded in the public response provided the data for an interesting and timely case study; moreover, since no social work response had been forthcoming, I felt my analysis may contribute to the debate about whether unwanted medical treatment should be forced on pregnant women for the sake of their fetuses. My preoccupation with the Baby R case grew as I realized its central importance to social work and to women's equality struggles and decided to make it the focus of my thesis.

Without a feminist perspective to analyze the construction of the problem and the interventions in the case, a conventional social work perspective, couched in androcentric bias, may do little more than

reinforce ideologies about female behavior and motherhood which assume pregnant women should be self-sacrificing (see Dominelli & McLeod, 1989; Marchant & Wearing, 1986). If, for example, a conventional social work analysis of the case accepted the assumption that Baby R was a *child in need of protection*, (which many social workers apparently did), then the human rights violation and pregnancy (sex) discrimination became obscured or of secondary importance at best. Therefore, I approached my study of the case from a social work perspective informed by a feminist analysis.

I began my thesis research with many questions. How did the mainstream and alternate (e.g., feminist) media differently describe and formulate the issues in the case? What were the parameters of the larger debate, that is, who commented on this and other such cases and why? The lack of interest and response from the social work profession troubled me. For instance, why was the matter of consent to medical treatment overlooked and obscured by child protection authorities (e.g., the Superintendent of Family & Child Services) and the courts by the claim that the fetus was a "child in need of protection"? Was the role of the child protection social worker who apprehended the fetus (and those who gave evidence in the hearing) ethically or legally legitimate? What role, if any, did the hospital social worker play in this case? What roles would have been ethically appropriate and indeed possible for the social workers under the circumstances? As my research continued I kept expecting to find commentary from the ranks of social work educators, policy makers, or practitioners yet found none. Why were social workers silent about this case? Was their silence a statement of agreement with or acquiescence to the lower court's finding? It seemed evident that without a feminist analysis, the role of the child protection (i.e., statutory) social worker may be gender-blind and work antithetically to the needs of pregnant women and other minority groups. My task in writing the thesis was to critically examine the facts of the Baby R case from the public record, to explore and unravel some of the legal, medical, and ethical issues involved and to initiate critical discussion of the larger debate about medical and legal interventions in the lives of pregnant women, especially among social workers. This thesis raises critical questions about the matter of the relationships between the social work profession, the medical profession and the judiciary, focusing on the question of consent and the role of child protection, and using the growing documentation of obstetrical and legal intervention to protect fetal rights in the United States to provide a broader context for the discussion.

The Baby R case has three critical ethical features. First, unwanted medical treatment was forced on a pregnant woman. Second, a fetus was called a "child" and illegally apprehended using B.C. child protection legislation. And third, the pregnant woman's fetus was extended rights which were effectively used against her.

The Baby R case not only brings the problem of forced cesarean sections and issues of women's equality sharply into focus, it graphically illustrates the ways in which women's rights are being violated by medical, legal and social work actions to protect fetuses. Moreover, the case dramatically foreshadows the role being cast for child protection social workers in these actions. Because the Baby R case has important, as yet unexplored, implications for women and for social work, a critical analysis of this case is necessary--that is, a feminist social work analysis that assumes that a basic tenet of ethical social work practice is to speak out on behalf of oppressed and victimized groups and to demand socially responsible governmental (state) actions and policies.

This thesis addresses the significance of the problem of forced cesarean sections for women and for social work. The ways in which fetal "rights" have been used to legitimize these interventions in the non-abortion context of coerced medical intervention will be explored; however, a full discussion of the debate about fetal viability, fetal personhood and women's reproductive rights in the abortion context[2] is beyond the scope of this thesis.

Plan of the Thesis

In order to provide background and context for a feminist social work analysis of the problem of forced cesarean section as illustrated by the Baby R case, in chapter two I discuss the existing literature as it applies to unwanted medical and legal interference with pregnant women's autonomy. For the purposes of this thesis I selectively reviewed five areas of literature: androcentric bias in social work, the ideology of

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[2] For a comprehensive account of the Supreme Court of Canada's verdict on abortion in 1988, see Day & Persky (1988). For an excellent feminist analysis of the abortion debate see Petchesky (1987, 1990); also see Figuiera-McDonough (1990); McLaren & McLaren (1986); Gavigan (1986); OCAC (1988).

motherhood and social work, the medicalization of reproduction, forced cesarean sections, and reproduction, violence and social control.

In chapter three I lay the groundwork for a critical analysis of the Baby R case, demonstrating the need for feminist and social work perspectives on the problem of forced cesarean sections. I first locate discussion of the problem within the context of the increased obstetrical and judicial interventions in pregnancy and childbirth in North America over the past two decades. Next, I provide a detailed account of the sequence of hospital events and subsequent decisions of the lower and supreme courts of B.C. in order to provide the background data for a study and analysis of the Baby R case and the key issues it raises.

In chapter four I extract two important issues from the hospital events and complex and confusing court rulings described in chapter three: namely, the issue of informed consent and the role of child protection. I argue that under the circumstances in the Baby R case, the so-called consent offered by the pregnant woman, Rose, was a "coerced consent" and was legally and ethically unsound. I then explore the role of child protection in this case and argue that the use of statutory child protection power and authority (by MSSH) was coercive. The predominant themes of coercion and control over the most socio-economically marginalized pregnant women by medical, legal and child protection powers, allegedly for the sake of fetuses, emerge. In response to these themes I argue that forced cesarean section should be understood as both a violation of rights and roles and as a *form of violence against pregnant women*. In advancing this position I argue that opponents of forced cesarean section have not gone far enough in their analysis.

In chapter five I draw general conclusions about the problem of forced cesarean section, both for women's equality rights and for the profession of social work. I identify the contradictory roles of the social worker as agent of change and of social control. The way forward for social work, I argue, is an integration of progressive social work and feminist values in which social workers can play a significant role, acting in both statutory and non-statutory agencies as agents of social change, to challenge oppressive acts and attitudes toward women and other minorities at the same time that they encourage the conditions and environment for pregnant women which will ultimately provide the best chance for healthy pregnancies and fetal growth.

General Theoretical Perspective of the Thesis

An examination of the Baby R case necessarily includes a feminist understanding of the importance of gender and its construction in society and an understanding of how women experience and negotiate reproductive rights. Therefore, the general theoretical perspective I take is a feminist perspective. Feminism, broadly defined, is the organized movement to end sexist oppression. The systematic forces that trap and cage women in oppressive situations, severely circumscribe the lives women lead (Frye, 1983). Feminists recognize that females as a group are oppressed in society simply because they are female. While feminism is not a unified political ideology,[3] certain basic commonalities in political perspective are at the core of all feminisms (e.g., liberal, radical, socialist, anti-racist).[4] Adamson, Briskin and McPhail (1988:9) put it succinctly: "all (feminisms) believe in equal rights and opportunities for women; all recognize that women are oppressed and exploited by virtue of being women; and all feminists organize to make change."[5]

I maintain that a feminist perspective on the Baby R case is essential since it places women at the centre of analysis. Thus, it not only enlarges the scope of the discussion but redefines the key issues in the case from a woman-centered, rather than a fetal-centered, approach. Drawing upon radical, socialist and anti-racist streams of feminism and theories of equality, reproductive autonomy and violence in the feminist literature, as well as feminist social work perspectives from the relatively small body of feminist social work

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[3] See bell hooks (1984) for a full discussion of feminism as a radical political movement.

[4] See R. Tong (1989) for a detailed discussion of feminist currents of thought.

[5] An exception to this definition would be the small group of feminists who advocate women's *superiority*.

literature, I apply what might be called an "integrated" feminist[6] social work analysis to the Baby R case and to my examination of the problem of forced cesarean sections. This theoretical approach incorporates radical, socialist and anti-racist feminisms. My values and perspective emerge from and reflect my location in society as a white woman with a working-class background and a university education who identifies professionally as a social worker and politically as a feminist.

Discussion of the Case Study Method

I use the case study method to analyze the public record (i.e., newspapers, journals and court records) of the Baby R case, recognizing the benefits and limitations of this method. One of the obvious benefits of the case study, a method frequently used in social work research, is the rich set of circumstances and questions the particular case presents for analysis. Taking the form of a documentary study of the public response to the Baby R case,[7] this approach permits an in-depth exploration of the issues, however, does not include an examination of the responses of those women who have been coerced and forced to undergo unwanted medical interventions, which would pose different sets of questions. One clear limitation of the traditional case study method is that generalizations cannot be made. To compensate for this limitation, I use the matter of Baby R to bring to light the larger debate which has been dubbed by the mainstream media the "maternal vs fetal rights" problem. By situating my analysis of the Baby R case within the context of the medical, legal, feminist and ethical commentaries which bear on the issues raised by the case, I am able to highlight structural relations of dominance and power on the basis of sex, race and class which are key ingredients of the problem. Because the literature on forced cesarean section is relatively small, absolute generalizations cannot be made. However, themes of coercion and abuses of

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[6] Angela Miles uses the term "Integrative Feminism" to describe a feminist politics which transcends male politics, (e.g., Marxism) and transforms and redefines humanity. Integrative Feminism is that feminism which most clearly articulates the "integrative and feminizing project" of changing oneself and the world through feminist research and practice (see Miles, 1982:9-23).

[7] Case study is a general methodological approach which can take many forms, for example, life history, community and organizational case studies.

power and position emerge which clearly threaten women's reproductive autonomy and promote a form of violence, that is, unwanted major surgery, on pregnant women. Further study of the debate from within social work is needed; especially valuable would be empirical studies which examine the beliefs and attitudes of social workers about the question of fetal protection and women's rights and studies of what forced cesarean sections mean to the women involved.

Conclusion

In two Canadian provinces child protection social workers have sought and been granted court injunctions--in British Columbia to force a pregnant women to undergo surgery, and in Ontario, to detain a pregnant woman in hospital. Both cases involved fetal apprehensions using child protection legislation. Forced cesarean sections are but one form of state intervention within a broad spectrum of acts and attitudes that are coercive and violent toward women because of their reproductive state, that is, pregnancy. Yet the implications of unwanted obstetrical interventions such as forced cesarean sections, so graphically illustrated by the Baby R case, are significant not only for women as an oppressed social group but also for the profession of social work. It is my argument that social workers and social work educators must critically re-examine these cases, discuss and debate the issues they raise, the commentary in the literature, and especially the implications for social work, in order to develop clear strategies for social change. I argue that a feminist perspective is both necessary and critical to this task. Moreover, the larger project for social workers is to examine the significance of women's inequality to our theory and practice (Marchant & Wearing, 1986; Dominelli & McLeod, 1989; Gilroy, 1990) especially in the area of reproduction, motherhood and violence against women (Levine & Estable, 1984).

Chapter 2

LITERATURE REVIEW

> Gender is a total experience for women. Social work practice defines women as wives, mothers, carers, adolescent girls, i.e. in relation to their sexual behavior, and not as people. But paradoxically gender is invisible (Hanmer & Statham, 1989:1).

Androcentric Bias in Social Work

To understand the response of social workers to forced cesarean sections, it is important to examine the underlying androcentric bias that exists in the discipline of social work. Social work has inherited, perhaps unwittingly, the sexism entrenched in other disciplines. Yet when feminists have criticized sociology, psychology, and economics, for example, social workers have done little to apply these criticisms to their own discipline. This is all the more surprising since, as many commentators have noted[8] social work is largely based upon the fundamental principles of equality, anti-discrimination, and social justice.[9]

Lacking a theory or practice of feminist social work, the discipline applies both concepts and methods which maintain the male-dominated, class structured social order (Wearing, 1986). For example, within the traditional casework method in social work, the focus on client problems as solely the result of individual pathology (an approach which is derived from and heavily reinforced by the psychoanalytic

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[8] See Affilia: Journal of Women and Social Work; Dominelli & McLeod (1989); Marchant & Wearing (1986); Turner (1991).

[9] Work for social justice and social change is integral to ethical social work practice. As stated in the BCASW Code of Ethics: "The social worker will take reasonable actions to prevent and eliminate discrimination against any person or group on the basis of race, ethnicity, language, religion, marital status, gender, sexual orientation, age, abilities, socioeconomic status, political affiliation, national ancestry or any other preference or personal characteristic, condition or status" (1989:28, 29); also see CASW (1983).

approach), or deviant behavior, maintains a "blame the victim" methodology within social work (see Wetzel, 1976). Such an approach does not question the status of women within the stratified social order.

Feminist social work writers such as Marchant and Wearing (1986) have, however, begun to explore the androcentric bias in social work and to suggest ways to re-examine social work theories and practice.[10] Marchant contends, for example, that family systems theory was uncritically accepted within social work and continues to be used despite the ways in which it ignores the unequal power dynamics in traditional nuclear family systems and de-politicizes women's oppression. Marchant brought into focus the implications for gender analysis in social work of adopting sexist theories such as systems theory:

> There are gender related overtones to the claims and promises articulated by those promoting systems theory. In connection with the avoidance of involvement in the political arena (Pincus & Minahan, 1973), one of the implicit assumptions is that if political issues are defined as being external to the business of social work, then too gender issues are defined as external. Thus the difference between the status of men and women is not addressed. The differing roles and power differentials between men and women in the family, in the workplace and in social life generally are not viewed as a social process that needs to be investigated and potentially changed. The existing power differentials in society are considered the norm. Deviance from socially accepted perceptions of the value of men and women is viewed as abnormal. Therefore the work of the social work practitioner using systems theory as the rationale for practice, is to support the status quo, by reinforcing differences in men and women as acceptable. Thus the politically conservative and consensus-oriented assumptions of systems theory promote a theoretical position that denies gender a place as a concept of some importance (1986:23-24).[11]

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[10] On feminist social work practice see Hanmer & Statham (1989); also Bricker-Jenkins & Hooyman (1986).

[11] See Helen Marchant "Gender, Systems Thinking and Radical Social Work," (1986) for a review and useful critique of systems theory and its incorporation into social work knowledge and practice approaches; also see Wharf (1989) and Lecomte (1989).

Like several others in the small but developing feminist social work literature,[12] Marchant and Wearing argue for social work to integrate gender analysis in conjunction with analysis of class, race, and sexuality discrimination. Attention to gender as an issue is particularly important to social work since, as Dale and Foster note, women are so centrally involved:

> First, both social workers and feminists are centrally concerned with the institution of the family and with women's role within it. Second, not only do women form the majority of social workers' clients, but even when they are not the direct 'problem' women are frequently targeted for social work intervention as the mothers, daughters or wives of those referred for social work help or supervision...Third, social workers themselves, unlike doctors, are predominantly female although female social workers--like female doctors--have never exercised control over their profession nor over those organizations in which social work takes place (1986:95-96).

While the development of a feminist social work literature has come some way, this literature has been virtually silent on women's reproductive self-determination.[13] Moreover, the social work profession has failed to comment on the arguments being advanced within medical and legal discourses which favor the protection of fetal rights[14] and support the use of fetal rights as justification for the violation of women's human rights. Social workers should be alarmed by the tide of sentiment which pits pregnant women against fetuses (and by extension children--a new form of mother-blaming and "maternal

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[12] For Canadian examples, see Levine (1982); Turner & Emery (1983); Levine & Estable (1984); McCannell (1986); Maier (1989); McCarthy (1989); Gilroy (1990). For American examples, see Affilia: Journal of Women and Social Work (1986-present); Van den Bergh & Cooper (1986), Rhodes (1986); Hanmer & Statham (1989). For British examples see Hudson (1985, 1989); Dale & Foster (1986); Dominelli & McLeod (1989). For Australian examples see Wearing (1984); Marchant & Wearing (1986).

[13] See McCarthy (1989), "On the Bias" in Affilia (1990) and Figueira-McDonough (1990) for exceptions.

[14] See, for example, Law Reform Commission of Canada, "Crimes Against the Foetus," Working Paper (1989); Bowes & Selgestad (1981); Pinkerton (1985); Segal (1987); Kluge (1987); also see the Canadian Medical Association's proposed recommendations (as yet unadopted) regarding the status of the fetus, which among other things, recommends that "When a fetus has become a person or there is a reasonable expectation the fetus will become a person, the doctor is obliged to prevent harm to the fetus" ("Doctors side-step," 1991).

culpability").[15] Social workers should also be alarmed by government and professional policies and practices which enforce medical treatment on pregnant women *under the auspices of child protection concerns*.[16] A feminist perspective is necessary to ensure that the profession of social work does not unwittingly collude in the current trend of increased medical violations of pregnant women.

The Ideology of Motherhood and Social Work

The most obvious form of androcentric bias that underlies social work practice and theory is the ideology of motherhood. Western society holds distinctive ideas about what motherhood should entail and how mothers should behave. Feminists have long understood the significance of ideological presuppositions in maintaining women's subordinate status. According to legal commentator Lorenne Clark:

> The test of strength of any ideology is the extent to which its basic pre-suppositions remain not merely unquestioned but literally unrecognized. The more such assumptions appear to be simply a part of the fabric of fact, the stronger the intellectual hold of the ideology they support and the greater the difficulty of changing the practices arising out of it (1976:35).

As many feminists note, women are particularly constrained by the powerful ideology of motherhood. Feminists (e.g., Rich, 1976; Levine & Estable, 1984) argue that a clear link exists between women's subordination and the institution of motherhood, and that the prescription of motherhood has ramifications for all women: "Whether we have children or not, issues relating to motherhood have implications for us all. The definition of motherhood is latent in every definition of womanhood" (Levine & Estable, 1984:7).

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[15] For the response from legal feminists in Canada, see, for example, the National Association of Women & the Law, Working Group on Health & Reproductive Issues, A Response to "Crimes Against the Foetus" (1989); also CBA (1990).

[16] The Baby R court decisions and legal commentary (Davis, 1987; Macdonell, 1988; LEAF, 1988; Majury, 1988; Phillips, 1988; Dawson, 1990) provide a powerful illustration and critique of this, as detailed in chapter three; also see Superintendent of Child Welfare, Leslie Arnold's memorandum (1988) in which she creates an *ad hoc* fetal protection policy within the legal framework of the child protection mandate.

Examining the origins and the effects of the social prescriptions for motherhood and the gender-division of labour in the private and public spheres, feminists argue that keeping women in the private sphere of unpaid work in the home as primary caretakers for the emotional and physical needs of children and men circumscribes women's lives and maintains their subordinate status (McDaniel, 1988). Women themselves internalize the notion that the only true "vocation" for women is motherhood (Rich, 1976; Wearing, 1984).

In a landmark work, Of Woman Born: Motherhood as Experience and Institution, Adrienne Rich (1976) argued that the institution of motherhood, under male control and male domination, forces women to be mothers, slotting women into rigid gender-role straightjackets which over occupy and often heavily overburden them. Rich felt women's understanding of the empowering potential of experiential and social motherhood is distorted and diminished by what she called the "institutionalization of motherhood." The "institution of motherhood," by virtue of its invisibility and strength as an unquestioned ideology, structures women's behavior and expectations. The institution of motherhood romanticizes and mythologizes motherhood at the same time that it ignores, distorts and diminishes how women experience pregnancy and motherhood. Rich, like many other feminists, analyzed and exposed (as false) some of the central features of institutional motherhood, for example: "maternal instinct" (as a social construct), "maternal deprivation" (as a woman-blaming and mysogynist theory) and "maternal duty" (as a tool of patriarchal control over women).[17] Rich, who argued that the *institutionalization* of such ideas and expectations about motherhood is the problem, not motherhood itself, noted that the alienation of women from their bodies and the reality of their lives is but one result of this institutionalization. How women experience and define their relationship to their bodies, minds, spirits and intelligence should be in the control of women, not men (Rich, 1976).

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[17] See Levine & Estable (1984) on "maternal deprivation" theories and the ideology of motherhood (also see Wearing, 1984); see Rowland (1985) on motherhood, alienation and the concept of choice (in the context of sex preselection); and see Mary O'Brien (1981) for a political analysis of reproduction and mothering.

The various "helping" professions are particularly instrumental in creating and maintaining the institution of motherhood.[18] According to Dale & Foster:

> [M]any social workers still hold traditional attitudes about women's natural and proper functions within the family and in society in general...[and] that professional social workers may play a similar role to doctors in controlling, or at least attempting to control, their female clients' lives, in ways which feminists regard as sexist and oppressive (1986:97).

While feminists have examined medical control of women, they have paid less attention to the ways in which social work has contributed to the social control of women (Dale & Foster, 1986). Gender analysis in social work is, however, beginning to focus attention on the role social workers play in maintaining and perpetuating women's subordination and more particularly the ideology of motherhood (Levine & Estable, 1984). In their daily practices, development and enactment of social policies, and educational training, social workers without the benefit of a *critical* "reproductive consciousness"[19] reinforce the idea that women's reproductive roles and their capacity to mother are natural and preeminent (Gilroy, 1990; Hanmer & Statham, 1989; McCannell, McCarthy, & Herringer, 1992). Moreover, social work, not considered an equal agent in the hierarchy of professions, (and partly in an attempt to shed the

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[18] Levine & Estable (1984) also persuasively argue that the institution of motherhood controls women by containing women within the private sphere of the home. Within the patriarchal family, constrained by the ideology of motherhood, women are prevented from seriously threatening the power and dominance of men in the public sphere. See this work for a fuller discussion of the power politics of motherhood from a feminist social work perspective. Rosalind P. Petchesky (1990:35-36) also makes the important point that social workers play a role in communicating the dominant bourgeois values of child-focused mothering and the meaning of maternal duty.

[19] The notion of women's reproductive consciousness, according to one of the most significant contributors to radical feminist theorizing on the relationship of reproduction to women's oppression, feminist philosopher Mary O'Brien, is that females "are conscious of themselves as reproducers" (while males "are conscious of being alienated from the process of reproduction") (1985:63). Her landmark work in 1981, The Politics of Reproduction, established the cultural and historical significance of birth and argued that males are biologically alienated from the process of reproduction and hence seek to mediate their separation from species continuity by controlling women's bodies (in order to control those of "their" children). O'Brien believes women's reproductive capacity is at the same time the source of women's oppression under patriarchy and capitalism, and the potential source of their liberation in a society where women have control of their reproductive and productive labour. O'Brien's work has arguably influenced a feminist understanding of women's oppression across a wide range of "critical feminisms" (Lena Dominelli's term, 1991).

"quasi"-professional label) tends to acquiesce in the patriarchal systems of medicine and law.[20] Consequently, not only the formulation of issues and problems but also the interventions are often driven (i.e., defined and controlled) by these professions, as was clearly the case in Baby R.

The ideology of motherhood and the gender-blindness in social work pose significant problems from a feminist social work perspective, the effects of which become graphically illustrated by the problem of forced cesarean section. When social work fails to challenge regressive social policies which support forcing pregnant women to have cesarean sections, social workers become part of the problem and perpetuate the oppression of women.

The Medicalization of Women's Reproduction

As previously noted, feminists have examined ways in which the medical profession has gained control of women's bodies and to a lesser degree, the significance of the medical professions' shaping of social work. Ehrenreich and English (1979), for example, have documented the history of the rise of medical experts. They argue that in the process of medicalizing pregnancy, women have fallen under the domain of the professionals, that is, the "scientific experts." The historic influence of scientific professionalism was pervasive; as Ehrenreich and English (1979:150) put it, "*even social work* was establishing itself as an exclusive and 'scientific' occupation."[21]

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[20] Levine & Estable (1984), for example, argue that the system of patriarchy, in which male power and domination over women in family, workplace and society is maintained within certain structures and institutions relegates women social workers to a status subordinate to their male social work colleagues (as well as to male medical practitioners). Other minority groups within social work are further disempowered within the social hierarchy, for example, Natives (Howse & Stalwick, 1990); women of colour (Dominelli & McLeod, 1989); lesbians and disabled social workers (Hudson, 1989; D'Aubin, 1990).

[21] Emphasis has been added. Within their historic analysis, Ehrenreich & English note that at the turn of the century social workers were moving away from charitable work and establishing social work as a profession within the realm of "expert" helpers. Yet they provide only cursory attention to social work and in so doing, fail to pursue the impact of social welfare workers' "expert" advice on women and the degree to which such advice simply "echoed" that of doctors. Mothering became the domain of scientific experts to the exclusion of midwives and other experienced but not credentialled women (see Strong-Boag, 1988, especially her chapter on mothering); see Levine & Estable (1984).

More recently Dale and Foster (1986), have focussed on the role social work has played in this process and specifically on the relationship of social work to the medical profession. Social workers, the majority of whom are employed in health and welfare settings such as hospitals and child protection agencies, have participated to some degree in both the historical and contemporary establishment of medical authority over and regulation of women's bodies. Dale and Foster, in their work on "welfare professionals" and the control of women, reveal how social work has moved passively alongside medicine (doctors) to reinforce submissive roles for women. They examine the link between feminist and social work values and pose significant questions about the relationship of social work to the state. Most importantly, their work Feminists and the Welfare State: Radical Social Policy, explicitly invites a critical analysis of the contemporary social control function of medicine:

> If we can see clearly that so much nineteenth-century medicine was a form of social control over women, should we not also question the motives of contemporary medicine towards women? Feminists who have investigated contemporary medical doctrines on the nature of women and their problems have indeed found a strong sexist ideology lying just beneath the surface of medical advice and treatment. They have discovered that whilst some doctors are now far less patriarchal in their attitudes and practices than their Victorian counterparts, many others are still overtly sexist. Moreover, despite the valiant efforts of some feminist doctors and a few male doctors sympathetic to the feminist position, the medical profession as a whole still exercises significant control over women's sexuality and reproductive functions (1986:83).

Dale and Foster's analysis is a useful departure point for the development of feminist analyses of social work within the health care field and for assessing the implications for social work of forced obstetrical interventions such as cesarean sections. Their work on the medical control of women is useful for understanding social work's lack of response to forced cesarean sections. But it has not gone far enough. It has failed to examine the way women have been not only controlled by "doctors' orders" but their bodies invaded and violated.

Socialist feminist Jennifer Terry (1989) makes an important contribution to the new literature on medical invasion of women's bodies. Like many other commentators on the legal status of the fetus, Terry makes the point that the well-being of women and their right to security of the person under law is almost entirely absent in discussions of fetal rights (see also NAWL, 1989; Furman-Seaborg, 1987; Rodgers, 1989,

Dawson, 1990; Gallagher, 1984; Johnsen, 1986, 1987; Annas, 1987). Terry examines the invasion and surveillance of women within the context of (indeed, *the extension* of) state power and control over females (see Corea, 1985). But what makes Terry's work so vital to the literature is that she extends feminist analyses about male dominated state control of the female body a good deal further. Terry discusses, from both an historic and contemporary point of view, the new trend to consider pregnant women a "suspicious" group requiring public surveillance (e.g., surveillance of prostitutes and suspected carriers of the HIV virus). A recent example of this is the trend to monitor and criminalize pregnant women drug users (see Sherman, 1988b; also Gustavsson, 1991). Most significantly, Terry's work highlights and names the violation of women because of their reproductive capacity using, as one example, forced cesarean sections. She problematizes the "new incarnation of fetal rights which posits the fetus as an entity independent of the pregnant woman, with interests that are potentially hostile to hers" (1989:22).[22] Her notion of the violation of women of childbearing age is particularly relevant to the notion of reproductive violation I attempt to develop in this thesis.

Forced Cesarean Sections

The alarming rate of cesarean operations has been both well documented and widely criticized in the medical and women's health literature as representing unnecessary and dangerous medical interventions on birthing women.[23] *Forced cesarean section* is defined as any case in which a pregnant or birthing woman does not provide her full, free and informed consent to a cesarean operation. While the

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[22] She argues, for example, that the new logic of fetal rights not only positions pregnant women as potential enemies of fetuses but creates the justification for state surveillance of all potentially pregnant women. The fetus, like the HIV virus, becomes the *means* of monitoring pregnant women.

[23] From Canadian sources, see the two published reports from the Nova Scotia (1990) & Ontario (1991) Task Forces on cesarean sections: the B.C. Task force (1991) plans to release its findings in the Spring of 1992. See also Caroline Sufrin Disler's (1990a-f) compilation of facts on cesarean sections and VBAC (vaginal birth after cesarean), including "What Does the Medical Literature Say?" "Considering a VBAC? Some Suggestions for a Positive Birth"; "Facts About VBAC and Cesarean Section"; for a good American source on pregnancy, birth and cesarean section interventions, see the Boston Women's Health Book Collective (1986).

actual scope of the problem of forced cesarean sections is difficult to determine, cases of court-ordered cesarean section continue to be documented within a body of medical, legal, and feminist literature on forced obstetrical interventions (see Appendix 1).[24] As writers Jordan & Irwin put it, "Rumours of court-ordered sections abound, but documentation is difficult to locate" (1989:13). By 1987, however, several commentators had brought attention to the problem of forced cesarean sections (e.g., Annas, 1982, 1987; Bowes & Selgestad, 1981; Kolder, et al., 1987; Furman-Seaborg, 1987). In the first study of its kind, Kolder et al. (1987) found that over a six-year period in the United States (from 1981-1987), women in 11 states were forced by court order to undergo cesarean sections against their will.[25] The Canadian Bar Association cites that there have been at least 24 reported court-ordered cesarean sections in the United State from 1985-1990 (1990b:9), and another recent source states 23 hospitals in the last decade have sought court directions on how to treat pregnant women ("Precedent setting agreement," 1991:7).

According to Terry, forced cesarean section is a form of reproductive violation aimed at women (1989), and one of many coercive and invasive medical directives which disregard the autonomy of pregnant women. But such an interpretation is missing in the literature on forced cesarean sections. Within the literature at least four main positions have emerged. The first, simply stated, is that women ought to relinquish control to doctors' expert opinions in matters of pregnancy and childbirth. Within this literature, support for forced cesarean sections is based on the belief that a doctor's assessment of what is best for the pregnant women and fetus should be paramount. This position has been articulated by members of the

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[24] Moreover, the actual incidence is unknown since reference is made to cesarean section numbers by state, hospital, and geographic location without cross-tabulation of these data, an important area for future research.

[25] As this study indicates, in addition, to forced cesarean sections, two states have provided orders for forced intrauterine transfusions, and two for forced hospital detentions for treatment of illnesses such as diabetes (see Kolder et al., 1987).

medical and legal professions as in the Baby R case.[26] For example, the legal finding of the lower court hearing on the apprehension of Baby R (Davis, 1987) explicitly took this position. As was the case in Baby R, justification for this paternalistic position often rests upon the underlying assumption that a "responsible" pregnant women *should* and would "do whatever it takes" to ensure the healthy delivery of a child, and the opinion that, where a danger is posed for the fetus, the doctor (or hospital administration) ought to act on behalf of the "other patient," the fetus, to allegedly strike some sort of "balance" between fetal and pregnant women's interests.

A variation of this position contends that the issue of forced cesarean sections is a "child" protection concern. This argument maintains that a fetus close to birth is a "child" and ought to be protected under existing child welfare legislation (see LEAF, 1988; Terry, 1989:24-28 for further discussion of this point). The child welfare authorities in B. C. (see Brighouse, 1987b) as well as the judge (Davis, 1987) in the lower court hearing took this position as did much of the mainstream news coverage of the Baby R case (see "II Newspaper & Newsletters," in Bibliography). Social workers, surprisingly, did not publicly register an opinion.

Another position within the proponents of reproductive interventions such as forced cesarean sections comes from the anti-abortion movement. Here the issue is strictly fetal protection based on the notion of fetal rights, and arguments are made for legally entrenched fetal personhood from conception onward.[27]

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[26] Eike Kluge, medical ethicist (University of Victoria), took this position on a radio interview on CFAX (1987) "Baby R." In addition many social workers framed the issues this way in a discussion session following a panel presentation of which I was part, at the "Life and Death--Who Is In Charge?" workshop presentation, (May 1988) B.C. Association of Social Workers, Annual General Meeting.

[27] As Terry (1989) points out, the new version of fetal rights (i.e., fetus-in-a-hostile-environment) espoused by fetal protectionists assumes that pregnant women themselves are a threat to fetal well-being. This approach is a powerful political strategy but an approach that is logically flawed (see also Johnsen, 1987; Gallagher, 1984).

Feminists and other human rights groups, frame the issues differently and take the view that forced cesarean sections violate women's equality rights and deny women reproductive autonomy. Within this woman-centred position, neither the medical status of a doctor nor the rights attributed to a fetus (however defined) is sufficient to justify superseding a pregnant woman's entitlement to full equality with other adults.[28] From this perspective, women's bodily integrity and decision-making autonomy are at stake. The dismissal or violation of such basic human rights is unfair, discriminatory and inconsistent with women's equality right under the Charter (see Leaf, 1988; NAWL, 1989; CBA, 1990). Opposition to forced cesarean sections as a violation of pregnant women's human rights has also emerged from a few commentators other than feminists within medical, legal and ethical realms (e.g., Annas, 1987; Kolder et al., 1987; Sherman, 1988a,b; Zimmerman, 1987). In short, where a real or perceived conflict exists between "maternal and fetal rights," the life of the fetus is not equated with the life of the pregnant/birthing woman. Legal attorney Janet Gallagher perhaps best captures the feminist position when she states:

> [if] we take women seriously as people whose bodily integrity and lives and choices are to be valued, decisions about those conflicts will be left to the pregnant woman herself (1984:135).

Reproduction, Violence and Social Control

The fact that control over pregnancy was historically appropriated from women by the medical profession (and pregnancy redefined from a natural reproductive event to a (manageable) medical problem) has been well established in the feminist literature on women's health and the medicalization of birthing (see Ehrenreich & English, 1978; Daly, 1978; and Rothman, 1989; Sufrin Disler, 1990c,d). What has not been well established is the violence that is implied by some forms of medical control of reproduction. Understanding and ending violence against women has been a central preoccupation of the women's movement. Violence may be used as a last resort to "keep women down" when the less visible

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[28] See for example, Rodgers (1989); Dawson (1990); CRIAW (1987); Furman-Seaborg (1987); LEAF (1988); NAWL (1989); Thompson (1987a,b); Terry (1989).

forms of social control fail to be effective, or as some feminists argue (e.g., Hanmer & Maynard, 1987), violence against them is the "ultimate" form of social control of women. Yet feminist analyses of violence tends to examine the most obvious forms of violence such as rape and battering, and has tended to center on male control of women's sexuality (e.g., Peterson, 1976; Clark & Lewis, 1977; MacKinnon, 1987). Feminists have paid much less attention to violence against women that is centered on their reproduction.[29] A study of forced cesarean sections permits an analysis of this question.

Some feminists have noted that women are more likely to be battered when they are pregnant (e.g., Levine & Estable, 1984; MacKinnon, 1987), but few writers have been concerned with the many different ways women are violated in their reproductive roles. An exception is Terry (1989). She argued that women are controlled, coerced and violated in a variety of ways in their reproductive capacities. Terry and others have identified certain groups of women--women of colour, Native women, poor women, "welfare mothers," disabled women, institutionalized women, third-world women and prostitutes--who have been historically subjected to forms of reproductive violation (such as forced sterilization) as part of the social control of women who were (and currently are) considered "undesirable" as reproducers and "unfit" as mothers within public policy.[30] On the other hand, those women defined within the patriarchal medical and helping professions as "desirable" reproducers and mothers are also denied reproductive control and autonomous decision-making (Dale & Foster, 1986:87-88). For example, Claire McCarthy (1989) found that Caucasian women, especially those under thirty-five, married and middle-class, have to struggle to

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[29] Mary Daly is an early exception; see Gyn\Ecology: the Metaethics of Radical Feminism (1978); also see Klein (1981); Levine & Estable (1984:16-18).

[30] See Terry (1989) on the reproductive violation of black women, poor women and prostitutes; see Rich (1976:59-61); D'Aubin (1990); and Goundry (1990) on the reproductive violation of disabled women; see Dale & Foster (1986:86) on the forced sterilization of third world women and "welfare mothers;" also see McLaren & McLaren (1986) on the history of eugenic practices and policies.

obtain, not to prevent, sterilization.[31] Practices which deny certain women access to tubal ligation procedures constitute a coercive withholding of medical services and as such are a form of reproductive violation.

Both Terry and McCarthy's analyses illustrate women's lack of control over reproductive decision making and the ways in which certain groups of women are subjected to coercive and controlling reproductive policies which operate by violation or violence (e.g., certain women are denied access to sterilization while others are pressured to undergo sterilization). Women who are forced to undergo cesarean sections, however, are subjected to violations (e.g., of patient and women's equality rights) and violence (bodily assault) because of their reproductive state.

In the literature used to describe or analyze forced cesarean sections on pregnant women, as in the case of Baby R (see Appendix 1 for a brief description of other forced cesarean and fetal apprehension cases), commentators have referred to the problems of interference, bodily intrusion or lack of reproductive choice (see, for e.g., Macdonell, 1988; Rodgers, 1989; Majury, 1988; Phillips, 1988). While all of these terms are correct, they fail to describe the actual violence of the incidents: that against their will pregnant women are being anesthetized and then operated upon.

Violations of women take place in a large variety of blatant and also more subtle forms. In order to make visible the relationship among reproduction, violence and the social control of women, I specifically name the violence intrinsic to the act of forcing women to undergo cesarean sections *reproductive violation* and provide evidence of its existence.

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[31] In Women Choosing Not to Have Children: Implications for Social Work Practice and Policy on Reproductive Choice, (unpublished M.S.W. thesis, University of British Columbia: 1989) McCarthy studies the implications for social work practice and policy of reproductive choice for this group of women.

Chapter 3

INCREASED MEDICAL AND LEGAL INTERVENTIONS IN PREGNANCY AND CHILDBIRTH: THE CASE OF BABY R

> The changed definition of childbirth has been dictated by obstetrical practices developed by men who operate in a society that believes more technology makes better medicine. From a psychological point of view, male obstetricians may find it easier to identify with the fetus than with the mother [sic], and this may explain their tendency to focus on the fetus rather than on the birthing woman. The current model for obstetrical care incorporates traits of aggressiveness and a need for control that are common to males in this society, together with a symbiotic relationship between male obstetricians and machines which may be congenial to men who view the machine as enhancing their power and control. The result of this dominance of males and male values is a move away from a biological focus to a technological one. The contemporary merger of business and health care systems represents another male alliance that further defines childbirth for women and controls the experiences of childbearing families. Both these male-dominated systems regard women as passive objects for whom the birthing experience must be controlled, regulated, and manipulated according to scientifically "credible" practices of organized medicine. Women have been denied the freedom to define their own birthing experiences (Kunisch, 1989:41).

In chapter two, the review of certain bodies of literature--androcentric bias, the ideology of motherhood, the medicalization of reproduction, forced cesarean sections and the broad area of reproduction, violence and social control--provides a background of relevant feminist and social work literature to contextualize my critical analysis of the Baby R case and support my thesis that forced cesarean section is not only female-specific oppression which discriminates along distinct race and class lines, but a form of violence against women in particular circumstances, that is, pregnant women. Given social work's fundamental commitments to client self-determination, human rights, social justice and advocacy, I will argue that forced cesarean section, a practice which discriminates most against poor, non-Caucasian women, is inconsistent with social work principles and ethical social work practice. However, the questions and issues raised by the Baby R case and the problem of forced cesarean sections in general are by no means clear, straightforward or easy to resolve. In fact, it is the complexity of the factors and circumstances under which such actions take place that make the issues ethically confusing and so difficult to grapple with, as the Baby R case so clearly illustrates. Does a pregnant woman's refusal to undergo a cesarean section operation constitute "child abuse?" Is a fetus a "child" under child welfare legislation?

Who should the social worker advocate for as client--the pregnant woman, the fetus, or both? Who is most vulnerable to this form of medical/legal intervention? What is the best way to "protect" the health and well-being of a fetus? Such questions raise complex issues with significant implications for the future of social work.

My thesis is that pregnant women ought to have the same rights as other persons to refuse medical treatment: anything less constitutes a fundamental violation of women's individual and social rights. I argue from a feminist (social rights) position that the implications of forced cesarean sections for social work are immense and that social work ought to be centrally involved in the debates about forced cesarean sections. I challenge the decidedly fetus-centered approach to the resolution of what have been called maternal/fetal conflicts and make the case that social workers have an ethical and professional responsibility to understand and oppose discriminatory and oppressive state actions against pregnant women as in the Baby R case,[32] and other recent forms of female-specific victimization related to reproduction, which I call "reproductive violations."

Picking up a steady yet underemphasized social justice theme within progressive social work, I argue that we not only have a duty to advocate on behalf of full human rights for all people, regardless of sex, race, class, marital status or any other factors (Howse & Stalwick, 1990), we should be explicitly aligned with clients and with the most powerless groups in society. Social work educator Brian Wharf puts it simply, "there should be no doubt whose side the profession is on" (Wharf, 1990:161; see also Levine & Estable, 1984). In social work, the conflict between helping and controlling is not new, but the problem of forced cesarean sections gives disturbing new parameters to this tension in social work practice. For women as marginalized members of society, and for minority women who are most vulnerable, the need for

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[32] The code of ethics of the Canadian Association of Social Workers states:

Social work is a profession, committed to the goal of effecting social change on society and the ways in which individuals develop for the benefit of both. Social workers are accountable to the people they serve, to their profession, and to society, and the well being of persons served is their primary professional obligation (CASW, 1983).

social work to evaluate self-consciously its role in forced cesarean sections through a critical lens focused on issues of gender, race and class dominance is compelling. It is imperative that social workers learn about power, its impact, and how it can oppress. As Howse and Stalwick remark in their article on social work and First Nations people, the conflict between social work "help" versus "social work" control has had the greatest impact on marginalized groups:

> Social work education has largely ignored the consequences of the exercise of power, and, given the amount of power vested in social workers in such fields of service as child welfare and mental health, this ignorance is inexcusable....While respecting clients and their right to self-determination is a cardinal principle in social work practice, it has all too often not been honoured where minority groups are concerned (1990:103).

In this chapter I begin by examining the increased obstetrical intervention in pregnancy and childbirth in North America, specifically addressing the cesarean section "epidemic" as a significant part of this trend and a historical precursor for forced cesarean sections. The contrast between "informed consent" and "forced" consent for cesarean section operations is sharply illustrated by the sequence of events in the Baby R case, which began in a maternity hospital and occupied the courts in Vancouver, gaining public attention over a period from May 1987 to September 1988.[33] After recounting these events I summarize the issues and examine the decisions of the lower and supreme courts, in order to unravel the issues and reveal the violation of women's rights and the unethical actions of social work in this case, which occurred under the auspices of child protection. In doing so I attempt to accomplish two things: first, to lay the groundwork for a critical analysis of the Baby R case and second, to demonstrate the need for a feminist and social work perspective on this and other forced cesarean cases. Increased medical and legal power over the bodies and lives of pregnant women, whether under the auspices of improved fetal and maternal health (the biomedical theory) or protection of fetal harm (the fetal protection theory), intensifies the oppression of all women and poses an especially significant threat to minority and marginalized groups.

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[33] It was not until November 1988 that the *child* apprehension (i.e., re-apprehension) hearing occurred in the courts and December when the final decision of Judge Kitchen was recorded; however, the significant issues of the case concern illegal fetal seizure and forced cesarean section not bona fide child protection concerns. My thesis for this study, therefore, does not include critical commentary on the *child* apprehension hearing which occurred after September 1988.

Increased Interventions in Pregnancy and Childbirth

The medical establishment's takeover of the birth process has been a significant historical and contemporary issue in the women's health movement and has led to a strong critique of the biomedical model of pregnancy and demands for women's full equality, for which a fundamental prerequisite is female sexual and reproductive control (Ehrenreich & English, 1973:26; Petchesky, 1990).[34] My thesis accepts the feminist theory that medical management of pregnancy and intervention in birthing has reduced the control women have over their bodies and lives. Moreover, I argue that forced cesarean sections take this female-specific subordination even further; they illustrate a convergence of medical and legal control over women's bodies which violate women and pose a significant threat to women's equality struggles. Forced cesarean sections are therefore incompatible with social justice and ethical social work practice. In order to contextualize and develop these arguments, I begin this section on the increased obstetrical and judicial intervention in pregnancy and childbirth by documenting the increase in cesarean section operations and the relatively recent phenomenon of forced cesarean sections, drawing from medical and legal commentary and a large, well-developed body of feminist literature on the gender implications of the medicalization of women's lives.

Since management of pregnancy and the process of birthing moved from home to hospital, care of pregnant women and delivery of babies moved from the hands of midwives and women healers into the control of (primarily) male medical doctors (see Ehrenreich & English, 1973, 1978; Rich, 1976; Daly, 1978). As a result of this transition, medicine has had a monopoly on information and treatment concerning pregnancy and childbirth. With the weight of medical knowledge and authority, obstetrical interventions in

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[34] For a classic feminist critique of patriarchal medical practice and an especially rich source of historical documentation see Ehrenreich and English's (1978) For Her Own Good: 150 Years of the Experts' Advice to Women. It is noteworthy, especially in light of the debate about the "new" reproductive technologies in the 1980s, that Ehrenreich and English suggested in this early work that the "scientific substratum" of medicine should also be critically studied, especially as it relates to women (1978:27). Another excellent feminist critique of patriarchal medical practice is the Boston Women's Health Book Collective (1984) The *New* Our Bodies, Ourselves.

birthing such as cesarean sections have become commonplace, despite mixed effects (both physical and psycho-social) on the well-being of women and their babies (Sufrin Disler, 1990b: Mutryn, 1984). On the one hand, the development of medicine has done much to decrease maternal and infant mortality (death) rates in complicated labour and birth situations. But for pregnant women as a social group, increasing medical control and intervention in the birth process has been a mixed blessing. Overall, pregnant women have had fewer choices and less control over where and how birth will take place (Rothman, 1989). Moreover, doctors have come to control and manage pregnancy and birth from the standpoint (and with the authority) of predominantly male medical "experts," often overlooking the pregnant patient as an active agent in the birth process (Boston Women's Health, 1984).

Does Doctor Know Best?

Many people, including social workers, continue to hold the belief that doctors are "experts" and thus know best (Roberts, 1989:217; Ethics in America, 1987). In fact, the very notion of a "good" patient is that of a compliant patient within the paternalistic and patriarchal practice of medicine (Rosser, 1988). Contrary to this conventional "wisdom," however, there is a great deal of medical evidence[35] that placing unquestioning faith in the advice of physicians is unwise and unwarranted. According to medical and legal commentator George Annas, (1987:1213) physicians not only often disagree about the appropriateness of obstetric interventions, they are often wrong.[36] For example, not long ago, physicians prescribed thalidomide and diethylstylbestrol (DES) for pregnant women. The consequences of both have been tragic; thalidomide was found to cause neurological damage to some pregnant women and skeletal defects in fetuses, and DES was linked to vaginal and cervical cancer in the daughters, and infertility in both the

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[35] As well there is a considerable body of women's health movement literature on this topic. For example, Boston Women's Health (1984); Roberts (1985); Ehrenreich & English (1978); see also McDonnell (1986) and "Side-Effects--A Play About Women and Pharmaceuticals," (1986).

[36] Within the context of the increasing incidents of court-ordered obstetrical interventions, see Kolder et al. (1987) for critical medical commentary on the fallibility of doctors' judgements; for feminist legal commentary see Dawson (1990); for an early feminist analysis see Boston Women's Health (1984).

daughters and sons, of women who took it (Daly, 1978; D'Aubin, 1990:163-64; Frankfort, 1983:101-103; Greer, 1987).

Thalidomide was widely promoted as a sedative and advertised to be non-habit-forming and safe for pregnant women (D'Aubin, 1990:164). DES was strongly recommended and prescribed to pregnant women by physicians for more "normal" pregnancies, that is, to prevent miscarriage and for what the pharmaceutical companies promised would be "bigger and better" babies (Greer, 1987:8). These two major pieces of bad medical advice regarding the management of pregnancy make it clear to even a casual observer of obstetrical history that compliance with medical recommendations is not always healthy for pregnant women or for their babies. And as women's health advocate Marianne Whatley points out,

> In addition to the risks from medical intervention and treatments it may be psychologically healthier to be a bad patient. 'Model' patients may not do as well, probably due to the extreme passivity and dependence this role often entails (1988:136 footnote omitted).

"Model" females are also expected to be obedient, passive and dependent, not only in relation to authority figures, such as doctors, but to males in general.[37] Traditional social gender role expectations of women encompass much more rigid behavioral expectations concerning pregnant women and mothers (e.g., to be patient, nurturing and self-less), and also encourage (if not force) pregnant women's compliance with medical advice. In the context of the doctor-patient relationship, pregnant women are doubly disadvantaged in terms of power and control (see Roberts, 1985). Depending on a woman's class, race, ethnic background, marital status (and a host of other possible factors), her ability to question or challenge a physician's advice may be even further reduced. In short, pregnant women are socially inculcated with both a "maternal" and "patient" *duty* to comply with physician's orders. Yet in light of the history of obstetrics and gynecology, which have not always been motivated by or served pregnant women's best interests (Ehrenreich & English, 1978; Rothman, 1989), the question remains, for their own good, can pregnant women afford *not* to challenge doctors when they believe them to be wrong?

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[37] The traditional expectations of a "good patient" are the same traditional gender role expectations for females in society; see Sanford & Donovan (1984); also see Rosser (1988) for a fuller discussion of the notion of passivity and enforced patient "compliance" and of the general resistance to feminism within health care settings.

Since the medical establishment's takeover of the birth process, the biomedical model of pregnancy has been established as the "norm" and in this view, rather than a natural physical event for pregnant women, pregnancy is considered an illness to be medically managed and treated (Overall, 1989). Critics of the medicalization of childbirth come from the ranks of both feminist and traditional women: all agree that the medicalization of motherhood and the treatment of pregnancy and birth as medical events have not always served the interests of women (Rothman, 1989:155; Carver, 1984). In addition, it is the medical institution's view of pregnancy and birth that has led to increased technological medical interventions (Boston Women's Health, 1984; Rothman, 1989; Ratcliff, 1989) and recently legal interferences with pregnant women prior to and during birth (see CBA, 1990; Jost, 1989).

The Cesarean Epidemic

The dramatic increase in cesarean section operations in North America over the last two decades is a case in point (Nova Scotia, 1990:4; Williams, 1991). This type of obstetrical intervention, normalized as "standard" medical management of pregnancy, has been difficult to challenge even though patient rights activists and a strong lobby of women's health advocates have argued that the benefits of cesarean section are over-rated.[38] Feminist health activists, for example, argue that the dramatic increase in cesarean sections has presented women with a new set of risks, dangers and humiliations associated with pregnancy (Sanford & Donovan, 1984:140) which have been largely downplayed or ignored by physicians and male-dominated medical institutions (Rothman, 1989:41). Moreover, what has been called the "cesarean epidemic" includes a recent trend toward *forcing* cesarean sections on women (Annas, 1982, 1987; Boston Women's Health, 1984:386; CRIAW, 1989; Furman-Seaborg, 1987; Kolder et al., 1987; Maier, 1988; Zimmerman, 1987).

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[38] See Boston Women's Health (1984:384-394) for a full discussion of the benefits and risks of cesarean section operations; also see Sufrin Disler (1990b,e,f); Mason (1989).

A cesarean section, defined as "removal of the fetus by means of an incision into [the] uterus, usually by way of the abdominal wall....",[39] is major abdominal surgery that poses significant risks to both pregnant women and their fetuses, for example, a non-trivial risk of maternal morbidity (disease) and even of mortality (death) (Boston Women's Health, 1984:385; Kolder et. at., 1987; Kunisch, 1989:53; Nova Scotia, 1990; Sufrin Disler, 1990f:2). Although the changing definition of "medical" indicators for cesarean section and the difficulty of gathering reliable statistical data on the incidence of cesarean section operations (particularly in Canada)[40] limit a clear understanding of the difference between medical "necessity" and medical "practice norms," according to the World Health Organization, on an average, cesarean sections are only necessary for medically detected problems 10-15 percent of the time (see Sufrin Disler, 1990b). Cesarean section deliveries are considered *life-saving operations* when women have particular problems before or during labour, such as:

> severe pre-eclamsia, serious diabetes, transverse lie of the baby [sic], failure of the baby [sic] to descend at all, cord prolapse, placenta previa, baby [sic] much too large, active herpes lesions, sudden unexplained fetal distress (Boston Women's Health, 1984:384).

These high-risk situations can sometimes overshadow the fact that cesarean section surgery also poses serious risks to pregnant women (Rothman, 1989). In fact, birth by cesarean section can actually *increase* the dangers of pregnancy for both the birthing woman and her future child (Sanford & Donovan, 1984:141, citing M. Harrison; Boston Women's Health, 1984:385-6; Sufrin Disler, 1990b). For example, American studies for the prevention of maternal disease indicate that cesarean section operations cause postoperative

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[39] Taber's Cyclopedic Medical Dictionary (Philadelphia: Davis Co., 1981).

[40] Recently in British Columbia (1991) provincial health authorities have struck a B.C. Caesarean Section Task Force to review information on cesarean section births in B.C. and to assess the available data to determine if the present rates of cesarean section "are appropriate in the best interest of the mother [sic] and child [sic]" and to make recommendations relating to future changes (Correspondence--B.C. Caesarean Section Task Force "Information Sheet" 1991). In a series of telephone conversations with me (Sept/Oct 1991), the Task Force Co-ordinator, Sherry Campbell, advised that her main activity for the previous four months was attempting to make sense of the very limited statistical information available on provincial and federal cesarean section rates (e.g., from sources such as hospitals, Vital Statistics, Statistics Canada). She reported that B.C. has the highest cesarean section rate in Canada at 22.9 per cent of all births in 1989/90, up from only 7 per cent in 1970 (second to Ontario). The B.C. Task Force plans to release their findings some time in 1992.

infection in 33 percent of women, and anesthesia exposures during cesareans may leave large numbers of babies with delayed motor development and other neurological defects (Boston Women's Health, 1984:385). In addition, cesarean sections sometimes cause respiratory distress problems in premature and full-term babies and psychological damage to the mother (Nova Scotia, 1990:8; "ICEA," 1990:4; Boston Women's Health, 1984:385). Moreover, maternal mortality rates from cesareans are reported to be two to four times higher than for vaginal births (Nova Scotia, 1990:7-8; Boston Women's Health, 1984:385); according to one source, the rate of maternal mortality *may* be as high as 27 times that of vaginal births (Dawson, 1990:268, citing Evrard & Gold).

In light of the dangers and risks to pregnant women and their fetuses, why do so many women accept cesarean section operations? Most females have been conditioned to place their trust in expertise and advice of males and physicians. Gender role conditioning, coupled with the social weight of medical authority and the hierarchical doctor/patient relationship, reinforce at the personal and social levels the notion that doctors know best and that compliance with their advice is not only *appropriate* but *expected* patient behavior (Ehrenreich & English, 1973; Rich, 1976; Roberts, 1985; Erickson & Erickson, 1989): indeed compliance is "model" patient behavior (Whatley, 1988). Consequently, most patients, and particularly women patients, are reluctant to question let alone disagree with their physicians. When a pregnant woman actively disagrees with physician's orders, for example, to have a cesarean section, she comes up against institutionalized medical authority and traditional female socialization. For example, the patriarchal institution of motherhood, which has mythologized and idealized pregnancy and motherhood, has not permitted women to define these experiences for themselves (Rich, 1976). This, in conjunction with the male medical monopoly on birthing and pregnancy, has diminished women's trust in their own bodies' ability to "properly/safely" give birth (Carver, 1984).

With the advent of reproductive technologies, women are less able to exercize meaningful choices that place confidence in their own labour of birth (Rothman, 1989). Moreover, without support or advocacy for their wishes, or information about other viable options for pregnancy care and birthing

(Warshaw, 1984), such as legalized midwifery (or birth attendants)[41] or woman-centered, community birthing centres, women may feel they have little choice *but* to comply with physician's orders (see Sufrin Disler, 1990a,b,c,d,e,f; also "ICEA," 1990). Furthermore, *after the fact* women seldom challenge the necessity of cesarean intervention for practical (i.e., they are unable to turn back the clock) and psychosocial reasons (women may be unable or unwilling to deal with the possibility that their cesarean section was unnecessary and may have been avoidable).[42] As one feminist source insightfully noted: "Almost every woman *needs to believe* that her Cesarean was necessary" (Boston Women's Health, 1984:385, emphasis added).

The rate of cesarean section intervention in the United States and Canada, *not* correlated to the established medical need for the operation, is *dramatically* on the rise. In the U.S., the fact that the cesarean section rate has increased from five percent of all births in the 1960s to over 25 percent in 1988 has resulted in a great deal of criticism and commentary about the unnecessary use of this serious operation.[43] According to two major investigative medical studies in the United States "33 to 75 percent of Cesareans were *not* necessary, having been performed as a result of current medical procedures and attitudes alone" (Boston Women's Health, 1984:385, n41, citing National Institute of Health and Marieskind; see Nova Scotia, 1990 and Ontario, 1991). In Canada, cesarean section deliveries comprise, on average, 19-20 percent of all births (a jump from 6 percent in 1970) (Nova Scotia, 1990; Ontario, 1991; "IJCE," 1990; Sufrin Disler, 1990b) with some cities, such as Thunder Bay, Ontario, averaging as high as 60

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[41] See Mason (1989) for useful commentary on the dangers of professionalized (i.e., licensed) midwifery.

[42] One woman, presenting a brief to the B.C. Task Force on Cesarean Sections, made the point that the "victim syndrome" of denial, self-blame, and projection of anger may be a reason why strategies to reverse the cesarean section trend have failed (Corcoran, 1991:1). In spite of this, many women are resisting the passive female patient role, questioning the necessity of operations and seeking education and alternative options to cesarean section births (e.g., the strong VBAC lobby). See Boston Women's Health (1984:392-395) and Sufrin Disler (1990c,d) for a good list of support and action groups on the problem of cesarean section operations and alternatives to it.

[43] See Gilbert (1990) for further discussion of statistics and surveys on the frequency of cesarean sections in the United States.

percent.[44] Ontario has one of the highest frequencies of cesarean section operations in the world at 20.03 per 100 births. Only Brazil and the United States have higher rates (Williams, 1991:6). According to Sherry Campbell, Co-ordinator of the B.C. Task Force on Cesarean Sections presently studying the problem, in 1989/90 B.C. had the highest provincial cesarean section rate at 22.9 percent of all births, up from 7 percent in 1970.

Other countries have significantly lower rates; in Holland, for example, the rate is about 4 percent, probably due to their high rate of home births. This may reflect Holland's reluctance to accept the highly medicalized and technological approach to birth in North America. Why is the rate so much higher in North America? According to British feminist theorist Marguerite Russell, speaking at the conference "Women, Reproduction, and the State" (1987), intervention in birth is simply an extension of other industrial "norms." Canadian legal commentator Brettel Dawson concludes that the cesarean section rates suggest "either an overly interventionist stance or an absence of medical justification for the procedure" (1990:268).

Women's health literature and more recently medical literature attempt to document the scope of the problem and while there is some dispute about actual percentages of cesarean section rates at any given time, researchers and critics alike come to the same conclusion--the high rate of cesarean section births is medically unjustifiable and socially unacceptable.[45] Despite the fact that cesarean sections pose serious risks to pregnant women and their future children cesarean sections continue to be performed in North America for a variety of *non-medical* reasons. Cesarean sections are being used as "an imperfect solution for a broad range of potential mishaps" (Finamore 1983:100).

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[44] Peter Leask, a lawyer speaking at "Women, Reproduction & the State," made this claim (1987).

[45] The dramatic increase in cesarean section operations has resulted in the organization of a strong woman-centered health movement opposing these medical developments and exposing the risks cesarean sections pose to women and children's well-being; as previously noted, recent consternation and criticism has also emerged from within the medical community.

Many non-medical factors contribute to the alarming rate of cesarean section births. What follows is a brief summary of the main reasons for cesarean section and critical commentary on their reliability and validity.

1) *Physicians' practice of defensive medicine.*

> The most common cause of Cesareans today is not fetal distress or maternal distress, but obstetrician distress. Physicians think that if they do a Cesarean and a baby is born "less than perfect" they have covered themselves legally (Boston Women's Health, 1984:385).

Canadian obstetrician Lynn Simpson concurs that many physicians' decisions are unduly influenced by "the potential litigation pressures and by consumer expectations which are sometimes unrealistic" (1991:3); however, "more suits have been instigated for malpractice associated with Cesarean surgery than for failure to perform it" (Boston Women's Health, 1984:385).

2) *Repeat cesarean surgery, i.e., the mistaken belief that "Once a cesarean always a cesarean."* While this belief is unfounded, it has been an obstetrical standard: 30 percent of all cesarean sections in the US (Boston Women's Health, 1984:385) and 35 percent in Canada (Nova Scotia, 1990:5) are performed for this reason. A recent study in Ontario reports that repeat cesarean sections account for 40 per cent of all cesareans, "despite increasing evidence that vaginal births after cesareans (VBAC) may indeed be safer than a second or third cesarean" (Williams, 1991:6).[46] Nevertheless, myths about the dangers of VBAC abound (see Sufrin Disler, 1990e).

3) *Dystocia--changing medical indications for cesarean section*, i.e., the understanding and meaning of labour "norms." The term "dystocia" (e.g., "labour too slow," "pelvis too small") has expanded, whereby previously normal processes are now called abnormal and therefore "medically" indicate cesarean section. In Canada, 35 percent of cesarean sections are performed for dystocia. As noted in the Nova Scotia Task Force findings:

> "Dystocia" has been variously defined as "abnormally slow or non-progressive labour", "failure to progress", "dysfunctional labour", "secondary arrest of dilatation" or, as one author wryly observed, "failure to wait" (1990:5, footnote omitted).

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[46] "Without routine repeat cesareans, the cesarean rate in Ontario would be around 12%" (Sufrin Disler, 1990a:2).

The report goes on to state:

> The "catch-all" diagnosis of dystocia seems to be partly the result of a regimented approach to obstetrics where there is an imperative to complete delivery in a pre-determined time, without appropriate recognition of the differing speeds at which women in labour attain the same degree of progress (Nova Scotia, 1990:5).

Dystocia is the reason for 43 percent of all United States cesarean sections, as compared to 30 percent in the period 1970-1978 (Boston Women's Health, 1984:386).

4) *Obstetrical training.* Since physicians are less experienced in delivering babies vaginally, the number of cesarean sections for breech babies continues to increase. In the United States, breech position accounts for 12 percent of the cesarean section rate (Boston Women's Health, 1984:388); in Canada, breech position accounts for 3.5 percent of the cesarean rate (Nova Scotia, 1990:5; Sufrin Disler, 1990a:2). Research shows that "breech-presenting babies [sic] can be safely delivered vaginally and with the same prognosis for healthy outcome as babies [sic] who present head down" under certain conditions (see "ICEA," 1990:5). Physicians and residents are not trained in normal obstetrics, and are not learning skills such as external cephalic version (gently turning breech babies around) or delivering breeches vaginally. Instead, physicians are trained to do technical surgical deliveries and "have to perform a certain number of procedures to meet a quota" (Boston Women's Health, 1984:385-6). While obstetrics and gynecology began as a low status field of medicine concerned with the medical management of pregnant women, it is rapidly growing as a prestigious surgical specialty and is changing its focus (and name) from obstetrics to "maternal and fetal medicine" (see Furman-Seaborg, 1987). Medical attention in pregnancy and birthing is shifting from the pregnant woman to the fetus in utero (Rothman, 1989), as evidenced by the emerging medical specialty of "fetal therapy."

5) *Physician attitudes.* Physicians' attitudes that pregnant women's bodies are not doing it right sometimes results in "heroic" physician interventions. As one doctor put it:

> By and large, I think American obstetrics has become so preoccupied with apparatus and with possible fetal injury that the mothers [sic] are increasingly being considered solely vehicles. In many cases small and uncertain gain for the [future] infant is being purchased at the price of a small but grave risk to the mother [sic] (Boston Women's Health, 1984:386 citing Marieschild).

6) *Economic incentives.* Cesarean births are more costly to perform. In the United States, many patient insurance packages cover most cesarean section costs but only a small portion of vaginal delivery cost. The US health system has no national health insurance plan, therefore women who have costly cesarean sections in the States are often those women with health insurance coverage (i.e., economic means), unlike in Canada, where most women have access to national health insurance. The present Canadian fees for cesareans and vaginal births are roughly the same, however, vaginal births can take hours whereas cesarean section operations are often over in less than an hour. The fact that cesarean sections take less time in the delivery room (Brighouse, 1987a:4) creates a financial incentive for doctors to perform cesareans when they may not be necessary (Williams 1991:6; Beresford, 1991).

7) *The belief that cesarean delivered fetuses mean "better babies."* For example, there is a mistaken belief that the decline in fetal morbidity and mortality is primarily due to obstetrical interventions: in actual fact, babies delivered by cesarean section are often harmed and distressed as previously noted (see Boston Women's Health, 1984:386; Rothman, 1989:41).[47]

8) *Convenience of scheduling.* Another reason for favoring cesarean section over vaginal birth delivery is scheduling convenience for physicians and apparently for parents (Brighouse, 1987a:4).

9) *Obstetrical practice and technology/Fetal distress.* Obstetrical practice is becoming more dependent on technology. The use of electronic fetal monitors (EFM), amniocentesis, oxytocin and prone-position labouring are all basic to obstetrical practice, yet all are known to cause problems for the labouring woman which may necessitate intervention such as the need for a cesarean section (Boston Women's Health, 1984:386; Kunisch, 1989). Moreover, once the technology is available and a medical procedure such as

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[47] It seems especially noteworthy that within the rapidly growing literature and debate on what have been called the "new reproductive technologies," some physicians are using similar-sounding arguments to promote in vitro fertilization, for example, the language used to describe in vitro as a "superior birthing method". For a comprehensive overview of the complex issues and questions embedded in debates about reproductive technologies, see CRIAW Reproductive Technologies and Women: A Research Tool (1989). This collaborative project includes a useful selection of abstracts and references on the topic. Also see Christine Overall's edited collection, The Future of Human Reproduction (1989) for another valuable Canadian resource on this topic.

cesarean section operation is accepted as "standard" medical practice, it becomes less likely that pregnant women will be willing or able to refuse the recommended interventions.[48]

Prenatal Technologies and "Fetal Distress"

As outlined above, many factors contribute to the high cesarean section rate in North America. Yet one of the most significant factors responsible for the rise in rate of cesarean section is that increasingly medical decisions about the management of pregnancy and labour are made on the basis of medical technology, i.e., machine output, such as fetal monitoring devices and ultrasound, rather than from a medical assessment of the pregnant woman herself (Kunisch, 1989). Electronic fetal monitoring (EFM), for example, has been effectively used in late-stage pregnancy (i.e., antenatal period) where there is concern about fetal growth or movement. More commonly, however, it is used in labour "to provide a continuous record of the baby's [sic] heartbeat and the frequency and length of contractions" (Holland & McKenna, 1984:416). In high-risk pregnancies, fetal monitoring can be an important medical assessment tool to reduce the incidence of death or injury to high-risk (e.g., low weight) fetuses. EFM can assist medical professionals and pregnant women with decision-making options for the best possible prenatal and labour health care. However, the ways in which EFM has been incorporated into the medical management of pregnancy and labour are distressing. For example, EFM is used *routinely* in some hospitals (not just in high risk situations) despite the fact that EFM does not improve the outcome in healthy pregnant women and babies (Kunisch, 1989). Furthermore, physicians may interpret the same EFM data in very different ways (Corea, 1985:220). Even the developer of EFM, Dr. Hon, confirms this problem with EFM use, linking the relationship of inappropriate use and inaccurate and misread EFM tracings by physicians, with the increased rate of unnecessary cesarean sections (Corea, 1985:221; Kunisch, 1989). Physicians increasingly rely on these devices "in spite of considerable evidence that such data are open to varied

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[48] The widespread use of episiotomies and forceps is another example of unnecessary "standard" interventions on pregnant and birthing women within the medical management of pregnancy and childbirth in recent obstetrical history (see Boston Women's Health, 1984).

interpretation" (Jordan & Irwin, 1989). For example, the EFM itself is variously estimated to be from 43-66 percent *inaccurate* as it tends to pick up the pregnant woman's intestines and circulation *as well as fetal activity* (Corea, 1985:220).

Both ultrasound and fetal monitoring are considered *standard obstetrical diagnostic interventions* within the rapidly growing new medical specialty of "fetal therapy." Both have benefits and risks for pregnant women experiencing complications with pregnancy and labour.[49] However, integration of such technological interventions into the medical management of pregnancy has been accompanied by a tendency for medical personnel to concentrate more on the fetus and less on the pregnant woman. As Rothman notes, "In a patriarchy, the sense of separation of the fetus and mother was already there as a concept; the new technology allows the separation to be reified (1989:158)."

The use of medical technology which monitors fetal distress such as EFM is significant to the problem of increased obstetrical intervention in pregnancy and childbirth in light of the fact that "fetal distress" is a factor contributing to the increased number of cesarean sections (Boston Women's Health, 1984; Kunisch, 1989). Moreover, medical technology that separates the fetus from the pregnant woman by focussing on the fetus as a separate entity (with separate "rights," e.g., to pre-natal care or "therapy") leads away from a focus on the pregnant woman's physical and emotional well-being and legal rights. The facts that the fetus is inseparable from the pregnant woman *without intrusive medical intervention before birth*, and that the fetus' well-being is dependent upon the pregnant woman's well-being are obscured by the technology (e.g., ultrasound beams an image of the fetus without reference to the pregnant woman) (see Petchesky, 1987). Furthermore, EFM may provide unreliable technical "medical evidence" of fetal distress

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[49] For example, ultrasound is a routine form of genetic testing, yet its efficacy has not been demonstrated (Lippman, 1989). In her article "Prenatal Diagnosis: Reproductive Choice? Reproductive Control?" Abby Lippman (1989) raises serious doubts about the routine use of ultrasound in pre-natal medical management of childbirth. She points out that ultrasound "is *not* recommended for routine use since its efficacy has not been demonstrated, but it is nonetheless so used, probably as a component of a defensive, if not "aggressive," medical approach" (see for fuller discussion of potential harms and benefits of this reproductive (prenatal) technology. Particularly of interest for this discussion is the fact that ultrasound "has become the first method of prenatal diagnosis for which informed consent is not obtained" (Lippman, 1989:190). Lippman suggests an aggressive medical attitude may account for this; she emphasizes that "Physicians alone determine when and by whom it will be used" (1989:190).

which can then be used to disregard the wishes of pregnant women with respect to their choice of birth delivery method. This potentially helpful obstetrical assessment tool can be turned against pregnant women and used as a coercive measure *to force* them to undergo cesarean section operations *for the sake of the fetus*.[50] The forceful use of intrusive and risky obstetrical interventions such as forced cesarean sections on pregnant women, are thereby seen to be *medically and legally* justifiable. Commenting on the problem from a legal standpoint, the Canadian Bar Association makes explicit the interconnected, complex layers of the problem:

> The problem of judicial intervention is a result of the recent shift in the way pregnancy and birth processes are understood. In the past, these processes were seen as natural and, therefore, left to unfold and progress independent of interference. Due to medical-technological advances, it is now possible to subject these processes to ever greater degrees of control and manipulation...Social changes which support this shift are the development of the concept of "fetal rights" through the abortion debate, the current attention on drug use and greater social awareness of child abuse...These social and technological changes culminate in an attempt to redefine the mother-fetus [sic] relationship. Rather than seeing the two as inseparable, mother [sic] and fetus are portrayed as having two separate and distinct identities and sets of rights. Inherent in the creation of this dichotomy is the potential for conflict between the two (1990b:1-2).

The routine use of cesarean section for birthing, the acceptance that obstetrical expertise and technology such as EFM provide valid and reliable health outcome predictors for the fetus and pregnant woman, and the growing trend to separate the fetus from the pregnant woman have paved the way for an even more controversial form of intervention, *the forced cesarean section*.

Forced Cesarean Section

A forced cesarean section occurs when an unwilling pregnant woman is coerced or forced to undergo the medical procedure over her objections; this includes a forced cesarean section which is directly ordered by the court. The operational definition of forced cesarean section I use therefore includes *any*

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[50] In some courts, EFM data has been part of the medical "evidence" of fetal distress accepted by the courts as evidence of "child abuse or neglect" where pregnant women have refused cesarean section operations. This is not surprising, given the fact that the successful marketing strategy for EFM emphasized it as a useful form of documentation which would be beneficial for physicians fearing malpractice suits (Kurisch, 1989:44-45).

case in which a pregnant woman does not provide her full, free and informed consent to a cesarean section operation. For example, in a number of cases where pregnant patients have been uncompliant and refused to accept cesarean section operations, physicians and/or hospital administrators have turned to the courts to enforce medical treatment on them under the auspices of fetal protection. Baby R is a case in point (Maier, 1988). The majority of cases in the literature on forced cesarean sections indicate child welfare legislation is used to "protect" the fetus; if not, the "compelling state interest in the fetus" argument is used by the courts to justify these invasive actions. One of the most dramatic examples of forced cesarean section is the Angela Carder case which occurred in Washington, D.C. in 1987. (I discuss this case in some detail in chapter four; also see Maier, 1992).

In the United States from 1981-1987, women in 11 states were forced by court order to undergo cesarean sections against their will (Furman-Seaborg, 1987:9; Kolder et al., 1987). Veronika Kolder, Janet Gallagher and Michael Parsons' widely cited study, the first of its kind, also found that "In three of the first five cases in which court-ordered cesarean sections were sought, the women ultimately delivered vaginally and uneventfully" (Annas, 1987:1213). While the actual scope of the problem of forced cesarean sections today is extremely difficult to ascertain or document (Jordon & Irwin, 1989), cases continue to be reported in medical and legal literature (e.g., see Gallagher, 1984; Rodgers, 1986; Johnsen, 1986, 1987; Jost, 1989).

Cases of court-ordered cesarean sections are legally decided under highly unusual and pressured crisis circumstances (in some case judges actually come to the hospital to hear the case). The courts often uncritically accept the physician's claim that the fetus is in "medical" distress and a cesarean section birth is medically required. Therefore *the pregnant woman's refusal* to accept the surgery presents the physician with a problem and is seen as posing a threat to the fetus; by extension, *the pregnant woman herself* is seen as "the problem"--the *barrier* to fetal "protection."[51] In a number of cases of forced cesarean section the uncompliant pregnant women are described by medical staff in a highly derogatory way (Jordan & Irwin,

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[51] Casting the pregnant woman in this light is not unlike the accusations hurled by anti-abortionists at women seeking abortions of "irresponsible and unnatural mother" and even "murderer" (see Petchesky, 1990).

1989) and labelled not only as "uncompliant" patients but as irresponsible, even "unfit mothers" who have abrogated their maternal duty. This quasi-medical psychosocial assessment opens the door to allegations of "child" abuse or neglect and to the intervention of state (i.e., statutory government) child protection authorities. In these situations, the weight of medical opinion, technological "evidence" (e.g., EFM) and the heavy ideological weight of the institution of motherhood,[52] sway the opinion of the courts sufficiently to justify the conclusion and court findings that the fetus-in-utero is a "child being abused." In the early 1980s, the Boston Women's Health Book Collective remarked on just such a scenario:

> Despite the evidence that C-section babies are not necessarily "better," at least two cases of forced Cesarean section have occurred where physicians got court orders, claiming that *failure to accept a Cesarean section was evidence of "child abuse"* (1984:386, n*; emphasis added).

While to date in Canada no reported cases of court-ordered injunctions to force cesarean sections on women have been reported, at least one forced cesarean section case (Baby R, 1987)[53] and one case in which a pregnant woman was detained in hospital against her will (Belleville case, 1987) have occurred.[54] Both Canadian cases involved the use of provincial child protection legal statutes to "protect" the fetus, a common feature of justification in the American forced cesarean section cases.

Proponents of forced cesarean sections (e.g., medical and legal authorities) argue that such interferences with pregnant women are justifiable because they are necessary or life-saving medical treatment for the fetus (Bowes & Selgestad, 1981; Jurow & Paul, 1984; Kluge, 1987; Segal, 1987). In this view, society has both an interest in and an *obligation* to protect the "personhood rights" of the fetus, who is considered a second medical patient (Simpson, 1987:749) and a legal person, with rights equivalent to a

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[52] See chapter two.

[53] The Baby R case was not a "court-ordered" cesarean case *per se*, since the court did not grant an injunction authorizing surgery without consent; nevertheless, the case falls within the operational definition of forced cesarean section, as previously noted (see chapter four, in which this argument is fully developed).

[54] See Rodgers (1986) and CBA (1990b) for discussion of at least two other Canadian cases which paved the way for these decisions.

child's human rights. This argument directly leads the way to allegations that a pregnant woman who refuses medical advice is an "unfit mother." This argument, coupled with the assertion that the unborn fetus is a "child" being abused or neglected, is used to justify not only medical intervention on behalf of the fetus, but also state "child" welfare protection *from the pregnant woman herself.* And since the statutory mandate of child protection falls within the domain of social workers, social workers are directly involved in carrying out forced cesarean sections on pregnant women (Maier, 1988; see Dawson, 1989).

Forced cesarean section, a complex and controversial new medical/legal phenomenon,[55] flies in the face of the legal doctrine of informed consent which protects all persons from unwanted medical treatment. According to this doctrine physicians, legally and ethically, are obliged to ensure proper consent has been given by a patient before undertaking medical treatment (see Annas et al., 1977). In this thesis I argue that forced cesarean section is inconsistent with women's equality rights and has implications for social work in general and specifically for ethical social work practice within child protection and health care settings. I draw upon legal, medical and feminist evidence to support this thesis, using as a case in point, the Baby R matter.[56] The court ordered cesarean section, one example of direct legal injunctive actions against pregnant women, illustrates the increased obstetrical and judicial intervention in pregnancy and childbirth and epitomizes women's loss of control over birthing and their bodies. Moreover, it signifies a new mechanism for medical and legal control over the lives of society's most discriminated groups--poor, non-white, females, upon whom the indignities and risks of unwanted obstetrical interventions are most likely to fall.[57]

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[55] Forced cesarean section was the topic of a televised PBS special, "Does Doctor Know Best? Ethics in America" (1989). The program presented hypothetical situations to which panelists role-played responses from their diverse standpoints, revealing the complex social, ethical, legal and medical questions and issues involved in this medical/legal practice.

[56] To my knowledge there is no social work analysis of forced cesarean sections other than my own.

[57] Medical/obstetrical history bears this out as low income women, Native women, women of colour and institutionalized women were the women upon whom most coercive reproductive practices were performed (e.g., see Dale & Foster, 1986; Terry, 1989; Nsiah-Jefferson & Hall, 1989:103-4).

The physical dangers and legal harms (not to mention psychological harms) for pregnant women are being overshadowed by the apparent distress of the fetus. In fact, the shift in focus from the pregnant woman to the fetus is one of the most significant factors in the conceptual and legal expansion of fetal "rights" (see Petchesky, 1990; Rothman, 1989). Moreover, the growing conceptualization of *inherent opposition* between maternal rights and fetal "rights", (see Johnsen, 1986; Sherman, 1988a,b, 1989; Rodgers, 1989; Terry, 1989; Gustavsson, 1991) is creating a socio-political context which legitimizes medical and legal interferences in pregnant women's lives.

From a feminist social work perspective the most critical issue that must be addressed is how best to protect the liberty of pregnant patients. This question raises other related issues which are crucial to consider: Do direct injunctive actions (such as court-ordered cesarean sections and taking custody of fetuses with child abuse statutes) *solve or compound* the problem of ensuring that women have optimally healthy pregnancies? How do other forms of structural oppression, such as those of sex, race and class, figure in court-ordered obstetrical interventions? How do social workers think about and understand these actions? Finally, the most basic political issue is Who or what is really being protected in these cases?

The 1987 B.C. fetal apprehension case known as "Baby R", in which a pregnant woman was forced to have a cesarean section and her fetus was apprehended under child protection legislation, illustrates the convergence of medical, legal, and social work state interventions which interfered with the rights of a pregnant woman in order to "protect" her fetus. Because Baby R is in no way an isolated or unique case scenario, and because it is the first Canadian forced cesarean section case, it provides a particularly timely and rich case study for an examination of the implications of forced cesarean section for women's equality and for social work. What follows from an examination of the public record is a reconstruction of the sequence of events and circumstances of the case, which began in B. C.'s Grace Hospital in May 1987 and concluded in the courts some eighteen months later.

Baby R: A Case Study

Sequence of Hospital Events

On May 20, 1987 at 3:00 p.m. a pregnant woman who came to be known in the media as "Rose," arrived at a Vancouver maternity hospital in British Columbia in premature labour. The attending obstetrician, Christo Zouves, told her the fetus was in a footling breech position and advised that "the best course of action was the standard management option of a cesarean section" (Brighouse 1987a:1). Rose disagreed, stating that she had given birth to healthy babies vaginally on four previous occasions. Rose refused to give consent for the cesarean surgery. This disagreement on the birth delivery method with the attending obstetrician led to the eventual apprehension of Rose's fetus.

Several hours later, at 7:40 p.m., Zouves called B. C. child welfare emergency services authorities (Ministry of Social Services and Housing,) and reported that his patient would not consent to a cesarean section operation, without which, in his opinion, the unborn fetus would either die or be seriously or permanently injured. Dr. Zouves then explored the possibility of having Rose temporarily committed under the Canada Mental Health Act, but, a hospital psychiatrist and MSSH's emergency health team found that there were not sufficient grounds to take such extreme action. They assessed Rose to be competent to make her own decisions (Thompson, 1988:15).

The obstetrician controlled the definition of the issues and the focus of intervention when he declared the fetus to be a "child" who he felt was in need of medical treatment. He did so in an attempt to get himself out of a serious dilemma: he had a pregnant patient who was refusing treatment he recommended for the sake of the fetus, whom he also considered to be his patient. Without consent to operate he could not proceed.

At 8:50 p.m. the physician again contacted the child protection social worker, Ivan Bulic. By pronouncing that the fetus was, in his opinion, "a child in the process of birth," Zouves reframed the problem from a medical dilemma to a child protection issue. The legal responsibility for child protection falls under the jurisdiction of child welfare legislation, therefore, at this point the issue became a child

abuse allegation, which necessitated a social work investigation under the Family and Child Services Act (FCSA). After the social worker consulted with the Superintendent of Child Welfare and legal advisors for the Ministry of Social Services, he was directed to apprehend Rose's unborn fetus--an unprecedented act in British Columbia. This required a finding that the fetus was "a child in need of protection" under the FCSA.

At 9:05, within an hour of receiving the second call from Zouves and after reviewing Rose's history of parenting problems in the child welfare records but having had no contact with Rose, (Thompson, 1988:15) Bulic, advised the obstetrician by telephone that he was apprehending Rose's fetus. The apprehension required an interpretation that the fetus was a "child" and meant the fetus immediately became a temporary ward under the legal custody and guardianship of the Superintendent of Family and Child Services (for whom the social worker is an agent), until the facts of the case could be presented at the initial court hearing to determine whether child abuse or neglect had occurred.

As temporary guardian of the fetus, the social worker has authority over "the person of the child" which includes authorization for necessary medical treatment. However, in the case of Baby R *a fetus, not a "child"* was apprehended, which seriously complicated the issue of social services providing consent to medical treatment on behalf of the fetus. This dilemma is clearly illustrated by the apprehending social worker's statement, "I consent to any necessary medical treatment to the fetus but not to the woman" (Brighouse 1987a:1; Davis 1987:1). This seemed to be an attempt to limit legal responsibility to only the fetus and thereby sidestep the issue of providing consent for medical treatment on the pregnant woman. The obvious problem is that in order to operate on the fetus the pregnant woman would also have to be operated on, since the two are physically enjoined and until birth, inseparable.

At 9:15 p.m., after viewing ultrasound images showing her fetus in a footling breach position, Rose verbally agreed to the cesarean section (Brighouse, 1987). She was six hours into labour and "consented" while being wheeled to the operating room ("Baby R," 1987; Macdonell, 1988:3-4; LEAF, 1988:7). At 10:49 p.m. Rose delivered, by cesarean section, a healthy baby boy (with no sign of drug or alcohol effects) who was immediately taken from her and placed in the custody of child welfare authorities.

The events in the Baby R case which occurred in the hospital, noted above, were followed by a series of child protection court hearings, which began with the initial "report to court" procedure, included a full, five-day child apprehension hearing in Family Court in July and concluded with the judicial review of that decision by the Supreme Court of British Columbia. The written decisions of the courts are part of the public record and provided the primary data base for discussion of the issues addressed by the courts, which I summarize in the following section.

Decisions of the Courts

The Baby R case circumstances raised two major legal questions for the courts. The first was whether the definition of child under the FCSA includes a fetus, which would mean the B.C. Superintendent of Family & Child Services had legal jurisdiction to intervene in the situation (i.e., to investigate child abuse and neglect complaints and take action to resolve them). The second legal issue was to determine whether evidence of child abuse or neglect could be found in the Baby R case. Both questions inevitably lead to the larger question the problem of forced cesarean section raises, that is: does a pregnant woman's refusal to comply with a doctor's advice to have cesarean surgery constitute evidence of abuse or neglect of a child? The Baby R case court records include the provincial (family) court decision (Davis, 1987), the B.C. Supreme Court decision (Macdonell, 1988) and the "Memorandum of Argument" of the Women's Legal Education and Action Fund (LEAF, 1988), submitted as part of the Supreme Court proceedings (LEAF was denied application to intervene at the Family court hearing).[58] What follows is a summary of those decisions regarding the Baby R fetal apprehension case.

As is the case of all apprehensions by Family and Child Services, the matter of Baby R was heard by the B.C. Provincial Court (Family Division). Under the Family & Child Services Act apprehension proceedings are authorized where a child is "in need of protection," based upon the definitions of "child"

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[58] LEAF intervenes in certain cases which stand to affect women's equality rights under the Canadian Charter of Rights and Freedoms. Being granted "Intervenor status" means LEAF's legal counsel is party to the proceedings and can present arguments on behalf of women as a disadvantaged group in society. Thus the written arguments of LEAF are part of the permanent court record of the Baby R case.

and "in need of protection." Such determinations are guided by certain basic legal and ethical child protection principles, including seeking the "least restrictive alternative" and supporting "a family reunification policy."[59] The Superintendent has authority under the Act to apprehend without a warrant. Thereafter the procedures are set out in the Act for a report to be filed in the court not later than seven days after the apprehension, setting out the basis of the apprehension. From there a review of the apprehension and temporary custody is dealt with, and thereafter permanent custody and guardianship assigned if appropriate. In the initial "report to court" procedure in the Baby R case, Ivan Bulic reported that "The child was apprehended as being in need of protection by reason of being (c) deprived of necessary care through the disability of his parent (d) deprived of necessary medical attention" (Macdonell, 1988:5). Judge Davis upheld the apprehension and set court dates for a full hearing of the case. The full lower court hearing took place in New Westminster from July 13-16, 1987. Judgement was reserved for six weeks--until September 3, 1987. In his written decision, Judge Davis upheld the fetal apprehension which took place in May 1987 (see Davis, 1987) and granted the Superintendent a permanent wardship (custody and guardianship) order for the child.

In the July court proceedings the main matter before the court was to determine whether the child, Baby R, ought to be committed to the care of the Superintendent permanently. In addition, the court reviewed whether the apprehension in May was jurisdictionally appropriate and whether the "child" was in need of protection, with respect to the facts of the case. Legal-aid appointed counsel for Rose and for the Superintendent both presented arguments.

The Ministry of Social Service's legal counsel, Tom Gove, presented a case which asserted the fetus was a child in the process of birth and argued, based on medical opinion supplied by the attending obstetrician (Dr. Zouves), that the cesarean section was mandatory for the safety and well-being of the so-

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[59] See Bala, Hornick & Vogl (1991) for a useful and accessible Canadian overview of child welfare proceedings. This work also addresses the important point of competing interests of different disciplines: the authors "demonstrate only modest tendencies to see legal rules and principles as the sure guide to correct answers" (1991:xx), a point of some significance to forced cesarean section and fetal apprehension debates.

called child. The Ministry's case for requesting a permanent order, however, focused almost exclusively on Rose's previous record of poor parenting (see Brighouse, 1987ab; Cruickshank, 1987; Davis, 1987; Still, 1987f; Thompson, 1987a,b, 1988). Gove argued that Rose was incapable of parenting Baby R based on her past history with her four other children. From this standpoint, Rose's refusal to have a cesarean section was but one more illustration that she was "unfit" to care for any child. The Superintendent's position was that Rose could not and should not resume custody of the child and "...the conditions that led to the child's apprehension still persist, and there is little likelihood that those conditions will soon be remedied" (Davis, 1987:4).

Jim Thomson, Rose's legal counsel argued, essentially, that the issue that was alleged to have endangered her fetus and thereby provided "grounds" for the apprehension was Rose's *refusal* to have a cesarean section, not her parenting history. Thomson argued that the fetus was not a child, and therefore Rose's refusal of a cesarean section did not constitute child abuse or neglect under the Act, and the child should be returned to Rose.

In the lower court's final decision, Rose's history of parenting was used to justify and legitimate the unorthodox apprehension. How the issue of Rose's past parenting behavior and lifestyle came to be "on trial" in this case is a telling point (see Thompson, 1988:15). It was only after the obstetrician discovered he did not have a compliant patient that he explored the possibility of invoking the Mental Health Act to assess Rose's mental competency, (see Leaf, 1988:3-4; Macdonell, 1988:2-3) a fact which was not mentioned in Judge Davis' written decision.[60] When this measure failed, Zouves successfully enlisted the state's child welfare legal machinery to apprehend the unborn fetus. In his testimony, "Zouves held that if the fetus was found to be in need of protection, then the Ministry was responsible for the fetus and he could perform a cesarean section without Rose's consent" (Thompson, 1988:15). In this way, the problem of liability for

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[60] It seems the obstetrician thought if Rose could be declared to be mentally incompetent this would remove the legal need for her consent to surgery (see Macdonell, 1988:2-3). According to Gerrit Clements, Senior Solicitor/Health Law Specialist with the Ministry of the Attorney General, however, this was an incorrect assumption (BCASW Annual General Meeting, 1988, "Life and Death--Who Is In Charge?") since committal under the Mental Health Act would not permit medical treatment without consent.

performing unwanted surgery on a patient then moved from the hospital to the courts. Zouves attempted to side-step the legal necessity of obtaining Rose's consent under the authority of the Family & Child Services Act and/or the Mental Health Act because "he obviously wanted some support or authority to perform the procedure against the will of the mother" (Macdonell, 1988:5).

Most of the evidence at the lower court hearing focussed on Rose's previous parenting and behavior which was contained in the child welfare records of Social Services and Housing and supported by the testimony of previous social workers and physicians (Davis, 1988; Thompson, 1988). According to this evidence Rose's history, which included the circumstances of the Ministry's wardship of her four children, was the main issue under consideration. Judge Davis summarized the evidence from that hearing as demonstrating her "inability ... to comprehend as a result of using alcohol or drugs," her "inability to organize her life or to keep a routine such as keep appointments," "very limited parenting skills," "unpredictable and inappropriate behavior," and "inability to recognize a problem" (1987:5).

Davis' judgement (1987) upheld the apprehension of Baby R on the grounds that the fetus (which he assumed to be a "child") was at risk and the cesarean section was necessary medical care to ensure a healthy birth. On the highly central and controversial issue of jurisdiction to apprehend (i.e., interpretation of the legal definition of "child" under the FCSA), Davis' remarked:

> Do I have the jurisdiction to make the order sought by the Superintendent in light of the timing of the apprehension? The short answer is yes. The evidence is that the birth was imminent and it in fact occurred within three hours of the Superintendent making the apprehension. The purpose of the apprehension was to ensure proper medical attention for the baby [sic]. This is not a case of Women's rights, Mrs. [R.] consented without coercion or threat to the operation. This case in my humble opinion ought not to be a concern for the right to life of the unborn person as suggested in argument by counsel for Mrs. [R.] when he quoted extensively from the House of Commons debates of Tuesday, June 2nd, 1987, which refers to the "right to life of unborn persons and right to life". This is simply a case to determine what is best for the safety and well being of this child [sic]. It is clear that this child [sic] was in the process of being born and the intervention and redirection of its birth were required for its survival. It was at or near term. It required no life support: it was "vigorous" at birth and indeed he was born healthy. I am mindful of the words attributed to Dr. Zouves by Mr. Bulic before Mr. Bulic decided to apprehend, and I am as well mindful of the definition of "child" contained in the Family and Child Services Act" (1987:6-7).

What seems most clear from this statement is that once Rose had submitted to "proper medical care" as defined by Zouves, (i.e., the cesarean operation) the grounds for apprehension were removed. Yet Judge

Davis not only upheld the original apprehension order, but went on to grant an order committing Baby R to the permanent care of the state.

In light of the *grounds* for apprehension, which was the medical necessity of the cesarean section, Davis' *justification* for making a permanent committal order is even more confusing. Section 14 of the FCSA lists the provisions for making a custody order committing a child to the permanent care of the Superintendent of Family & Child Services. Section 14 states: "The conditions that led to the child's apprehension still persist, and there is little likelihood that those conditions will soon be remedied" and Davis (1987:4) quoted directly from that section. The *condition* that led to the apprehension of Baby R was Rose's *refusal* to have the operation. Clearly, the court's reasons for authorizing a permanent order do not follow logically from the court's reasons for apprehending the fetus and thus constitute a legally subversive and unethical application of the FCSA in this case. Davis (1987:5) used Rose's social background first to legitimize the (illegal) apprehension of her fetus and then to justify the permanent care order he granted for her child.[61]

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[61] In his findings, Judge Davis (1987:7-8) relied heavily on the concept of "anticipatory abuse" used in the Proudfoot case in the Supreme Court of British Columbia (see Rae, n.d. citing the (1982) decision of Madam Justice Proudfoot which found a child born with fetal alcohol syndrome was born abused) to support his decision. However, in the Baby R case, Davis' interpretation and application of the anticipatory abuse concept is questionable. Rae, a member of the B.C. Branch of the Canadian Bar Association, had a very different legal interpretation of the Proudfoot decision. Rae (n.d.,:4) stated:

> The wording of the Family and Child Service Act is very clear in Section 1 that "in need of protection" means in relation to a child that he is (not could or should be) abused, or neglected, abandoned, deprived of necessary care, or any of the other factors that are set out in that section. In actual fact, in the McDonald decision there was a finding that the child had been abused and I believe it is questionable whether Proudfoot, L.J.S.C. would have or could have made the comments she did concerning anticipatory abuse if she had not *made first a finding that the child in fact had been abused or neglected.* (emphasis added)

Essentially, what Rae argues is that the concept of anticipatory abuse requires a finding of abuse or neglect that at some time in actual fact did occur; implicitly her conclusion also assumes *the actual existence of a child.* Rae's understanding of anticipatory abuse according to Proudfoot calls into serious question the anticipatory abuse argument that Davis relied on in his initial finding that Baby R was in need of protection. If Rae's arguments are correct, Judge Davis's application of the anticipatory abuse reasoning was legally faulty because Rose had never actually abused or neglected Baby R, *the child* (see Leaf, 1988 and CBA, 1990 for further discussion of this concept and argument).

Furthermore, granting a permanent committal order for a child required the Superintendent to make a strong case indicating why the circumstances which led to the apprehension were unlikely to change. According to Davis (1987:2), the cesarean section, purportedly the operation needed to ensure the safety and well-being of the fetus, was successful. Clearly this implies the apprehension order and the custody order ought not to have been pursued, let alone granted, by the court. When Rose agreed to the cesarean section the social worker (vested with the authority of the Superintendent of FCS) had several legitimate courses of action. First, the social worker had the option of reporting to the court (at the initial "report to the court" protection hearing stage) that the circumstances which ostensibly placed the "child" in need of protection no longer existed; that is, Rose had received the cesarean section. This would effectively let the initial apprehension order drop and revoke the Superintendent's authority over the fetus, returning full parental rights to Rose without further involvement of the provincial child welfare authorities. If *bona fide* child protection concerns arose (after the live birth of the infant), the social worker could have explored other options provided by statute, such as offering services to the mother and/or seeking a supervision order to monitor the infant's well-being. If the social worker determined that these minimal intervention measures were insufficient to ensure the child's safety and well-being, the child apprehension measures of the FCSA could then have been used. (For example, in a high-risk scenario where an infant is deemed to be in need of protection *following birth*, a social worker is legally and ethically within her/his mandate to apprehend a newborn infant directly from the hospital if the child is at risk and no other viable options exist). But child apprehension is clearly intended to be the state's last resort, *after* exhausting all other alternatives (see Bala et al., 1991). In light of child protection principles and ethical social work practice standards of the "least detrimental alternative," that is, the principle of minimal intervention, these options should have been considered. Instead, the Ministry of Social Services brought the fetal apprehension before the courts as a test case.[62] The decision to apprehend a fetus-in-utero was not only

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[62] Although this case was turned around at the B.C. Supreme Court level, there is nothing barring other child welfare agencies from bringing "test cases" to the courts. However, a series of recent rulings of the Supreme Court of Canada in which the court has rejected or refused to consider assertion of fetal rights gives a hopeful indication of the courts position. For example, in 1989 the Supreme Court of Canada refused to hear constitutional arguments on the issue of fetal rights by anti-abortion crusader Joe Borowski.

the *most* interventionist, it was an *unprecedented* and *illegal* course of action deliberately taken by the Superintendent to test the limitations of the child protection statute (i.e., the FCSA) with respect to extending the scope of child protection legislation to include the "unborn child." Justice Macdonell brings this issue into focus when he says:

> Counsel for the Superintendent argues that at the time of the hearing evidence of the petitioner's past conduct and inadequacy as a parent persuaded the learned Provincial Court judge that custody and guardianship should go to the Superintendent. This history was not the reason for the apprehension. The Superintendent took a calculated risk in apprehending the child before birth and was mindful of the ramifications of such action, but was prepared to test the legality of a prebirth apprehension (1988:7).

The other significant legal "test" issue was that of Rose's right to refuse medical treatment, protected in the doctrine of informed consent, which was never adequately addressed by the courts, although it was taken up in LEAF's Intervenor arguments (1988).

In Rose's case the question of whether Zouves' opinion that cesarean surgery was "necessary" medical treatment *for the infant* [sic][63] was valid or reliable, and the question of whether the legal (and ethical) requirements of Rose's "informed consent" had been met, were virtually unaddressed in the written decision of the court, yet both questions are central to the medical and legal controversy over the legality and ethics of forced cesarean section cases (see Johnsen, 1987). Judge Davis simply states, "The mother in giving her consent to Dr. Zouves knew what she was doing, as according to Dr. Zouves, she cooperated with the insertion of the epidural anaesthetic and she even appeared relieved after making the decision" (1987:2). Although there is little doubt that Dr. Zouves felt a cesarean section was medically necessary, as

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In the same year the landmark case of Chantal Daigle (whose boyfriend obtained a court order to block her abortion) found a fetus has no rights that could be enforced under civil law (see Loyer, 1989; also see *Tremblay v. Daigle*, 1989, 62 D.L.R. (4th) 634 (S.C.C.). The most recent ruling by the Supreme Court of Canada in the Sullivan and Lemay case (1991) held that a fetus is not a legal person and has no guarantee of life under the Criminal Code of Canada. See LEAF's "Factum" as Intervenor (1990) for an invaluable, detailed discussion of the legal and social relationship of the fetus to the pregnant woman. However, as a LEAF spokesperson notes, the court has not yet decided the status of the fetus for the purposes of the Constitution (Brown, 1991).

[63] This comment is a semantic slight of hand if ever there was one: one observer of the court proceedings wondered "if the fetus needed a cesarean section" (Thompson, 1988:15). LEAF addressed this point "There was no care or medical attention anticipated for the person of Baby R or to the body of Baby R until he was in fact born" (1988:13).

it may well have been (given physician's limited training and experience turning or vaginally delivering breech births, as noted in the previous discussion), he made this decision without consulting another specialist (Thompson 1987a:2).[64] Moreover, when the judge accepted this version of reality as indicated by his dictum "This is not a case of Women's rights, Mrs. [R.] consented without coercion or threat to the operation..." (1987:8) he overlooked significant circumstances of the case that leaves much doubt about the nature of Rose's consent, not the least of which is the fact that she verbally consented to the cesarean section "practically at the door of the operating room" (Macdonell, 1988:3-4). Other commentators on this case challenge the legitimacy of Rose's "informed consent," a matter which will be taken up in depth in the following chapter.[65]

The mother of Baby R petitioned the Supreme Court of British Columbia to review the lower court decision which granted permanent custody of Baby R to the Superintendent. This hearing took place in Vancouver, just over a year later, on June 29 and 30, 1988. In the B.C. Supreme Court, the main issue at law before Justice Macdonell was the jurisdictional question, that is, whether a fetus is a child within the meaning of the Family & Child Services Act, which would give the Superintendent legal jurisdiction to apprehend. The feminist legal organization LEAF, (The Women's Legal Education and Action Fund) was granted intervenor status by the court:

> ... on the limited basis of arguing the question of whether an unborn child [sic] is a child within the meaning of the Act, as the topic is of some interest to that group because of its effects on the rights of the mother and the possibility of interference with her person" (Macdonell, 1988:2).

Wendy Baker, legal counsel for LEAF, addressed the implications of the Baby R fetal apprehension for women's equality guarantees under the Canadian Charter of Rights and Freedoms. Essentially their intervention put forth the argument that granting fetuses rights which can be used against women is

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[64] See Dawson (1990) for a detailed discussion of Dr. Zouves' options in the Baby R case, and a full commentary on the Baby R case from a legal point of view; also see Majury (1988) and Phillips (1988).

[65] For example, legal feminist commentator B. Dawson (1990:266) maintains that "Ms. R. had actively refused consent."

inconsistent with women's constitutionally guaranteed equality rights under the Charter (see LEAF, 1988:1-36). LEAF also argued that failing to respect Rose's legal right to refuse medical treatment was a violation of her "security of person" under the Charter (1988:25-30).

On August 9th, 1988, the B.C. Supreme Court overruled the lower provincial court's decision, finding that the Ministry of Social Services and Housing acted illegally when it seized custody of a fetus--Baby R--hours before birth. The court held that a fetus is *not* a child and that the apprehension of Baby R was a specific interference with the rights of the pregnant woman, Rose (Macdonell, 1988). This meant the state had no jurisdiction for the apprehension and that the child's legal custody automatically reverted back to Rose as the birth mother. Such a ruling, however, did not prevent the Superintendent from acting swiftly to re-apprehend the child ("Baby R stays in foster home," 1988).[66]

The B.C. Supreme Court decision is a victory for women in that it confirms that actions that interfere with the rights of women are unlawful state interventions. For child protection social workers, the decision is equally important since it clearly restricts the use of child welfare legislation to the protection and apprehension of living post-partum children only.

An analysis of the elements of power, control and abuse of pregnant women by predominantly white, male medical and legal authority and institutions (e.g., child protection) in cases of forced cesarean section is needed, particularly using gender, race and class as categories of analysis. For example, in the Baby R lower court decision, as discussed in the next chapter, Rose's location in society was that of a poor, socially marginalized woman with significant problems and a damning past history of difficulty parenting. As we shall see, her social class status, as much as her parenting background, was on trial and was used to

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[66] The "re-apprehension" and final court hearing in the Baby R case occurred in November 1988; baby Roininen was made a permanent ward of the Superintendent of Family and Child services. The written "Reasons for Judgement" (authored by Judge Kitchen) followed on December 8, 1988. In the "re-apprehension" hearing the judge examined Rose's history of behavior prior to and after the birth of her child to determine whether she was fit to parent. A child protection case was made and the child was legally committed to the permanent care of the Superintendent. In this ruling, Rose's refusal to consent to surgery was not cited as a reason for deeming the child to be in need of protection (see Kitchen, 1988). Because this court decision is not about forced cesarean section or fetal apprehension, but instead deals with the legal apprehension of a child, it is only tangentially related to the case study of Baby R and the data for this thesis.

justify the violation of her basic human right to "security" of the person and to refuse medical treatment. Rose was a poor, uncompliant, white female patient: a pregnant woman who disagreed with a powerful, prestigious, white male obstetrician on the method of birth delivery. For this she paid the heavy price of being forced (e.g., with the threat of apprehension of her fetus and herself, see Macdonell, 1988:8) to undergo a cesarean section and subsequently losing her infant permanently to child welfare authorities. The *social rationale* used to justify the apprehension of Baby R is important to consider, because it shows how the most socio-economically marginalized, powerless groups in Canadian society--poor, pregnant women--are most at risk and most vulnerable to state-enforced obstetrical interventions--reproductive violations by another name.

What follows in chapter four is a critical feminist analysis which explores the race and class issues embedded in the medical legal phenomenon of forced cesarean sections. The discussion of the Baby R case is contextualized within the literature on forced cesarean section, and other cases are used as evidence of the sex, race and class components of this phenomenon. In chapter four I argue that forced cesarean sections are inconsistent with women's equality and progressive, ethical social work practice and should be understood as not only a female-specific violation but as a form of violence against the most socially disadvantaged women. I provide evidence that child protection social workers may be cast into the role of protecting fetuses through child welfare legislation, which by extension, potentially makes them the adversaries of pregnant women as a social group. These practices are not only inconsistent with women's equality struggles but with progressive, ethical social work practice. I maintain that all social workers should endeavor to understand and oppose such oppressive actions.

Chapter 4

PREGNANT WOMEN: "FETAL CONTAINERS" OR PEOPLE WITH RIGHTS? A CRITICAL ANALYSIS OF BABY R

> Courts and legislatures are increasingly being called upon to restrict the autonomy of pregnant women by requiring them to behave in ways that others determine are best for the fetuses they carry. The state should not attempt to transform pregnant women into ideal baby-making machines. Pregnant women make decisions about their behavior in the context of the rest of their lives, with all the attendant complexities and pressures. Our interest in helping future children by improving prenatal care would best be furthered by helping pregnant women to make informed, less constrained choices, not by punishing women or depriving them of choices altogether (Johnsen, 1987:33).

Even though the B.C. Supreme Court decision in the Baby R case does not support the trend for doctors to obtain court orders to enforce medical procedures on uncompliant pregnant women, the danger that is clearly foreshadowed by the lower court decision in the Baby R case and the growing incidence of forced cesarean section cases is that a woman's failure to heed a physician's advice may, in itself, constitute *prima facie* evidence of her being an unfit mother and hence may be grounds for apprehending the fetus. What is more, the significant concerns cases like Baby R have raised, such as the protection of patients' rights and the role of child welfare in forced cesarean sections, go largely unnoticed by the general public (Sherman, 1988a,b). Most alarming for the purpose of this thesis, is that these critical incidents seem to also go unnoticed in social work. Since May 1987, when the Baby R case received media and court attention in B. C. and in Canada, the social work literature has been virtually silent on the legal and ethical implications of forced cesarean section and fetal apprehension.

The complex and convoluted court rulings in the Baby R case raise many questions relevant to the problem of forced cesarean sections. However, for the purposes of this thesis, two important issues, in particular, need to be examined: the issue of informed consent and the role of child protection. Integral to the modern practice of medicine is the patients' right to refuse medical treatment under conditions of informed consent. I therefore begin the chapter with an examination of the legal and ethical dimensions of informed consent in the doctor-patient relationship. I argue that in the Baby R case, as in many other such cases, informed consent was not practiced: at worst there was no consent at all, at best, it was a coerced

consent. I then provide an analysis of the role of child protection in the Baby R and other forced cesarean section cases, which I argue is also improper and coercive. Specifically, I examine the definition of "child" and "abuse" under provincial child protection statutes such as the Family & Child Service Act to address the question whether fetuses are the legal equivalent of children under this legislation. I then examine the assumptions and relevance of Rose's social background and past record of parenting within the context of grounds for intervention on the basis of "child" protection. My argument here is that the social work assessment of Rose's "fitness" to mother/parent was irrelevant until a child was born, and under the circumstances was an unethical and illegal social work intervention. I conclude with the argument that the collaboration of medical, legal and social work authorities to force pregnant women to undergo unwanted medical treatment undermines the equality of women and perpetuates a specific form of violence against women. Moreover, the most socio-economically marginalized women are "high-risk" for unwanted medical treatment (see Kolder et al., 1987). Since a well-established tradition and theme in social work is human rights advocacy and progressive social change enactment (see Wharf, 1990), the problem of forced cesarean section has particularly significant implications for the role and responsibilities of social work.

A critical feminist social work analysis[67] of the two significant issues of informed consent and the role of child protection provides evidence of the coercive use of power and authority which underpin the problem of forced cesarean section. Nowhere is the coercive nature of medical and legal state interventions in pregnancy and childbirth more graphically illustrated than in the case of the court-ordered cesarean section which moves the problem and the conflict of maternal rights from the hospital to the courts. Authorizing legal injunctions which force medical treatment on pregnant women for the sake of the fetus leaves no doubts about whose "side" a court is on (Annas, 1987).

In a final section, I describe one of the most well-known cases of court-ordered cesarean section, the Angela Carder case (1987) which occurred in Washington D.C. Extending my substantive arguments that forced cesarean section is a violation of pregnant women's rights and women's legal and equality rights,

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[67] As previously discussed in chapter one, my analysis is informed throughout by my feminist perspective and my direct social work experience in the child protection and health fields.

I argue that forced cesarean section should be understood not just as a violation of rights but as *a form of violence against pregnant women*. By advancing this position I assert that opponents of forced cesarean section have not gone far enough in their analysis.

"Informed" versus "Coerced" Consent

The issue of informed consent is fundamental to understanding the complex set of circumstances and questions that arose in the Baby R case. To what extent did the physician ensure that Rose understood his proposed treatment and her options? How free was she to choose the option that suited her best interests? What were the circumstances of her so-called consent? And most importantly for this thesis, what were the roles and responsibilities of social workers (in both the hospital and the child protection agency) in ensuring that Rose's human rights were protected? An examination of these questions sheds light on the question of consent in forced cesarean section cases such as Baby R.

The right of anyone to refuse medical treatment is firmly grounded in law (Annas et al., 1977; Storch, 1982; Gallagher, 1984). Moreover, the right to control one's body, and by extension, the right to be free from bodily intrusion of any kind, stem from the notion of the autonomy of persons, which is among our most fundamental legal and social principles in Canada and other western societies.

Medical caregivers have a legal and ethical obligation to obtain patients' free, full, and informed consent for *any* medical treatment they deem necessary (Englehardt, 1985; Jurow & Paul, 1984; Dawson, 1990; Gallagher, 1984).[68] "To be legally adequate, a patient's informed consent must be competent,

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[68] For example, the Registered Nurses Association of B. C. (RNABC) state in their policy paper on informed consent that the legal right to consent to treatment "is one of the most basic of all patient rights." They define informed consent as "the process of communication that takes place between the health care professional and the patient" and underscore the requirement that the patient be provided with sufficient information to make a reasoned decision:

> Consent to some medical treatment and virtually all surgical treatment requires that the patient sign a written consent form. The consent form specifies the proposed treatment and is an administrative tool used by the health care agency to document that the process of informed consent has taken place...physicians are legally responsible for informing patients of impending medical or surgical treatment ("Position Statement on Informed Consent," 1990; see also Storch, 1982).

knowing and voluntary" (Raines, 1984:598). The exceptions for the legal need of informed consent are clearly spelled out, i.e., in cases where the situation is an emergency such that consent cannot be obtained, (e.g., where a patient is comatose) and in cases where the patient is not mentally competent to make a decision.[69] Neither applied in Rose's case.

The doctrine of informed consent is meant to protect patients' rights to refuse medical treatment (Annas et al., 1977; Storch, 1982). Failure to obtain proper consent has traditionally been treated as an assault/battery (non-consensual touching) action (Annas et al., 1977:27). For cesarean sections, as for any medical operation, before undertaking treatment, a physician must first obtain a signed consent form from the patient, confirming that a process of physician-patient consultation and patient decision-making took place. The physician must provide the patient with information about the proposed medical treatment, its advantages, risk and alternative options in order for the patient to make an informed decision about whether or not to consent to the proposed treatment (Simpson, 1987). In theory, the legal doctrine of informed consent requires physicians to respect the self-determination of patients, and therefore the right to refuse treatment. In practice, however, the patient consents to a decision the physician often *has already made* (e.g., Rose's cesarean surgery, see chapter three). The *concept* of informed consent, based on a paternalistic and patriarchal (hierarchical) model of health care in which the physician and other health care "experts" have most of the power, is particularly problematic for women patients. Some feminist health activists advocate replacing the notion of informed consent with "informed decision-making." Informed decision-making suggests an active, rather than passive, role for the patient which may enhance the real possibility of "informed refusal" (see Whatley, 1988; also see Colodny, 1989).[70] This notion also

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[69] In such a case the appointed guardian for the person would have the power of consent; see Dawson (1990) and Annas et al. (1977) on this point; also Boston Women's Health (1984:584-588).

leans toward a more balanced relationship between physicians (and other health care providers) and patients, such as the "consumer/service provider model" of health care delivery advocated by feminists.

The medical and legal requirements of informed consent for medical treatment are clear: consent must be freely given and the patient must be fully informed about the proposed treatment and its implications. After examining the circumstances of the Baby R case recounted in the previous chapter, to conclude that Rose freely "consented" to the cesarean section operation the doctor "advised" her to have would be dangerously euphemistic (see Segal, 1987, for example). It should be evident that her consent was neither "free" nor "full," since she never signed a consent form and her verbal agreement was given while she was being wheeled to the operating room (Davis, 1987; "Baby R," 1987; LEAF, 1988; Majury, 1988:226; Rodgers, 1989:177-78). Obviously the obstetrician made the decision to operate *without* the patient's consent, since the operating room had been booked and Rose was on her way there before she verbally agreed to the cesarean section operation. Even though the lower court judge declared Rose's consent to be proper (see chapter three), other legal perspectives refute this interpretation. For example, feminist legal commentator Brettel Dawson identifies the coercive hospital circumstances under which Rose gave her so-called consent after actively refusing surgery:

> Nevertheless, Ms. R. was prepared for surgery, and all "that stood between the foetus and its independent existence, separate from its mother was, put simply, a doctor's scalpel."
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> Ms. R. "consented" to the caesarean whilst being wheeled into the operating room, moments before the arrival at the hospital of several cars containing an Emergency Response Team consisting of three police officers and several social workers. At the initial guardianship hearing, the provincial court judge referred to this as consent "without coercion or threat", which in the circumstances, rings hollow (1990:272, footnotes omitted).

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[70] In the literature on reproductive technologies the notion of informed consent is recognized as a central issue and significant problem (see Overall, 1989; Colodny, 1989; Goundry, 1990). A number of groups and individuals from B. C. who presented briefs to the Canadian Royal Commission on Reproductive Technologies raised as problematic the issue of informed consent, among those was a social work committee, who recommended: "That 'informed consent' as a term and concept be replaced with "informed decision-making" (see BCASW Task Force on Reproductive Technologies, "Brief to the Royal Commission on Reproductive Technologies," 1990). In a recent informational update, the Royal Commission on Reproductive Technologies (June 1991) made a distinction between "informed choice" and "informed consent" (1990).

Was Rose's consent "informed"? From the lower court record (Davis, 1987) it is unclear what information Rose was given and to what degree she understood the medical reasons for a cesarean section. Some writers suggest she was not made fully aware of her condition until viewing the ultra sound, the point after which she "agreed" to undergo the operation (Brighouse 1987b:4). In other cases of doctor/patient disagreement, the question of how adequately doctors informed patients has been, similarly, unclear and difficult to resolve. For example, in the widely publicized Pamela (Monson) Rae Stewart case in the United States, Stewart was actually charged with her baby's death for failing to obey her doctor's advice during pregnancy, yet it was unclear whether her doctor had fully explained the need to comply with his orders (Bonavoglia 1987:92; "Drop The Charges," 1986-87).[71] Some commentators (e.g., physicians) applauded the attempted criminal prosecution of this California woman (Annas, 1987:1213). In the Baby R case it is unclear what information was given to Rose about the footling breech position of her fetus and the problems that she could face with a vaginal birth. What is clear in these cases is that the benefit of doubt regarding whether the physician's responsibility to provide adequate, understandable information was met, goes, not to the women, but to the predominantly male specialists under whose care pregnant women find themselves. The general requirements of informed consent seem to diminish when the patient is a pregnant woman (Gallagher, 1984:134).[72]

The obstetrician's dilemma in the Baby R case cast the problem in a specific way, that is, that the fetus would suffer serious harm or death if a cesarean section was not performed and therefore required protection (Davis, 1987; Dawson, 1990). Two assumptions were made by Dr. Zouves: first, that the fetus was his patient, in addition to but with separate interests from his patient, Rose. And second, that on

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[71] In Pamela Stewart's case the issue was not forced cesarean section, however, it is a case which clearly threatens pregnant women's autonomy and as Johnsen points out "is noteworthy as one of the few criminal prosecutions of a woman for allegedly acting in a way that may have harmed her fetus (1987:33).

[72] As noted earlier, in law, a competent individual has the right to refuse even life-saving treatment (Boston Women's Health, 1984:585; see Dawson, 1990 for a Canadian Legal perspective on this and Gallagher, 1984 for an American perspective). For a discussion of examples of case law which refuses to force adults to suffer harm to save others, see Gallagher (1984); also see Judith J. Thomson (1971) for a discussion of this in the abortion context.

balance, his duty was greater to the fetus than to the pregnant woman. If he had followed the general practice of informed consent, he should have respected the pregnant patient's clear refusal of the cesarean section, after attempting to carefully inform her of the potential implications of her decision for herself and her future child. However, the physician attempted to resolve his dilemma by ignoring Rose's refusal and *forcing* the operation upon her *via* other means, as indicated by the sequence of hospital events detailed in the preceding chapter. By calling in child protection authorities to resolve his dilemma (that Rose would not consent to the cesarean section), for example, the physician clearly attempted to get around the general informed consent legal requirements.

Social workers vested with the authority to act on behalf of the Superintendent of Child Welfare are permitted to investigate child abuse and apprehend children in need of state protection. Once a child has been deemed "in need of protection" by the courts and has been taken into care, a child protection social worker is legally conferred with the status of temporary (or permanent) guardian of any "child-in-care" (of the Ministry of Social Services), which provides the authority to consent to any necessary medical treatment for a child. In the case of Baby R, however, the so-called "child" was in fact a fetus-in-utero, a fact which was deliberately side-stepped by the physician and overlooked by MSS authorities and the lower B.C. court. The apprehending social worker acted as though the fetus was a child and as such, provided medical consent which authorized Dr. Zouves to operate on the so-called "child-in-care" but not on the pregnant woman, Rose. But the social worker's medical "consent" instructions were clearly nonsensical in anyone's construction of reality, since no treatment could be given to the fetus without literally cutting through the body of the pregnant woman. This fact was later addressed by Justice Macdonell in the B.C. Supreme Court decision (1988:6) who commented that the social worker's consent did nothing to get the obstetrician out of his dilemma; he was still facing the decision of whether to operate on a competent patient (Rose) without her consent (LEAF, 1988:1; Dawson, 1990:273). While the social worker's directions were physically absurd, they were also ethically and legally coercive under the circumstances. The social worker was directed (by senior MSSH administrators) to act in a matter clearly outside of the legal jurisdiction of the child protection legislation using powerful state authority. He was directed to act in a way which compounded the coercive and abusive measures being used by Dr. Zouves and the hospital

administration to force a cesarean section operation on an unconsenting pregnant patient. The role cast for social work in forced cesarean sections, made blatantly clear in the Baby R case, illustrates the need to understand and analyze the proper role for social work[73] and the relationship among social work, medicine and the judiciary. Moreover, it graphically illustrates the disembodiment of pregnant women that forced cesarean section perpetuates: the social worker's "consent" to operate on the fetus both admits and denies a pregnant woman's unique relationship with the fetus she carries.[74] Furthermore, such a statement highlights the impossibility of "balancing" pregnant women's rights and fetal rights in these cases, since what is done *for* the fetus must be done *to* the pregnant woman.

While the Supreme Court subsequently recognized the fetus apprehension as not legal vis-à-vis child protection jurisdiction which only includes the protection of living children, the apprehension should also have been criticized by the social work profession as a highly unethical social work intervention and professional abuse of power and authority. If pregnant women are to be treated as persons with full human rights in Canadian society, they must be guaranteed the unequivocal right to *refuse* medical treatment.[75] Brighouse, a feminist writer and commentator on the Baby R case, puts it succinctly, "To be equal women must have absolute control over our bodies. That control must be unequivocal--it applies to the worst case scenarios as well as the best" (1987a:9).[76] Brighouse, like many other commentators, claims the use of forced cesarean section is inconsistent with women's equality rights (Graham, 1987; M. Thompson, Kolder

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[73] The role of child protection will be more fully examined in the following section.

[74] See LEAF's arguments in the Sullivan and Lemay case (1991) for a useful discussion of pregnant women's relationship to the fetus.

[75] See Eichler (1989:228-29) for a discussion of this point from a social policy perspective.

[76] Even in what could be considered a "worst case scenario," when two lives would be lost without treatment, the woman should be granted the legal and moral agency to decide whether or not to consent to treatment. See the final section of this chapter for a chilling description of such a worst case scenario. In the Angela Carder case, the pregnant woman was forced by court-order to undergo a cesarean section after which both she and her 26 1/2 week old fetus died.

et al., 1987; Gallagher, 1984; Johnsen, 1987; LEAF, 1988). Legal and medical commentator George Annas similarly points out that no other group of people are required by law or threat of criminal action to undergo medical treatment against their will (Annas, 1987). Even in cases where refusal of treatment will result in the death of a person, for example when an adult Jehovah's Witness refuses life-saving (e.g., blood transfusions) medical treatments for religious reasons--physicians must respect patients' rights and allow adults to die rather than violate their right to refuse medical treatment (Griffin, 1987; Van Loon, 1990). Lack of informed consent is a pivotal issue in forced cesarean section cases, yet to date, little attention has been given to the implications of this problem (Sherman, 1988a). However, an exception can be found in the growing feminist literature on reproductive technologies.[77]

Women refuse cesarean sections for many reasons, including religion, distrust of physicians, suspicion and/or fear of medical interventions, or simply a belief in the superiority of natural vaginal deliveries. Regardless of their reasons, however, women's rights as consumers of medical care include the right for patients to control what happens to their bodies; they have the right to refuse treatment and the right to "informed consent." Forced cesarean sections and other forms of coercive obstetrical interventions violate these rights and seriously thwart the possibility of women's reproductive self-determination, central to the struggle for women's equality. Moreover, the forced cesarean section literature suggests that, regardless of their reasons for refusal, the most socio-economically powerless and marginalized groups in society, such as Native, working class and poor women, will be most vulnerable to forced cesarean section (Kolder et al., 1987; Annas, 1987; Jordon & Irwin, 1989; Dawson, 1990). Social workers, as professional human service providers, human rights advocates, and policy makers, have a distinct role to play ensuring that clients' rights are respected and protected and challenging coercive obstetrical practices and policies

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[77] The phenomena of forced cesarean section is a contemporary medical/legal trend which falls under the broad umbrella and within complex debates about the implications of invasive "new" reproductive technologies (e.g., ultrasound) some of which are in fact very old (e.g., artificial insemination) (see CRIAW, 1989; CBA, 1990; Corea et al., 1985). In the literature on reproductive technologies the notion of informed consent is recognized as a central issue and significant problem (Colodny, 1989; Overall, 1989; Goundry, 1990), as previously noted.

such as forced cesarean section (these issues are more fully developed in chapter five).[78] This is especially important in light of the fact that child protection legislation is being used in cases of forced cesarean sections to justify overriding maternal autonomy, since the mandate to provide child protection services falls exclusively in the domain of social work, and social workers are predominantly employed in health and welfare settings in which such abuses occur. As I shall argue in the following chapter, social workers are well-situated to intervene as client advocates in hospital settings and in general as critics of such clear-cut cases of human rights violation and violence against pregnant women.

The Abuse of Child Protection Legislation

How does a pregnant woman's refusal to consent to a cesarean section operation end up in family court under the auspices of a child protection matter, when competent adults have the fundamental right to refuse medical treatment? What assumptions are being made by physicians, child protection social workers and judges when they participate in such actions? As with the question of consent, the public record of the Baby R case sheds considerable light on another crucial issue--the role of child protection in forced cesarean cases.

The role of child protection in society is to ensure the safety and well-being of children whose parent(s) are unable or unwilling to do so. Social workers are authorized as agents of the state to carry out that legal mandate by investigating complaints of child abuse or neglect and intervening when necessary. When a child protection matter is brought before the court, the standard statutory question is whether or not a child is being "abused or neglected so that his/her safety or well-being is endangered" (Family and Child Services Act, S.B.C. 1980, c.11). Several questions arise from this statute: how a child is defined, what the age limits are, what abuse or neglect is, and in general, what the paramount principles of child protection are. Following a finding of "in need of protection," the court then decides on the disposition of

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[78] See Erickson & Erickson (1989) regarding the role of social workers in health care settings; see Knee (1987) for comment on health care social workers' responsibility to protect patients' rights; also see Wharf (1990) for a good discussion of the role of social workers as human rights advocates within the mandate of social work to enact progressive social change.

the case, that is, whether the child can safely remain in the care of the parent(s) or should the child be made a temporary or permanent ward of the court. Child protection statutes recognize the problem of conflicting claims but are fashioned from the principle that children's rights to be free from abuse or neglect are paramount and will therefore supersede parents' rights to privacy. These statutes authorize a range of state interventions guided by the practice principle that social workers must take the least interventive measure to ensure that minimum standards of care are met (as spelled out in the statute and regulations, e.g., FCSA, see Bala et al., 1991). At issue in the discussion and analysis of fetal apprehensions such as occurred in the Baby R case, is whether the definition of "child" in the child protection statutes includes the unborn fetus, and therefore whether child protection measures, that is, the issue of child "abuse or neglect" and the assessment of parental "fitness," are legitimately involved or relevant to the courts.

Child protection practices and processes as they currently exist are far from perfect. Child protection statutes and regulations have been criticized, for their vagueness and sweeping powers to interfere with the lives of children and their parent(s) based upon largely unattainable middle-class "minimal standards,"[79] a fact easily apparent by a cursory look at the demographics of apprehended children and families. As one child welfare commentator (Thompson, 1986:58) puts it, "it is no accident that seventy-five percent of those parents whose children are apprehended are poor." Racist child welfare policies are also evidenced by the fact that aboriginal children are apprehended and taken into care at more than three times the rate of other Canadian children (Bala, 1991:16). Yet for all the potential problems and real abuses which occur under the domain of child protection practices, society's goal to protect children from abuse or neglect by caregivers is a laudable and vital one. My argument is not against child protection *per se*. In the Baby R case, I am not arguing that the "best interest of the child" principle which child protection social workers are bound by should be set aside, nor am I arguing that "Baby R" ought to have remained in Rose's care after birth. I maintain that to focus on either of these issues is to ignore the

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[79] A critique of child welfare practice is beyond the scope of this thesis; for several useful critiques, see Poirier (1986); Thompson (1986); also see Howse & Stalwick (1990) and Barnhorst & Walter (1991) on the topic of child protection policies and practices with First Nations children and families.

central issue, which is Rose's right to bodily integrity, that is, security of the person, and the coercive violation of her basic human rights under the guise of fetal protection or as it was called in this case, "child" protection.

In this section I examine the extension of child protection from the "child" to the "fetus," the definition of "abuse and "neglect," and the determination of parental "fitness" in forced cesarean cases, using Baby R as an illustration. I argue that the expansion of the child protection mandate for this purpose is another way to force medical treatment on pregnant women without their proper consent and rests on several questionable assumptions about the definition of the problem as a child protection matter and the appropriate interventions or solutions to be taken. I also address the question of which group of women may be most at risk of this form of intervention and argue that, like child apprehension, forced cesarean sections pose a greater risk to poor and otherwise socio-economically marginalized women. Finally, I locate the use of child protection legislation to force cesarean surgery on women within a broader socio-political context: I examine the notion underlying claims that a conflict exists between maternal and fetal interests within the emerging context of "maternal vs fetal" rights debates, which in turn are situated within the much broader realm of women's reproductive rights claims. I conclude that the assumption of competing interests is logically, ideologically and politically problematic and show how a collaboration of medical, legal, and child protection "experts" works against women's interests. When forced cesarean sections are legitimized as acceptable state interventions, the abuse of child protection and the abuse of pregnant women are being perpetuated. Moreover, the practice of forced cesarean sections is likely to harm more fetuses than it helps, since many women will quite reasonably avoid physicians, other health professionals and social workers altogether during pregnancy, if failure to follow medical advice can result in forced treatment, child apprehension, involuntary confinement, or criminal charges (Annas, 1987:1214; Dawson, 1990; Johnsen, 1987; Bonavoglia, 1987).

I first turn to an examination of the definitions of "child" and "abuse" under the Family and Child Services Act, the child protection statute used to apprehend the fetus, "Baby R" (in May, 1987). The Act defines a child under Section 1: "A 'child' means a person under 19 years old." Other Canadian provinces and the two territories have similar definitions of child; what differs are upper age limits (i.e., the age of

majority) of these acts (Bala, Hornick, & Vogl, 1991:37). Two exceptions are New Brunswick and the Yukon Territory. New Brunswick specifically refers to the "unborn child" in its definition of a "child" for protection purposes.[80] Although the Yukon Territory child protection statute does not specifically include the unborn in its definition of child, its Children's Act specifically states the discretionary power of the Director to apply to a judge for an order to supervise or counsel a pregnant woman where she is believed to be using addictive or intoxicating substances which may pose a risk to the fetus (Bala, et al., 1991:36). Critics of the apprehension of Baby R, including the defense attorney for Rose in the case, and the Intervenor LEAF, all argued that the B.C. FCSA applies to only living children that have been delivered, and therefore the extension of the definition of "child" to include "fetus" was outside the jurisdictional bounds of the legislation (see LEAF, 1988; also CBA, 1990). If the statutory definition of child does not include the fetus, then the entire question of whether a child is in need of protection, that is, whether parental neglect or abuse exists, is a moot point, since no legal jurisdiction would exist for child protection social workers either to investigate or to intervene.[81]

Even in the absence of specific legal jurisdiction under the FCS Act, the Ministry of Social Services and Housing in B.C. made a decision to "test the waters" and took the unprecedented act of apprehending a fetus and calling it a "child." An examination of the public record of the family court protection hearing reveals that the prevailing legal definitions of "child" and "abuse" were skillfully side-stepped by the physician, the Ministry and the judge/court, as detailed in the court proceedings discussion in chapter three. Consequently, the lawyer for the Ministry argued that Rose's refusal of the cesarean section was

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[80] The term "unborn child" is a contradictory and confusing misnomer. I prefer to use the redundant (but correct) term "unborn fetus" as a way to emphasize the fact that the fetus exists within the body of a pregnant woman until it is born (or removed). "Unborn fetus" places emphasis on the relationship of pregnant woman and fetus which provides a representational counterpoint to the current use of fetal-centered language and the "fetocentric" (Rosalind Petchesky's term) socio-political climate. Definitions of the fetus which deny the relational aspect of fetus to pregnant woman distort and disembody the pregnant woman herself. Analogous to this usage is the redundant term, "incest abuse" used by some feminists (e.g., Lena Dominelli, 1989), to emphasize and thereby politicize the abusive nature of incest and child sexual abuse.

[81] This was the ruling of the B.C. Supreme Court on the Baby R case in 1989.

"medical neglect" of a "child." Rose's refusal to accept the proposed cesarean surgery was presented as evidence of the "child" being "in need of protection" and evidence of Rose being "unfit." The Ministry's lawyer submitted evidence about Rose's *history* of parenting (i.e., her other four children were in the care of the Ministry) and her past social problems to prove the existence of "abuse or neglect." Much as in cases of sexual assault in which the victim is indicted by her history of sexual activity (in which the issue of consensual sex is persistently confused with sexual assault/rape), Rose's past history of parenting problems (which confused her right to refuse medical treatment with her ability to parent a child) was used by the courts to indict her as an "unfit parent" *before she even gave birth to, let alone parented*, the fetus known as Baby R. The use of child protection legislation to force compliance with medical advice allowed the physician's solution to a perceived moral/medical dilemma, (i.e., a claim to have an obligation to two "persons/patients," that is, the "baby" and the "mother") to extend the legal definition of child to a fetus, an interpretation inconsistent with major legal decisions of the day (see Leaf, 1991; Day & Persky, 1988). The question of mental competence to consent, an issue raised by the attending physician, as noted in chapter three) and the investigation of parental abuse or neglect (i.e., a child protection investigation) follow as though they are legitimate concerns and interventions. But child protection actions are legitimate *only after the birth of a living child*, an interpretation consistent with existing Canadian child welfare statutes.

The family court judge hearing the protection case of Baby R unequivocally accepted the doctor's creative definition of child (i.e., the unborn fetus was "a child in the process of being born," Davis, 1987:6), even though this definition of "child" flew in the face of the legal definition of "child" under the FCSA as well as the legal status of the fetus at law (the fetus has no status as a person until born alive, see Day & Persky, 1988; "Fetus ruled not," 1991; LEAF, 1991). Moreover, in the Baby R lower court decision, Judge Davis went on to make his own declaration, which expanded the statutory powers of the state at the same time that it dismissed the rights of (pregnant) women: "This is not a case of Women's rights . . . This is simply a case to determine what is best for the safety and well being of this child" (Davis, 1987:).

Davis' pronouncement, from his position of power and privilege (as a white, male judge),[82] dismissed the serious violation of Rose's and other patients' rights to an uncoerced, informed consent to medical treatment. He also dismissed the violation of women's equality rights when he erroneously declared that the case was not one of concern to other women (e.g., women's health advocacy groups such as the Maternal Health Society) or to groups who actively defend human rights. Judge Davis' remarks not only ignore the sexist social context in which women live, but other structural inequalities of socio-economic class, race and professional status (i.e., doctor/patient relationship, which often involves a privileged, white man/poor, marginalized pregnant woman) which have significant social and political implications in this and other cases of forced cesarean sections.[83] His interpretations of "child," "neglect"[84] and indeed "rights" in this case were much more than just logically, legally, and ethically flawed. His interpretations were also grossly misleading: the rights, responsibilities and freedoms of all women, (especially minority oppressed groups) are central to the discussion and analysis of this case and other forced cesarean section cases. Moreover, his definition of the problems and parameters of this case reflects an arrogance in the sense that he used the authority of the courts to establish what he obviously felt was "the final truth" in the matter. His attitude is typical of a male-dominated, paternalistic judicial system which in many rulings dismisses, out of

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[82] Judge Davis, incidentally, is married to a Vancouver obstetrician who gave birth to their two children by cesarean section (Maternal Health Society, conversation with Laurie Brant, 1991).

[83] Rose's social status as an unmarried, poor, inarticulate pregnant woman was what brought her refusal to comply with a physician's orders to the attention of the child welfare authorities. As we shall see, the social rationale embedded in attempts to force cesarean sections on pregnant women in other cases also reveal, in addition to pregnancy (i.e., sex) discrimination, race and class discrimination (Kolder et al., 1987; Jordan & Dawson, 1990). It should be noted, however, that well-resourced, middle-class, white women who refuse cesarean sections in similar circumstances have been forced by court-order to undergo cesarean surgery, for example, the Angela Carder case (1987), as mentioned.

[84] That is, Rose's *refusal* to have a cesarean section, (an operation deemed by one physician to be "necessary medical care" for the fetus), the initial grounds for the apprehension.

hand (and under the privilege of "discretion"), the implications of such declarations for women's lives.[85] Not only did Judge Davis ignore the issue of Rose's legal right to refuse medical treatment, he allowed Rose's refusal itself to be considered evidence of "child" neglect, even though clearly she refused the cesarean section while still impregnated with an "unborn fetus." As a result, the case became judged as a child protection case, which it clearly was not. The question as to whether "a child in need of protection" can include a fetus for whom medical treatment is refused was circumvented, which effectively dodged the issue of whether a "child" can be abused during gestation.

In most forced cesarean cases, the question of the pregnant women's competence (or "fitness") is raised, either directly, as in the request for a woman to undergo a psychiatric assessment, or indirectly, as in the assumption that a pregnant woman's refusal of medical treatment which may benefit the fetus is evidence of mental, social or parental incompetence, that is, unfit parenting (see Appendix I). Both strategies were used by Dr. Zouves in the Baby R case. A study of the Baby R case illuminates the essential ingredients of most forced cesarean section cases in which medical, legal and child welfare institutions collude to threaten, force and ultimately coerce pregnant women to undergo surgery. If consent is not freely given, it is extracted. When women do not cave in under pressure, the legal implications of the consent issue are side-stepped. Seeking "custody" of the fetus under the auspices of "child" protection then provides a "legal" means[86] to invade pregnant women's bodies.

Reported incidents of forced cesarean sections in the United States show the same patterns. For example, in 1979, in what is believed to be the first reported case of forced cesarean section, a 33-year-old woman in Denver, Colorado, fearing surgery, refused doctors' recommendations for a Caesarean section based on the position of the fetus and "desultory" progress of labour (Jost, 1988:417). The woman was

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[85] Recent efforts on the part of a strong feminist lobby to make gender-sensitivity training compulsory for judges have politicized and attempted to challenge such "discretionary" and sexist actions, a significant problem addressed by the feminist legal community (e.g., see report of the "Gender Bias Committee" of the B.C. Law Society, to be released sometime in 1992).

[86] That is to say, United States child protection social workers (and other third parties) have been given the so-called legal power and authority to consent to medical treatment on the fetus.

described as angry, uncooperative, and obese. When her family and a hospital lawyer could not persuade her to change her mind, lawyers for the University of Colorado Hospital asked a juvenile-court judge for an order allowing them to perform the surgery *without the woman's consent.* After a psychiatrist judged her neither delusional nor mentally incompetent, the hospital sought a juvenile court order finding the fetus dependent and neglected and ordering a cesarean section. At the judge's request, a hearing was held in the woman's hospital room with court-appointed attorneys representing both the mother and the fetus. The court ruled in favor of the hospital, and surgery was performed eleven hours after admission.

Similarly, consider the circumstances in an Illinois (1982) forced cesarean case. After a woman refused a cesarean section "A juvenile court judge ruled that the fetus was suffering medical neglect and awarded temporary protective custody to a hospital lawyer along with the power to consent to a section and to other medical or surgical procedures" (Jordan & Irwin, 1989:15; see Appendix I).

As these examples illustrate, certain fundamental assumptions regarding who is the patient, the pregnant woman or the fetus, and what is in the patient's best interests, are made by the medical profession and accepted by the legal and child welfare professions. In the case of forced cesarean sections, physicians drive the decisions, that is, they make the assumptions and then define the problem from a medical perspective. In these cases, a woman's refusal to consent to a cesarean section may lead to a medical diagnosis of potential "fetal harm" which calls for surgical treatment as the intervention plan. The justification for such actions falls within the debate about maternal/fetal conflict and legitimizes the physician's role as "fetal advocate" to "balance" the interests of the pregnant woman and the fetus. Such physicians consider the fetus a "patient" in its own right with interests "in opposition to" the pregnant woman, as was the case in Baby R. When Rose refused medical treatment, her behavior was taken to be evidence of fetal "neglect," since she was allegedly "depriving" her "child" of necessary medical treatment, as the recorded facts of the case indicate in chapter three.

This was also the situation in the other fetal apprehension case in Canada, the Belleville case (1987), which occurred after a pregnant woman refused medical advice. In the Belleville case, a 38-week-old fetus (full term is approximately 40 weeks) was made a ward of the Belleville child protection authorities "because its mother refused all appeals that she obtain medical treatment and planned to give

birth in the underground parking garage she made her home" (Eichler, 1988:375; see Kirkland, 1987). Both Canadian women were deemed socially "unfit" by virtue of their rejection of medical advice (even though neither B.C. nor Ontario child protection statutes include the unborn fetus). The assessment of "unfit," also used in a number of American cases of forced obstetrical intervention (see Gallagher, 1984; Jost, 1989; Jordan & Irwin, 1989; CBA, 1990; also Appendix I), redefines the physician's problem, having an "uncompliant pregnant patient," to a child welfare and legal problem, having an "unfit parent." Thus the stage is set for increased judicial intervention during gestation and childbirth: control of the conduct of pregnant women through child welfare legislation (and through criminal sanction) are the means by which this is accomplished (see CBA, 1990a,b; also NAWL, 1989).

While the question of competence and fitness is common to cases of forced cesarean cases, what is unique about the Baby R case is *the way in which Rose's history* of parenting was used. It was only after the physician found he had an uncompliant patient that he contacted child welfare authorities. The fact that Rose had a history of inability to parent in the Ministry records significantly contributed to the actions taken against her. Judge Davis first states Rose's "refusal to accept the cesarean section" was grounds for the apprehension. But it was her poor parenting history which was the primary focus of the hearing and was subsequently cited by the court as grounds to justify child protection interventions. Since Davis called the fetus a "child" (and by the hearing there was in fact a child) the issues became entangled, as discussed in chapter three. In the final analysis, Rose's background was the state's major reason and justification for intervening and keeping her child permanently in care.

How did Rose's poor parenting history become so central to the court's arguments? First, Rose's character and "fitness" as a mother-to-be were called into serious question by the physician when she refused the cesarean section he offered as "standard management" for a breech position fetus. Other women who are not willing to undergo medical intervention on behalf of their fetuses, by and large, evoke anger, frustration and disgust from some medical and legal institutions. For example, Jordan & Irwin (1989:18) found a strikingly negative character portrayal (in the medical and legal records) of women who had refused (and been threatened with court-ordered) cesarean sections. Indeed, the cultural ideology of motherhood (i.e., the institution of motherhood) indicts women who do not conform to the self-sacrificing

"ideal" associated with traditional female roles. Hence women who refuse cesarean sections are portrayed as selfish women and "unfit mothers" simply for refusing to act on physicians' advice. Thus the issue of state-sanctioned violation of pregnant women's autonomy and rights and literal violence of their person is overshadowed by the cultural character indictment of pregnant women who fail to conform to ideological assumptions about female "nature" and social prescriptions for "proper" female behavior.

As discussed in chapter three, Rose's previous record of parenting (especially the fact that her four other children were in the Ministry's permanent custody) seemed to cement the judgement of the physician, child welfare authorities and the courts that if she was irresponsible enough to refuse medical treatment on behalf of the fetus, she was also too irresponsible to parent the child.

Socio-Economic Discrimination

What made Rose vulnerable to the forced cesarean section as much as her status as "uncompliant" female patient and parenting background was Rose's socio-economic location in society. Her social status made her "unfit." She was dependent upon the state for welfare (i.e., income assistance), lived a "transient" and impoverished existence, was unmarried with a history of being the victim of violence, had limited formal education, and had a history of alcohol and drug problems. One of several feminists who attended the court proceedings, Maggie Thompson, health activist, gives her impressions of the hearing:

> The State-approved abuse of Rose which began in the hospital, continued over the five long days of the hearing in New Westminster. MSSH lawyer Tom Gove carefully planned an attack on Rose, her friends and lover. His case was nothing less than a character assassination designed to make Rose look so bad that the impropriety of events on May 20 would be overlooked (1988:15).

One is immediately struck by the similarity of the abuse of rape victims by the courts when past history is used to justify sexual assault and the issues of coercion and consent are glossed over (see MacKinnon, 1989). Enforcing cesarean section operations with court orders because of women's backgrounds (or for whatever reasons) legitimizes assaults on pregnant women.

My argument is not that the child <u>should</u> have remained in Rose's care <u>after</u> birth, since that is a different issue. But the fetal apprehension should never have happened, and moreover, I would argue, would rarely be <u>attempted</u> on a white, married, middle-class, university educated pregnant woman, or put

another way, a woman who conforms to mainstream society's expectations of female roles and behavior. Rose's marginalized social status[87] placed her most at risk and most vulnerable to unwanted medical interventions and, moreover, left her virtually powerless to defend herself against the state's interventions. The fetal apprehension was a form of child welfare "entrapment"--a type of "social sterilization" of a pregnant woman deemed be "unfit" as mother (and reproducer).[88] Her marginalized status made her vulnerable to coercive medical directives; the fact that she refused the acquiesce to medical prerogatives further marginalized her.[89]

The Baby R case is not unique in this regard. Systemic class and race discrimination have also been identified as part of the problem which exists in many cases of forced cesarean sections, on top of the sex discrimination or more specifically, pregnancy discrimination. In Canada, both cases of fetal apprehensions involved marginalized women who refused medical treatment: in the Baby R case, Rose was a poor, socially marginalized woman; in the Belleville case, the woman was poor and homeless. And in the United States where the majority of forced cesarean sections have occurred, "Almost all the pregnant women involved in the reported physician-initiated court actions have been black, Asian, or Hispanic, and all were poor" (Annas, 1987:1213; see Kolder et al., 1987).[90] One recent commentator stated that 91

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[87] By marginalized women, then, I mean women who are not part of the most powerful dominant groups in society and whose lifestyles may not conform to a patriarchal, nuclear family form, for example Native, poor, unmarried, lesbian or homeless women and therefore who would be deemed "deviant" or "unfit" by mainstream, conformist standards of "the family" (see Nsiah-Jefferson & Hall, 1989). See Kolder et al. (1987); Annas (1987); Terry (1989) for general comments on this; Dawson (1990) and Rodgers (1989) for specific comment on the Baby R case (although it is important to note that Dawson is incorrect in asserting Rose was an Aboriginal woman--Rose is Finnish; on this point see Kitchen, 1988). For comment on the marginalized status of the pregnant woman who was detained in the hospital in the Belleville case, see Eichler (1988:375).

[88] For a useful discussion of the assumed social "unfitness" of lesbian mothers, see Levine & Estable (1984:17).

[89] If the baby had died, it is comprehensible that criminal charges could have been laid against her, such as occurred in the Pamela Rae Stewart case previously discussed.

[90] The Angela Carder case court-ordered cesarean section, which occurred in 1987, is an exception.

percent of the pregnant women upon whom cesarean sections were performed were non-white and poor (CBA, 1990). Jordan & Irwin's description of those women most vulnerable to unwanted cesarean sections perhaps says it best:

> As a group, they appear to be poor and ethnically diverse, sometimes single, uneducated, and without fluent command of English; some belong to marginal religious groups. They are not part of mainstream U.S. society (1989:18).

The risks of pregnancy for women include not only physical/medical risks, but clearly risks that are linked to race and social class. Women who have the least amount of power and who are the most oppressed by virtue of their socio-economic or racial status are the most vulnerable to forced cesarean sections. Poor women, native women, lesbian women, disabled women, women of colour, immigrant women, women in institutions--all will be more at risk of having their fetuses apprehended and being subject to unwanted state intervention. Any woman who has what may be perceived as a negative "lifestyle" or a "negative social history," that is, one which could be seen by the patriarchal medical system and state welfare system as incompatible with making responsible "parenting" (read "mothering") decisions, is potentially vulnerable to this kind of enforced medical/legal intervention.

The trend to force cesarean sections on pregnant women is relatively new.[91] However, other highly interventionist "legal" forms of fetal protection measures are becoming commonplace, for example, forcibly confining (i.e., "jailing") women in hospitals, and criminalizing and jailing pregnant women with alcohol and drug dependencies for "contributing to minors" or for "fetal (or child) abuse" (CBA, 1990a,b; Dawson, 1990; NAWL, 1989; Denniston, 1989; Sherman, 1988a,b). The history of women's health provides ample evidence of the abuse of pregnant women and of reproductive injustices, for example, the pattern of violation of rights and bodily invasions by the state on groups of women deemed by "experts" to be "unfit" for reproduction or for mothering (e.g., sterilization without consent for social and/or "medical" reasons; see Terry, 1989; Petchesky, 1990; McLaren & McLaren, 1986; Dale & Foster, 1986; and Strong-Boag, 1988). These examples, in conjunction with the emerging trend to force cesarean sections on poor or

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[91] The first known case seems to have occurred in 1979, according to Jost (1989, see description in Appendix I).

otherwise marginalized pregnant women requires not only that the sex discrimination of these actions be recognized, but that discrimination on the basis of other factors such as class, race, and marital status be made explicit and inform any analysis of the issues.[92]

In forced cesarean sections, the interpretation of child protection is clearly a crucial issue, since it defines the parameters and definition of "child" protection investigations which include an assessment of the "fitness" of the pregnant woman ("mother") within what amounts to a socio-economic hierarchy of fitness with white, married, heterosexual, able-bodied, middle-class pregnant women on top. Moreover, the language of "fetal abuse," has developed out of the discourse on child abuse (CBA, 1990b:2), which constructs the problem in a way that further obscures the issues (e.g., the "unborn child" needs "protection" from the prime fetal "hazard," that is, the "unfit" "mother").[93] Fetal rights arguments are being bolstered at the expense of women's rights, using the arena and expansion of mandate of child protection to further confuse the issues, and perhaps unwittingly advance the claim that fetal personhood should be recognized and legally protected, even if at the expense of women's legal personhood protections. From a feminist perspective, as applied here, the control of the conduct of pregnant women through child welfare legislation brings the predominant themes of unjust and coercive interventions into women's bodies and lives sharply into focus.

The legal incorrectness of Judge Davis' interpretation of "child" was set straight by the B.C. Supreme Court when it overturned the provincial court finding in 1988 (see Macdonell, 1988; LEAF, 1988; Majury, 1988; Phillips, 1988). But the biomedical and patriarchal assumptions and expectations upon which legal decisions such as Davis' are based, that is, that the control and violation of pregnant women by medicine, social work and the law for the sake of the fetus is acceptable, are rarely challenged by the public. Moreover, such interventions have not been challenged by child protection social workers, the very group

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[92] See, for example, the socialist anti-racist feminist analysis of Gordon (1979); Terry (1989); Petchesky (1990); also see Rothman (1989) and Cox (1991) for feminist analyses which specifically incorporate a critique of the ideology of technology as a contributing factor to women's subordination.

[93] See earlier discussion of terminology in chapter three.

which is responsible for child protection and would likely be responsible for "fetal protection" should any such legislation be created.[94] Most significant is that the coercive, illegal and unethical use of state power and authority which occurred in the Baby R case, first in the hospital and then in the courts, remains largely unacknowledged and unaddressed by social workers. Child protection social workers are not in an equal relationship with physicians and judges in the state hierarchy. And because we often wait for medical and legal experts to define moral and legal issues (especially with respect to women's reproductive rights matters) my concern is that the Baby R case may have been seen as a legitimate child protection case or simply a highly unusual and isolated case of misinterpretation of the FCSA. Moreover, acceptance of the terms of the debate may lead to the assumption that such matters are within the appropriate sphere of "child protection."

Reframing the Problem: A Feminist Standpoint

Construction of the problem of forced cesarean section as maternal versus fetal rights or as child protection matters has gained a great deal of currency over the past decade. Yet the whole question of what might constitute fetal "abuse" and what measures could be taken to prevent or correct such situations (apart from criminalizing pregnant women or severely interfering with their human rights) remains largely unaddressed in the Baby R and other forced cesarean section or fetal "rights" cases. In fact, Macdonell's concluding comments on the Baby R case reveal that the B.C. Supreme Court decision in this case is both promising and threatening. Most significant may be the implications that Macdonell foresees in the long term: the apprehension of pregnant women. Justice Macdonell states:

> I conclude therefore, after examining the Family and Child Services Act and the other relevant law, that the powers of the Superintendent to apprehend are restricted to living children that have been delivered. Were it otherwise, then the state would be able to

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[94] In the health care arena, doctors, nurses, and social workers may be enlisted as "pregnancy police," which would likely deter pregnant women from seeking the help they need (CBA, 1990b) and create even more harms to the woman and to the fetus than one can imagine from the present vantage-point.

> confine a mother [sic][95] to await her delivery of the child being apprehended. For the apprehension of a child to be effective there must be a measure of control over the body of the mother [sic]. Should it be lawful in this case to apprehend an unborn child [sic] hours before birth, then it would logically follow that an apprehension could take place a month or more before term. Such powers to interfere with the rights of women, if granted and if lawful, must be done by specific legislation and anything less will not do (Macdonell, 1988:13).

On the one hand Macdonell's decision clears up the statutory jurisdiction question and limits the use of the FCSA to living children. On the other hand, from the perspective of protecting pregnant women's rights, his concluding comments do not bode well since they seem to imply that a solution might be the creation of specific fetal protection legislation.[96]

Making a similar point, feminist legal commentator, Brettel Dawson (1989:274, 275), criticizes Macdonell's decision for failing to in any way "resolve the debate" about the alleged conflict between maternal and "fetal rights" (also see CBA, 1990). The problem is that no way exists to "balance" maternal and fetal rights, and any such attempt leads away from the critical focus on the violation of women's rights and the oppression of pregnant women by forced cesarean section.

From a feminist standpoint, the issues are framed differently (Gallagher, 1984). The focus is on the pregnant woman, and the fetus is viewed as a part of the pregnant woman's body. In this view, moral and legal decision-making powers regarding pregnancy and birth (e.g., birth delivery method as in the Baby R case), in the worst as well as the best case scenario, are ultimately the pregnant woman's. Feminists maintain that the question, who has the power to decide, when a conflict between fetal and maternal rights is perceived, is the most significant question and a political issue. Feminist sociologist Barbara Rothman says:

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[95] Here, too, we see the confusion of terms "child" and "fetus" which seems more ironic in light of the context of Macdonell's decision.

[96] As feminist attorney Janet Gallagher (1984) notes in "The Fetus and the Law--Whose Life is it Anyway?" many American states are developing fetal protection legislation pertaining to "feticide" and workplace fetal harm. Predictably, the harms to the pregnant woman seem inconsequential while the duty to prevent such harms fall predominantly on individual women. Some successful legal challenges to this area of law are encouraging, see "U.S. Supreme Court rules" (1991).

> Bad decisions will sometimes be made in a birth situation by patients and by doctors. It's a question of who you're going to allow to make mistakes (as cited by Gallagher, 1984:135).

The most crucial feminist solution is also a basic feminist strategy--empowerment by way of supporting a fully informed, carefully considered decision-making process. Physicians, other health care professionals, and judges must respect the decisions of pregnant women. A good example of this is illustrated in a New York case, in which Judge Margaret Taylor was called to a hospital and told by doctors that the umbilical cord was wrapped around "an unborn child's" neck and that a ceasaren was necessary:

> The hospital wanted Taylor to take responsibility for overriding the birthing woman's objection to a cesarean, which she believed was unnatural, in violation of God's scheme. Taylor spoke at length with the patient, a 35-year-old woman who had borne 10 children and who insisted she knew what she was doing. *Taylor refused to authorize forced surgery on the grounds that the woman was capable of making her own decision* (Gallagher, 1984:134, emphasis added).

Although this judge recognized the serious implications of the situation, she explained her rationale:

> Even *assuming that the doctors were right*--that there was a very real chance of death or brain damage to the baby, *it was that woman's body. She had the responsibility for herself and for her child [sic]. The only role the courts should play in that sort of situation is to make sure that the woman has got the freedom to make her own decision* (Gallagher, 1984:135, emphasis added).

And the role social work should play in such a situation, is also to make sure the woman has been given adequate information to make a careful, considered decision.

Social workers in hospital settings are both skilled communicators and skilled mediators who could play an active role in ensuring the patient's decision-making process is respected and her self-determination is considered. At both the practice and policy levels, such a role for social work is consistent with hospital social work roles (see Knee, 1987; Erickson & Erickson, 1989; Holosko, 1989; Taylor, 1989) and ethical social work practice (CASW, 1983), as it embodies a client-centered perspective which places a premium on client self-determination (i.e., agency), human dignity and social justice. One writer, in her discussion of social work practice roles for the 1990s, states:

> The role of social work in helping patients make choices for themselves is clear. Not only is the basic tenet of social work embodied in the directive of 'helping the patient to help himself' [sic] but the expressed values of the profession support this approach. Self determination, acceptance and a non-judgmental attitude lend themselves to an approach that supports the patients' right to be included in the decision making about their care. Empowering patients to maintain a level of control over their treatment without alienating

> themselves from medical services is critical. The role of social work in advocating for this empowerment within the health care team is equally important (Taylor, 1989:642).

In addition to empowering the patient, the role of social work must include an analysis of power and oppression (Howse & Stalwick, 1990).

From a feminist social work perspective, the best ethical and legal strategies for fetal protection would be to create the means to ensure that the primacy of the pregnant woman's decision-making rights regarding her pregnancy, body and life be respected (Dawson, Gallagher, 1984; Kolder et al., 1987; Annas, 1987). Any legislation created to "protect fetuses," justified under the auspices of child protection principles and standards, assumes a legal personhood status for the fetus that diminishes the status of pregnant woman under the law. Moreover, such developments open the door to an unprecedented potential for abuse of medical and state power.

Fetal protection legislation would greatly expand the already intrusive powers of child protection statutes and the classist and racist ways in which child protection is practiced (see Howse & Stalwick, 1990). When the institutions of medicine, law and social welfare amass their collective authoritative weight to turn a pregnant woman's refusal of cesarean surgery into a case of child neglect or abuse, pregnant women will have almost no way to resist such actions, short of altogether avoiding health and child welfare authorities when pregnant. Few would argue that this would really enhance the well-being of either the fetus' or the pregnant woman's health. The results of pregnant women avoiding doctors and other health professionals, including social workers,[97] could create more dangers and risks for both pregnant women and their fetuses (Gallagher, 1984; Kolder et al., 1987; Annas, 1987, Thompson, 1987; Graham, 1987; Maier, 1988; Gustavsson, 1991). Moreover, enforcing a standard of behavior for pregnant women that is tantamount to that of a "splendid Samaritan" (Judith Jarvis Thompson's term, 1971, cited in Zimmerman, 1987), and that

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[97] It should be noted/remembered that many people already have a dim view of social workers, viewing them as meddling agents of the state--out to snatch children or to find some financial wrongdoing (to some degree, a realistic assessment in light of the dictates of the institutions in which social workers are employed). The need for social workers to dispel the misconceptions and ignorance about the role of social workers (and to actively define it) is a perpetual one (see Erickson & Erickson, 1989). A broad definition of social work is that of a helping profession dedicated to client empowerment and social justice (notwithstanding the varying mandates of statutory and non-statutory social work agencies and the conflicting expectations).

is not expected of anyone else, is an affront, especially since women occupy an inferior socio-economic status and still are expected to carry the largest burden of social responsibility to create a "healthy" environment for the fetus.

For legal, ethical and political reasons, the excuse of child protection should not be used to coerce or force pregnant women to accept medical advice and treatment such as cesarean sections. If pregnant women can be forced to undergo major surgery without the requisite "full and informed" consent we require for all other persons, we effectively strip fertile women of their human rights to bodily integrity and treat them as objects--fetal containers (Graham, 1987; Gallagher, 1984; Furman-Seaborg, 1987; Maier, 1988). Social workers should be alarmed by the tide of sentiment which pits pregnant women against fetuses (and by extension, children). The danger of "fetal protection" becoming an ideological (Overall, 1987) and legal tool to oppress pregnant women is real (Gallagher, 1987). The Baby R case in B.C. was evidence of the state using its authority to direct a child protection social worker to enforce medical treatment on a pregnant woman--against her will--under the auspices of child protection concerns. Not only does forcing cesarean sections on pregnant women strip women of their dignity, human rights and personhood, it is assault (touching without consent). Hence, in the future, pregnancy may be a perilous condition (physically and psychologically) for women, especially poor and non-white women, those most vulnerable to forced cesarean sections and other forms of reproductive violation.

The prevalence of other forms of reproductive violations, such as detentions, civil suits and criminal prosecutions of chemically dependent pregnant women for harming fetuses, is frightening. Responses to this problem reflect an acceptance of the "maternal versus fetal rights" argument. Child protection legal reasoning and language (e.g., "best interests of the fetus") is being used to describe the "abuse and neglect" of fetuses and the culpability of pregnant women who use or abuse drugs (see Gustavsson, 1991). In yet another vein, a neo-conservative legal and political agenda is promoting social policies that subjugate women's rights to the interests of the fetus, making the pregnant woman herself disappear or be the "culprit" (Gustavsson, 1991:64-65). Concern for the treatment needs of chemically addicted babies is a legitimate social concern, however, the main focus of this problem has, predictably, been a micro-focus on the fetus and child, not the pregnant woman, who herself is faced with myriad

physical and social problems which require intervention (Gustavsson, 1991; also, see the growing discourse on pregnant women criminalized for drug dependency, e.g., Sherman, 1987a,b). A meaningful consideration of her needs, personal and material resources and availability of community services (e.g., women's chemical dependency treatment programs) is a more ethical, respectful and potentially helpful way to approach the problem, as opposed to taking punitive measures such as restricting her behavior, prosecuting, or jailing her (Gustavsson, 1991; CBA, 1990; NAWL, 1990; Gustavsson, 1991:69-71). A feminist perspective reframes the issues and refocuses on the pregnant woman and the implications for women's autonomy and ultimately control over their lives and bodies. Since this form of control over pregnant women, like forced cesarean sections, has direct and far-reaching implications for child protection and hospital social workers alike, Canadian feminist social work research and policy development in this area is urgently needed. On the policy level, an area for future feminist social work participation would be to ensure that the child protection legislative framework is not used as a tool to further oppress women in society. A feminist analysis leads to a reframing of the terms of the conflict of rights and a reexamination of the intent and effect of such fetal protection policies and laws, which should be considered within the current examination in B. C. of child welfare legislative review.

Forced Cesarean Section is Violence Against Women

Feminists and other critics have noted that forced cesarean sections are a form of social control over women's reproduction and sexuality. And as many feminists have established, violence is a form of social control of women (Klein, 1981; MacKinnon, 1987, 1989; Hanmer & Maynard, 1989). But what has not been well established in the discourse on unwanted medical and legal intervention in pregnancy and childbirth is the violence that is implied by some forms of medical and legal control over reproduction, such as forced cesarean sections. What most analyses fail to describe is the actual violence of the incidents: that against their will such pregnant women are being anesthetized and operated upon; they are being violated and assaulted.

A critical analysis of forced cesarean section leads to the issue of reproductive violence. I use the broader term *reproductive violation* to refer to the violations against women because of their assumed or

actual ability to become pregnant--the fact of their having wombs. Reproductive violations include acts of reproductive harassment (like denying, harassing and insulting women seeking abortion),[98] acts of forcible confinement (like jailing drug-dependent pregnant women "for the sake of the fetus")[99] and acts of reproductive violence (like forced cesarean sections).[100]

Reproductive violation is more specific than, yet clearly a part of, the spectrum of violence against women.[101] I describe and name the act intrinsic to forcing women to undergo cesarean sections *reproductive violation* in order to bring the violence into sharp focus--to make it visible as part of the reality of what forced cesarean sections mean for women. For example, in 1984 in a Chicago hospital, a Nigerian Woman who refused a cesarean section was physically restrained with wrist and ankle cuffs in order to administer the anesthetic required before a cesarean section could be undertaken. When the woman (and her husband) refused the surgery, Chicago hospital attorneys obtained a court order granting the

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[98] For example, cases, such as the Chantelle Daigle and Barbara Dodd cases (1989) in which the boyfriends of these women sought injunctions to stop them from having abortions, (see Bastien, et al., 1989 and Loyer, 1989) can easily be situated at the harassment end of the spectrum of reproductive violation. These cases bring into sharp focus the exercise of state and individual male control of women's bodies and the wrongs done to individual women because of their reproductive capacity and pregnant condition. I believe the very introduction of Bill C-43, the bill proposing to recriminalize abortion in Canada, was another form of reproductive harassment (Bill C-43 was passed by parliament in a vote of 140-131 but subsequently rejected by the Senate). Like the numerous attempts to criminally prosecute Morgentaler, the introduction of Bill C-43 seems like a form of harassment--a strategy which takes many forms, designed to continually wear down the collective energy of women and men fighting for reproductive autonomy.

[99] For an example of a fetus-centered approach to this problem, see "The Children of Cocaine Addicts," a social work analysis by Johnston (1990). By way of contrast, see Gustavvson's article, "Pregnant Chemically Dependent Women: The New Criminals" (1991) for a feminist perspective; see also Amaro et al. (1990) for a discussion of the relationship between violence against women and their substance use.

[100] Another example of reproductive violation is the use of unconscious women patients--without their knowledge or consent--by doctors in teaching hospitals for instructing other medical staff how to do pelvic exams. Doctor Cynthia Carver, writing about these practices on anesthetized women waiting for surgery, calls them not only an outright violation of human rights, but questions whether such actions are assault (Carver, 1984:10-11).

[101] I am thinking of all the acts, attitudes and images of violence against females as we name them, from misogyny and pornography to rape and murder (see Kelly, 1989).

administrator temporary custody of the triplets and authorizing the surgery as soon as she went into labor (Jost, 1989:417, see Appendix I). Forced cesarean sections, as I have shown, are not just medical or legal matters. They do not accord pregnant women full human rights and they condone and constitute violence against women.

When the practices of medicine, social work and law, which are grounded in patriarchal ideology, legitimize medical and judicial interventions on pregnant women against their will, the action is tantamount to physical, bodily assault (Raines 1984:599). Such a state practice is strikingly similar to the past patriarchal practice of husbands being able to sexually assault their wives with legal impunity.[102] Forced cesarean is nothing less than a form of violence against women--against their will pregnant women are being forcibly anaesthetised and cut open.

As other writers have argued, reproductive coercion entails violence towards women. Feminist legal commentator Kathleen Lahey (1987:23) comments: "Women's lack of reproductive self-determination is one of the material conditions of women's inequality and leads directly to what I would call the abuse of women and children." Socialist feminist Jennifer Terry also makes the historic link between reproduction, social control and violence. She argues that women have been violated in a variety of ways in their reproductive capacities. For example, Terry identifies certain groups of women--black women, poor women and prostitutes--who have been historically subjected to forms of reproductive violation such as forced sterilization as part of the social control of women who were (and currently are) considered within public policy "undesirable" (i.e., unfit) as reproducers/mothers. According to Terry (1989), forced cesarean section is one current form of reproductive violation aimed at women. My assertion is that the ideological nature of the issue should be made explicit: forced cesarean section should be seen as reproductive

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[102] This situation changed legally when the sexual assault provisions of the criminal code were amended in 1985.

violation, a form of violence against women and of female-gendered injustice, that is, discrimination on the basis of being female and pregnant.[103]

In the United States, reproductive violations are shocking in both their frequency and severity. Consider the circumstances of this 1981 case, in which the wishes of a pregnant woman were overridden in Los Angeles, California:

> A pregnant woman with terminal cancer wanted her doctors to attempt to resuscitate her first if she went into cardiac arrest as a result of chemotherapy and if a choice had to be made between saving her or the fetus. The ob/gyn staff urged that she be compelled to undergo a cesarean, a step that other doctors argued would result in her immediate death. The Department of Social Services filed a court petition charging the woman with neglect and being an unfit parent, asking that the fetus be named "a dependent child of the court" and that the woman's instructions be reversed. The court ultimately ruled in favor of the woman, but she died soon thereafter (Gallagher, 1984:134).

It is unknown whether the cesarean section actually took place. About the recent events in the Angela Carder case in Washington, D.C., however, a considerable amount is known.

Angela Carder's fourteen year struggle with leukemia abruptly ended in June 1987, "two days after George Washington University Hospital performed a court-ordered Caesarean section over the objections of her family, her doctors and the lawyer appointed to represent her" (Gellman, 1990:A1-2). She was 27 years old when she died; the 26 1/2 week old fetus, given primacy of patient rights by the hospital, died 2 1/2 hours after being forcibly extracted from its mother. Not only was Angela Carder denied treatment for her cancer, which would have harmed the fetus, she was forcibly operated on against her will. Two days after the cesarean section operation she died. Two and a half hours after the operation, the extracted fetus died (see Rogers, 1990).

The George Washington Hospital administration denied Carder her most fundamental right to refuse medical treatment as well as to have the medical treatment she required and requested to combat active cancer. The hospital and its lawyer brought the case to the courts for disposition: the lower court decided in favor of the fetus. At that point, all the control over Angela Carder's life was in the hands of the

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[103] Or potentially pregnant, as in those women who are denied the right to sterilization procedures, as previously discussed (see McCarthy, 1989; Dale & Foster, 1986).

courts, which decided that her life could be sacrificed for the life of her fetus. This case graphically illustrates the reproductive violence Angela Carder was subjected to because she was pregnant, and exposes the fact that in light of the trend to force cesarean sections on women, pregnancy may be a perilous condition to be in. Angela Carder's parents, in addition to appealing the court decision, filed a civil suit for medical malpractice against the doctor who performed the surgery and the George Washington Hospital (Sherman, 1989).

On April 28th, 1990 the Carder case was heard by the District of Columbia's highest court. The court overturned the lower court decision when it ruled "that a pregnant woman has a virtually unlimited right to decide the course of medical treatment for herself and her fetus" (Gellman, 1990:A1). Writing for the majority which had a surprising (given the ultra-conservative political climate in the United States) seven to one margin, Judge John A. Terry wrote: "The right of bodily integrity is not extinguished simply because someone is ill, or even at death's door. . ." (Gellman 1990:A1; Rogers, 1990). The Carder decision is described by legal journalists as the leading precedent in American law on the question, "May a woman's right to control her care be balanced against the interests of her fetus?" While the finding in this case gives some hope for women who campaign for reproductive rights, it does not mitigate the fact that Angela Carder is dead, and the taking of her life should be called murder. Moreover, the hospital and lawyer responsible for initiating this action--the self-appointed guardians of the fetus--should be held accountable, as they were complicit in this crime. And finally, the Angela Carder case circumstances require further investigation[104] and analysis, since it reveals not only a worst case scenario in terms of legislated abuse of pregnant women, but also a civil suit remedy for medical malpractice which is both creative and instructive for women's rights advocates and groups opposing reproductive violations. Despite its importance, the

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[104] For example, nowhere in the lengthy court decision in this case is there mention of the role played by social workers or other potential patient and family advocates. This is true of every case I have read data about. Research addressing such gaps in information is important to provide feminists and social workers with greater understanding of how forced cesarean cases originate and thus help determine potential individual and collective strategies of resistance.

court victory received marginal press coverage (e.g, see Sherman, 1988a,b, 1989; dar, 1988; "Court backs pregnant women," 1990:A5; "Course of medical treatment," 1991:A8).

Carder's parents launched a 3 1/2 million dollar civil suit in 1987 after their daughter's death. Their complaint alleges "medical malpractice, wrongful death, and deprivation of human rights" (Sherman, 1989:22). Their recent settlement included a requirement that the George Washington Hospital establish a clear policy that unequivocally states that a pregnant woman is the primary patient to whom a physician (and hospital administration) is responsible ("Precedent setting agreement," 1991:7). This *disposition*, while arguably of significant interest to physicians, lawyers, women and the public at large, received virtually no mainstream press to my knowledge.

Forced cesarean cases, such as these examples illustrate, are violent matters which occur as a result of women's reproductive (i.e., pregnant) condition. I raise the concept of *reproductive violence* as a way to bring into focus the links between violence, reproduction and social control. But further analysis of the scope of reproductive violations and the theoretical and practical usefulness of the concept of reproductive violation is needed, projects clearly beyond the scope of this thesis.

What most cases such as Baby R have in common is a narrow focus on the fetus, in part as a result of the technological, biomedical model of birth and in part as a result of patriarchal ideology, which seems to all but make the pregnant woman herself disappear. The comment of feminist attorney Janet Gallagher perhaps captures this best:

> There is a well-established legal principle that concern for the individual's "bodily integrity" is basic to human dignity and self-determination...But the law's concern for human dignity and self-determination can all too readily yield to the recurrent temptation to view and treat pregnant women as vessels, the carriers of children. There seems to be an unspoken assumption that pregnancy renders a woman legally incompetent to make decisions. Society's tendency to treat pregnant women as lacking the capacity or right to make choices has made recent medical advances seem laced with threat as well as promise (1984:134).

When medicine, child protection agencies and the courts define and interpret women's refusal to follow physician's orders or consent to cesarean section operations as a problem of fetal "rights," citing medical/technological "evidence" of "fetal distress" or possible "fetal addiction" under the auspices of child protection principles and legislation, the problem is redefined from a patient's refusal of treatment to a

"fetal protection" matter. From this fetal-centered perspective, the rights and problems of the pregnant woman are virtually invisible; the serious harms done to them by such medical/legal interventions are invisible or seen as necessary "side effects" of treatment for the fetus. Strikingly, most women involved in cases of forced cesarean section are poor; a majority of these are non-white or socio-economically marginalized in some way (e.g., single, transient women whose lifestyles may not conform to a patriarchal, nuclear family form; see Dawson, 1990).

The Baby R lower court decision is but one illustration of how women's individual and collective assertion of self-determining reproductive needs and their struggles for reproductive rights are being thwarted. This type of unwanted obstetrical intervention, rationalized as medical necessity, and propped up by child welfare interventions and other legal interferences, not only intensifies the oppression of all women, it unquestionably exposes the socio-economic and racial biases structurally embedded in the use of obstetrical interventions and other forms of reproductive technologies

In addition, the Baby R case and others like it expose the hypocrisy of a state which claims to want to protect fetuses out of a concern for children's welfare yet prevents poor and underprivileged women from achieving expected community standards of care and personal responsibility by denying them access to adequate economic, educational and social resources. The true lack of concern for the welfare of children is evident in existing social policies which determine the social conditions under which the poor must live (see Eichler, 1988). Take, for example, the level of poverty under which most female sole-parent families must live, appropriately referred to by anti-poverty and women's groups as "legislated poverty." It legislates a sub-standard of living (Wharf, 1990:26-28) that is, in and of itself, at odds with the "minimal standards" expectations for "fit" parents. Canadian feminist social work educator, Joan Gilroy, describes this reality:

> Social assistance legislation and programs clearly illustrate conservative and stereotypical images of women and men...the state enters the lives of single mothers on welfare in very personal, controlling, and sexist ways. These women are expected to raise their children on amounts of money below the recognized minimum costs for food, clothing, and shelter, and this means that they live far below the poverty line. If these women are not able to feed, clothe, house, and care for their children to the satisfaction of child welfare agencies, they may become part of a protection caseload or their children may be taken from them. Women on welfare are afraid they will be found to be unfit mothers and feel threatened by contacts with child welfare workers or, indeed, with most officials from state agencies (Gilroy, 1990:60-61).

In B.C. the plight of sole-support mothers and their children has been particularly strained under the conservative, regressive and often punitive policies of the Social Credit provincial government (see Magnusson, 1984). Motherhood is rhetorically espoused as the most important occupation for women and for maintaining families, yet government policies have repeatedly undercut the value and labour of all but the most traditional approaches to mothering within a patriarchal family form.

Protectionist, "moral" motives for the apprehension of fetuses become thinly transparent, revealing ambiguous and contradictory fetal and child protection state measures, when illuminated by the stark social reality in which children live. R. Thompson summarizes it clearly:

> [It] should be remembered that our societal commitment to child welfare has not extended to guaranteeing all families adequate income to assure all children can receive basic nutritional and medical care, adequate housing or any of the other advantages we would like parents to provide. Nor have governmental bodies been willing to make day-care, homemakers, or other services available to all who would use them voluntarily (1986:78).

The critical examination of the problem of forced cesarean section in this chapter analyzes several problematic issues and raises many more. An analysis of the issues of informed consent and the role of child protection reveals the coercion practiced by medical, legal and social work experts in situations such as the Baby R case. The assumption of a maternal-fetal conflict and the notion of maternal culpability--that is, the notion that pregnant women are a suspicious group and pose a threat to the well-being of the fetus--informs the medical, social work and legal construction of the problem and solution. Moreover, the convergence of patriarchal medical and legal control over women's bodies so graphically illustrated by court-ordered cesarean sections signifies a further loss of control for women, already a socially disadvantaged group. Forced-cesarean sections are therefore inconsistent with society's commitment to end discrimination and promote social justice in general and with women's equality goals in particular.

The trend to seek legal sanctions to force medical treatment on a specific group of people has sounded the alarm to many human and civil rights advocates, particularly from the feminist community (CBA, 1990; NAWL, 1989; Johnsen, 1986, 1987; Gallagher, 1984; Rodgers, 1986, 1989). Social work has not, however, been part of the debate, let alone in opposition to these actions. Since child protection legislation is often being used to justify overriding pregnant women's rights to autonomy and to refuse

medical treatment, the implications for social work are vast. In the following chapter, some of the broad implications for social work will be explored, taking a feminist perspective which argues that social work, by its very mandate as a progressive force for social change and a "helping profession," has an obligation to understand systemic sex, race and class domination and to fight structural discrimination. This interpretation of its mandate draws from a long tradition within social work of being a progressive force for social change.

Within the limited context of this study I have made many suggestions for social work policy and practice which reflect a respect for the choices women make in our society and the constraints within which they are made. The development of feminist social work praxis, a topic to which I turn in the final chapter, is one way forward for progressive (feminist) social work.

CHAPTER 5

FEMINIST SOCIAL WORK: THE WAY FORWARD

> The profession of social work is a microcosm of the society that supports and legitimizes it. Thus, we should expect concerned women to reflect the conflicts and contradictions embedded in the larger society. These conflicts and contradictions may, in fact, be heightened by the fact that social work is commonly characterized as a woman's profession; a majority both of clients and workers are women. Ironically, the societal mandate to those who deliver social services is to control and monitor the prescribed behavior of women so that they will better fulfill their roles as wives, mothers, daughters, carers. The profession all too often accedes to such mandates, which violate its humanistic values (Hanmer & Statham, 1989:xi).

As I have argued throughout this thesis, forced cesarean section is a problem that perpetuates and sanctions coercive interventions on pregnant women, practically and legally subordinates the rights of pregnant women to that of fetuses and promotes reproductive violence against the most socio-economically and racially marginalized pregnant women. Such interferences by medicine, social welfare and legal institutions not only contradict their own objectives of fetal protection and the principle of minimal intervention, but they are discriminatory practices that violate the equality rights of women: hence they fly in the face of Canada's commitment to equality under the Canadian Charter of Rights and Freedoms (1982). Furthermore, forced cesarean section is inconsistent with patient rights, civil rights, human rights and concepts of self-determination, autonomy, dignity, humanitarianism and justice. In essence, it is a problem that is in contradiction with Western democratic society's broadest objectives of equality and social justice "for all."

For social work, forced cesarean section portends an oppressive role which is not only at odds with social work ethics and objectives to further the good of the individual and society (CASW, 1983), but also at odds with progressive social work values to promote social change and to challenge and change relations of domination and subordination for the larger social good (see Gilroy, 1991; Dominelli, 1991). By failing to address the ways in which the problem has been defined and constructed, social work has been complicit in perpetuating forced cesarean sections. I have argued that social work can and must play an active role in the debate about forced cesarean section and other medical and legal interferences with pregnant and birthing women, because silence from social work in the face of such injustices registers a strong social

comment--an endorsement of the status quo. More than by its silence, however, social work has been directly involved in measures which coerce birthing women to accept unwanted medical treatment by apprehending their fetuses. Furthermore, social work itself forms part of the material and ideological base of women's oppression (Dominelli, 1991), and without an assessment of problems and interventions, which self-consciously recognizes this fact, social work is unlikely to pursue its mandate to alleviate oppressive relations of domination and abuse (Wharf, 1990).

Continuing to be part of the problem and failing to analyze it from the standpoint of women or from a feminist (social justice) perspective will take social work in a direction which is at odds with its fundamental values and objectives as a helping profession. But within social work there exists conflict of mandate: the dual role--to "help" and to control (Poirier, 1986). In this final chapter I address this tension and argue that the way forward for progressive social work is to develop and incorporate feminism within social work education and practice.

The Contradictory Roles of the Social Worker as Agent of Change and of Social Control

Social workers have competing roles and responsibilities to the client, agency and society. The objectives of social workers depend upon such variables as our organizational location, personal and political values (formed by our location in society, life experiences and formal education), and our social work philosophy and perspective. Various social work factions/elements have been preoccupied with promoting progressive social change while other elements have been concerned with maintaining the existing social order (see Dale & Foster, 1986; Wetzel, 1976). This tension is both an historical and contemporary issue in the development and practice of social work. Throughout its history, however, the social change mandate in Canadian social work has received short shrift (Wharf, 1990).

Attempting to connect private troubles to public issues, early architects of the social work profession helped to define social work as a discipline with a unique perspective and practice which emphasized the importance of understanding and changing the social environment of clients (Wharf, 1990). But social work's preoccupation with social change came into conflict with its bid for legitimacy, as more than a "quasi" profession, in mainstream society. In addition, the historic influences of psychology and

sociology (i.e., psychoanalytical and functional approaches to human behavior, the family and society) led social work away from a strong social-based analysis of problems and social reform actions to favor, instead, a casework approach (Wetzel, 1976; Marchant & Wearing, 1986; Hudson, 1989). This view reinforced a "victim-blaming" stance and steered social work interventions toward a social adjustment model. For example, Freudian theories of biologically determined personality development had a significant impact on the newly developing field of social work, entrenching the view that the "proper" role of females is in the private sphere of the home as mothers, wives, and caretakers (Wetzel, 1976:233). Social workers "helped" women adjust to these roles. Primarily employed by the state, social workers became part of a group of welfare professionals in the business of social control and changing deviant individual behavior, especially concerning women (Dale & Foster, 1986; Hudson, 1985). As Ehrenreich & English (1978) put it, social workers were becoming "experts" in the social welfare field. Throughout social work history, this conflict between social work "help" versus social work "control" has had the greatest impact on marginalized groups such as Native peoples (Howse & Stalwick, 1990:103; Hudson, 1989; see Sinclair et al., 1991).

The influence and incorporation in social work of prevailing ideologies of control and domination particularly thwarted an analysis of power relations: two examples in social work are the acceptance of patriarchal arrangements (i.e., assumed superiority of males and androcentric bias) and the scientific approach (e.g., systems theory). As a way to enhance the "professional" status and respectability of social work in the 1940s, men were actively courted to join the ranks of the predominantly female profession of social work (see Wharf, 1990). Predictably in a patriarchal social context, men quickly "rose to the top" to control the profession and those organizations in which social work takes place (Dale & Foster, 1986:95-96). In the 1960s, social work educators and practitioners seemed to incorporate uncritically a systems theory approach into social work (Marchant, 1986), which brought with it male control of theory-building and the goal of filling a gap in a supposedly "theoretically bereft" discipline. Systems theory was claimed to be a "more scientific and objective," *competent* approach than the three traditional methods of case work, group work and community work. As a result of such promises of superiority, systems thinking had a strong "male-stream" appeal in the scientific community and was quickly adopted in social work education

(e.g., see Compton & Gallaway, 1984; Pincus & Minahan, 1973 cited in Marchant & Wearing, 1986). Feminist social work educator Helen Marchant (1986:24) suggests androcentric bias, the scientific jargon (e.g., equifinality, multifinality), and the promise of objectivity helped promote the acceptance of systems theory in the field. Furthermore, Marchant argues that an implicit assumption behind this line of argument is that the predominantly female profession of social work was "illogical" and "unconcerned" about theory. Feminist social work educator Kathryn McCannell (1986:65), examining family practice theory and family policy in social work, makes the related point that the female voice has been silent (and silenced) in social work theories. Systems theory does provide a useful conceptual tool for social work assessment and intervention; however, such an approach has serious limitations because it does not account for or analyze unequal power relations in client systems, for example, the patriarchal family system. Systems theory and its offshoot, ecological theory, are influential theoretical and practice approaches in social work today (Wharf, 1990). Because such androcentric perspectives and their largely hidden ideological assumptions have been adopted, the development of social work has been punctuated by the incremental acquisition of legitimacy and expertise within the existing "male-stream" social order.

Other streams in social work, however, have criticized the historic depoliticization (Marchant & Wearing, 1986) and deradicalization of social work (Wetzel, 1976). Hanmer and Statham (1989), for example, emphasize that social work needs to question and ultimately reject its "control and monitor" mandate. Such writers focus on the potential for social work to empower clients, (e.g., individuals, families, groups and communities) and to challenge and change social conditions of oppression which are the result of patriarchy, racism and capitalist relations (e.g., see Dominelli & McLeod, 1989; Carniol, 1990). The incisive critique of the ideology of patriarchy, developed by feminist social worker Helen Levine (1979), is one example of an empowerment approach. Feminist approaches to social work make the sexist assumptions of dominant ideologies visible (in theoretical, practical and social policy terms) and maintain that to support the status quo circumscribes women's lives and maintains their subordinate status (Wearing, 1986; McCannell, 1986). For example, Levine and Estable (1984) claim that the ideology of motherhood and the system of patriarchy "in which male power and domination over women in family, workplace and society is maintained within certain structures and institutions" relegates women (e.g., female clients and

social workers) to a status subordinate to that of their male counterparts. Dale & Foster (1986) make the important point that while social work professionals (especially statutory social workers) wield a good deal of power over clients, female social workers remain at the bottom of the hierarchy of "health and welfare experts." Other marginalized groups of social workers, such as non-whites (e.g., Native and women of colour) are further disempowered, as British feminist social workers Dominelli & McLeod (1989) discuss in their work. They call for social work to adopt an "anti-racist, feminist socialist" analysis of private troubles and public issues. Social work has, historically and structurally, embraced a conservative bias within social work theory and practice. Clearly the quest for "male-stream" professional legitimacy in social work has exacted too great a toll from social work's potential to be a radical force for progressive social change.

Implicit in the persistent debate in social work discourse about the role of social workers as agents of social control or agents of social change is whether social work, in its continual bid for recognition and legitimacy as a *bona fide* profession, can or should criticize the institutions upon which it depends for its legitimacy. While conflicting values and responsibilities affect all social workers on a daily basis (Rhodes, 1986), statutory social workers perhaps experience the most conflict in this regard, since they are by definition agents of the state whose mandate is social control.[105] Child protection social workers, for example, must consider several potentially conflicting obligations at once, including responsibilities to the client, the family unit, the agency, the law and society as a whole. On the one hand, social work has an allegiance to dominant powers and social institutions (who are our primary employers) while, on the other hand, social work allies itself with the oppressed in a bid to understand and promote social change from the perspective of racially and socio-economically marginalized peoples. Perhaps it is because dominant ideologies are largely invisible and unacknowledged within conventional social work, that our relationship

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[105] Statutory social work agencies and large bureaucracies may, by virtue of their philosophy and mandate, even encourage unethical (Rhodes, 1986) and oppressive (Howse & Stalwick, 1990; Wharf, 1990) social work practices. For example, bureaucratic agencies may, by virtue of their policies, promote unwarranted, punitive interventions into the lives of marginalized peoples (e.g., sole-parent, mother-led families in receipt of income assistance benefits have been subject to MSSH's sexist "man in the house" policies, enforced by social service agency staff (see McCannell, 1986). Such unnecessary and unjustifiable social work actions reveal a relationship to the state that is both too close and too uncritical.

to the state and our social control function is so enmeshed (see Dale & Foster, 1986). Furthermore, the ethical conflicts which arise from competing claims create significant, often unacknowledged, problems for the social work practitioner (Rhodes, 1986). Unfortunately, many of the staff of child protection agencies, called "social workers," lack professional training (Wharf, 1990:18) and are guided not by a consideration of, nor commitment to, a code of professional ethics and standards of practice (e.g., BCASW, 1989; CASW, 1983), but by the governing policies, procedures, and mandate of their state employer, the child protection agency.

Professional hierarchies, with medicine and law on top, relegate social work to a low power, low prestige position in the social order of the professions (Holosko, 1989). This subordinate position seriously circumscribes not only the ability of social work to criticize a medical/legal definition of the problem, but also the ability to support the female client's perspective of the problem and therefore to promote female well-being. Like pregnant women, social workers are structurally discouraged from disagreeing with physician's advice and the bio-medical model of pregnancy (Dale & Foster, 1986). Furthermore, social workers tend passively to *accept* medical (and legal) decisions and constructions of social problems. Rather than *lead* society's understanding of them, social workers tend to collude with actions we should oppose. Monique Bégin perhaps sums it up best:

> Medicine is practiced within an extremely authoritarian, hierarchical, impersonal and distant organization. In addition, modern medicine is over-specialized and hence very fragmented in its application and is most alienating for the patient. The structure of power is a vertical one with the (male) physician at the top, the (female) nurse as an obedient and respectful assistant, and the patient as a passive creature, an infant, at the bottom. We may assume that this mode of relationship is even more damaging for women than for men since our socialization and the prevalent ideologies and power structures favour the conventional hierarchy and reinforce the traditional model of medical care (1989:33-34).

In a situation such as occurred in the Baby R case, the child protection social worker was constrained not only by the mandate of the agency, but also by the power of the hospital and the courts (including scientific medical and legal "experts") to analyze and define the problem. For example, the physician's conceptualization and "name" for the problem as "child abuse" was accepted and adopted by the child protection agency (i.e., senior child welfare administrators). As a result of this interpretation, the child protection social worker was directed to apprehend the fetus Baby R under the interpretation of an

expanded statutory definition of "child abuse." Moreover, the door opened for other so-called "fetal protection" intervention when MSSH issued an *ad hoc* fetal protection policy (see Arnold, 1987). In relation to the dominance of law and medicine, such actions reflect and reinforce the conservative elements in social work as well as the political climate and right-wing philosophy of the state (i.e., the B. C. Social Credit government) at the time the fetal apprehension occurred.

While non-statutory social workers arguably have somewhat fewer role constraints,[106] many conflicting factors circumscribe a social worker's perceived or actual ability to act outside the mandate of social control agent.[107] But whatever the constraints, resistance to forced cesarean section, fetal apprehensions and all forms of oppression and violence against marginalized groups should be the cornerstone of ethical social work practice.[108]

The Baby R case was construed by medicine, child protection, the courts and the mainstream media as a case of child abuse due to "maternal incompetence," which diverted attention from an analysis of the social context of the circumstances. It was primarily feminist and human rights commentators, not social workers, who made visible the regressive link between private troubles and public issues in the Baby R matter: that is, that forced cesarean sections are a form of reproductive control over--and I argue violence against--pregnant women which effectively increase the oppression of all women.

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[106] For example, in such settings, fewer bureaucratic policies and the fact that government funding may be more arms-length makes social work autonomy and ethical practice more possible.

[107] Consider the hospital social work role in forced cesarean sections. For example, in theory, the hospital social work role includes acting as a patient and human rights advocate (Knee, 1987:243), but in practice the social worker may not have the control to effect change on behalf of a patient or may passively accept the medical interpretation of the problem without question and simply help the patient accept the medical perspective (e.g., "individual adjustment").

[108] Notwithstanding the conflicting ethical and political points of view within western society (which make the adoption of a unified set of social work values impractical and undesirable), social workers need to evaluate self-consciously our own ethical points of view and practices and be prepared to assert a "bottom line" with respect to our control function (see Rhodes, 1986).

Some recent social work commentators, attempting to answer the question of how social work can effect progressive and just social change, argue that social work should more explicitly align itself with its mandate to promote progressive social change. This should be done at all levels of social work, including social work education, research and social policy (action), as well as direct social work practice (casework, group work, community development), with a goal to eliminate all forms of discrimination. Social work has always attempted to link private and public issues, although as social work educator Brian Wharf points out, by and large the social work agenda for social change has never been as strong as it could be (1990:13). As a strategy to strengthen the social change mandate, Wharf (1990) argues that social work can and should learn lessons from the social movements of the time, that is, the First Nations Movement, the Women's Movement and the Labour Movement. This is also the contention of many feminist social workers and a central argument of this thesis. In order to challenge the structural barriers erected by privileged groups to maintain their control and advantage over the underprivileged, social workers must be able to identify the "cages of oppression" (to borrow Marilyn Frye's metaphor). In other words, social workers must self-consciously evaluate, in both micro and macro terms, relations of power in society. Only then can they develop what Ben Carniol (1990) calls "social empathy" for those who are disempowered by systemic oppression. If social workers are to acknowledge a greater duty to oppressed groups because of the ways in which dominant social forces silence and dismiss their history, perspectives and needs (e.g., Native child welfare, see Howse & Stalwick, 1991), social empathy and political action are crucial.

It is critical, as progressive social work commentators point out, for social work to endeavor to change oppressive conditions and thereby improve the daily realities of people's lives (Dominelli, 1991). In a society dominated by patriarchal, capitalist and racist institutions and ideologies, this is no small task. The first step for social workers, however, requires the development of a critical analysis of power relations. Feminist social work educators Jalna Hanmer & Daphne Statham (1989) state that this begins with self-awareness, self-evaluation, and a process of value clarification. Another step toward more progressive social work involves making and stating a clear commitment to social and political change (Howse & Stalwick, 1990) and developing multi-faceted strategies at all levels of social organization--personal, familial, community, professional and political. For example, reframing personal troubles into social

concerns and understanding the commonalities and differences of groups oppressed on the basis of sex, race, class, sexuality and disability should be an essential feature of clinical practice, social policy development, and social planning (action). If social work is to be seen as an ally of the oppressed, rather than an agent of oppression, it is essential that social work critique the social control function within our education, agencies and practices, and promote a progressive social change agenda within social work. Social work must face the question: who benefits and who suffers from our social control efforts?

Toward a Feminist Social Work

> Social work, except for some feminist social workers, has yet to play a significant part in the women's movement. While the profession embodies the contradictions and progressive themes in the larger society, on balance it reinforces rather than challenges dominant ideology. The profession has yet to confront an economic and political system that favours the interests of the powerful at the expense of those of the majority, particularly at the expense of the interests of oppressed groups, of which women are a large proportion. Social work is deeply enmeshed in the structures of inequality that exist in the wider world, including the inequality between women and men. The dominant models of theory and practice are inherently sexist and oppressive to women. In addition, social workers' location in government or government-funded agencies makes their participation in the struggle for women's equality very problematic (Gilroy, 1991).

As echoed by the above sentiments, social work and feminism need one another for at least two good reasons: both social workers and feminists are centrally concerned with families and with women's roles within them, and both social workers and feminists work predominantly with women (Dale and Foster (1986:95-96). Marchant & Wearing (1986) suggest feminist social work is only in *the process* of formation, while Dominelli & McLeod state, "feminist practice has already made a significant contribution to welfare in the sphere of social work. It has done so in respect of the four main activities that comprise social work: the definition of social problems for intervention, community work, counselling and statutory social work" (1989:10). A feminist social work perspective, Hanmer & Statham (1989) note, allows social workers to see

worker/client commonalities and differences in complex ways which can be empowering for both social workers and women clients (i.e., as both human service providers and users, see Levine, 1979).[109]

While the development of feminist social work literature and feminist social work practice have come some way, the literature is noticeably silent on women's reproductive self-determination and the pro-choice movement. Mainstream social work has kept well away from debates about women's reproductive rights and campaigns for choice on abortions.[110] Even feminist social work, with few notable exceptions (e.g., see McCarthy, 1989), has failed to address the significance of reproductive choice issues or to incorporate the contribution of feminists who have theorized and organized extensively on the issue of women's reproductive autonomy. Given the degree to which the realities of women's daily lives are affected and circumscribed by a lack of real reproductive choice on issues of abortion, pregnancy, motherhood and parenting, this is a serious omission within the developing feminist social work literature. In the context of the problem of forced cesarean section, social work has an important role to play. As generalists (see Collier, 1984), social workers claim to be able to see people's lives from a much more expansive view than either a medical or legal perspective permits. Social work education is interdisciplinary, (e.g., social work education draws from sociology, communications, psychology, economics, political science, women's studies) and recognizes that social workers are concerned with the total person within her/his social context (Erickson & Erickson, 1989). With the additional advantage of a

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[109] Feminist social work includes the conventional methods of social work practice, (that is, case work, group work and community work) infused with feminist theories and ways of working (feminist methods) in all social work settings. It seeks to work toward challenging and changing all existing social relations of domination and subordination. Feminist social work educators Dominelli and McLeod (1989) say a feminist practice in "the most recalcitrant of settings--that of statutory social work" is necessary, and that to be effective, the development of feminist social work requires a well-established presence of feminism in the broadest political context. But feminism and social work have distinct areas of incompatibility, see Hudson (1986) for a useful discussion of the problems of incorporating feminism and social work.

[110] Even though BCASW has a policy supporting a woman's right to decide on abortion, executive decisions have prevented women from taking the BCASW banner to pro-choice community rallies. Moreover, almost no commentary or analysis emerges from social work associations at the provincial or national levels on reproductive matters. This illustrates an all-too-common gap between policy and practice.

feminist perspective, social work can take a very broad view of problems that begins from the standpoint of the client in her/his social context. As feminist social worker Claire McCarthy puts it:

> Social workers have important roles as members of multidisciplinary health teams in advocacy for a woman's right to choose how she will handle her reproductive choices. While other health disciplines may consider the woman within a more narrow perspective of health care, social workers must consider her within her social context and support her decision-making rights through a process of empowerment (1989:9-10; see also Knee, 1987).

A feminist social work perspective redefines the problem and frames the debate about the Baby R matter and forced cesarean section in terms of the existing power relations (e.g., between men/women, physician/patient, middle-class/poor, white/coloured, able-bodied/disabled). Such an analysis enlarges an understanding of the problem and transforms one pregnant woman's private woes into social issues, politicizing the implications for both women's equality and social work. As Dominelli (1991:19) points out, redefining personal problems into political issues is one of the hallmarks of feminist action. The preceding critical analysis of the Baby R case illustrates that the integration of social work and feminist perspectives to the problem of forced cesarean sections suggests ways to effect progressive intervention strategies.

The social work community *as a whole* has failed to comment on the arguments being advanced within medical and legal discourses and by child welfare practices which promote forcing cesarean sections on pregnant women for the sake of the fetus. Social workers, and especially *feminist social workers*, should be among the most vocal critics of medical, social work and legal interventions such as fetal apprehensions and forced cesarean sections, which not only violate women's rights but condone a form of violence against women. Moreover, feminist social workers must actively oppose the development of social policies which are inconsistent with ethical social work practice (see BCASW, 1990).

Conclusion

A study of the Baby R case in B.C. is vital to feminist social work, since it poignantly illustrates the typical scenario of most forced cesarean interventions, that is, where, when, why and how such interventions occur. Actions to force cesarean sections on pregnant women occur in hospitals and are initiated by physicians and hospital administrators after pregnant women refuse to consent to cesarean surgery. Under

child protection legislation, a pregnant woman's refusal of medical treatment is interpreted by child protection social work administrators as "abuse" (which interprets "fetus" as "child" and therefore refusal as "child abuse"). Justification for forced cesarean sections is based on medical evidence alleging the existence of fetal risk and on patriarchal, middle-class ideologies of motherhood. Thus, a new form of "mother-blaming," opens the door to state interrogation of the mental and social "fitness" of pregnant women and even before they give birth, ushers in the full gamut of child welfare standards and measures (e.g., to determine what is "in the best interest of the child"). Feminist social worker Jalna Hanmer elaborates on this:

> Women are being policed by the shaping of the role 'fit mother'. Motherhood is being more tightly structured; to be a 'fit mother' is a more carefully defined concept. It is monitored from antenatal care onwards and involves medical personnel, health visitors, teachers, social workers, social security, housing and legal workers. The state directly shapes and supervises the 'fit mother' as concept and individual through the personal social services, social security, housing, the health services, education, law and the legal system. Reproductive technology offers the possibility to extend the shaping of the 'fit mother' to include the 'fit reproducer'. The state is directly involved through its support for, and control of, science and technology. There is no corresponding 'fit father' role (1985:103).

Refusal of a cesarean section is not, and ought not to be seen, as a child protection matter. It is a battle for control. And many feminist commentators note that the language and construction of "fetal rights" is a powerful tool in the battle. For example, legal feminist commentator, Dawn Johnsen (1987:37) remarks, "'fetal rights' language is dangerously misleading...the real issue is whether the physician or the pregnant woman will determine the course of the woman's medical treatment." Another commentator puts it more precisely: "The slogan of 'fetal rights' has become a replacement for 'Doctor knows best' in the battle for control over decision-making in the birthplace" (Johnsen, 1987:37 citing Gallagher).

While women's struggle for reproductive control has always been fought on contested social and political terrain (McLaren & McLaren, 1986) the increasing politicization of women's reproductive rights in the 1970s and 1980s has brought feminists from many different theoretical perspectives together in force (see Adamson, Briskin, & McPhail, 1989). As the occurrence of reproductive violations of pregnant women raises the stakes for women, the insistence that for women to achieve social equality they must have control over their bodies may continue to be the galvanizing cry of feminist organizing for change in the

1990s. I hope it will also be a cry heard by social work educators, policy makers and practitioners interested in organizing for progressive social change.[111] Debates about the general compatibility of social work and feminist objectives need to occur in a much more deliberate and self-conscious way, and be acknowledged within mainstream social work education and practice. Such debates are crucial to further development of feminist approaches to social work. Essential to this task is feminist social work research on the development and implications of new reproductive technologies,[112] because whether by virtue of the "institution" of motherhood or the medicalization of the birth process, the site of the potentially pregnant female body is the battleground upon which the struggle for women's equality has and continues to be fought.[113] This analysis of the critical incident of Baby R, from both a social work and feminist perspective, contributes to such a project by expanding an understanding of the implications of forced cesarean section for women and for social work. Therefore, an important area of future research and analysis for social workers and feminists is to explore the roles of social work in relation to (historical and contemporary) critical incidents of reproductive violations, which are forms of forms of social control, coercion and violence against women, and to develop multi-level strategies to resist such oppressive actions. The development of feminist social work networks (formal and informal) in which to discuss, debate and develop action strategies to resist reproductive violations would be one collective approach.

Baby R and other forced cesarean cases show how a collaboration of medical, legal and child protection "experts" works against social work responsibilities to be vocal and organize when decisions are

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111 For a good example of feminist social policy on reproductive choice see McCarthy (1989). Wharf's (1990) edited social work text, Social Work and Social Change in Canada, is particularly useful in its arguments for progressive social change.

112 See Jalna Hanmer, one of the few social workers writing about the issues of reproductive technology from a feminist perspective. Also see the BCASW Brief to the Royal Commission on Reproductive Technology, (1990) prepared by a feminist social work committee of which I was a part.

113 A proliferation of recent feminist literature focuses on the female struggle for the body; see, for example, Dawn Currie & Valerie Raoul's edited text, The Anatomy of Gender: Women's Struggle for the Body (1992); Zillah Eisenstein's The Female Body and the Law (1988); and Emily Martin's The Woman in the Body: A Cultural Analysis of Reproduction (1987).

made that will dramatically alter one group's access to full human rights. Social workers should join our voices to those of the many groups, led by feminists and civil rights activists, who have spoken in strenuous opposition to the misuse of child protection and welfare legislation, and the development of policy and legislation that could violate women's rights. As practitioners, social workers must also realize the potential of cases like that of Baby R to alter social policy and legislation, which could change the expectations of our roles and responsibilities vis-à-vis the rights of our clients. A coalition of feminist and social work forces is needed to oppose and end such practices.

APPENDIX I

FORCED CESAREAN SECTIONS AND FETAL APPREHENSIONS: SELECTED CASE HISTORIES

The following case histories have been excerpted (paraphrased or verbatim) from the literature on forced cesarean sections to detail some of the circumstances and common features of forced cesarean section scenarios.

Denver, Colorado (1979)[114]

> A 33-year-old woman, fearing surgery, refused doctors' recommendations for a Caesarean section based on the position of the fetus and "desultory" progress of labor. Lawyers for the University of Colorado Hospital asked a juvenile-court judge for an order allowing them to perform the surgery without the woman's consent. After appointing lawyers for the woman and the fetus and hearing testimony from three obstetricians and a psychiatrist, the judge issued the order--apparently the first in such a case (Jost, 1989:417).
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> [Details of case] A cesarean section was advised three and a half hours after the woman's membranes had ruptured, because of meconium-stained amniotic fluid, electronic fetal monitor data suggestive of fetal distress, high station (the baby has not properly descended in the birth canal), and failure to progress. The woman was described as angry, uncooperative, and obese. She refused to consent to a section, indicating fear of surgery (not an unreasonable fear given that she weighed over 300 pounds). Her family and a hospital lawyer could not persuade her to change her mind. After a psychiatrist judged her neither delusional nor mentally incompetent, the hospital sought a juvenile court order finding the fetus dependent and neglected and ordering a section. At the judge's request, a hearing was held in the woman's hospital room with court-appointed attorneys representing both the mother and the fetus. The court ruled in favor of the hospital, and surgery was performed eleven hours after admission.
>
> The baby was reported to be healthy; the initial Apgar score was 2 but the five-minute Apgar score was 8. (Named after pediatrician Virginia Apgar, this score is 10; anything below 7 is considered indicative of fetal distress.) Although the initial low Apgar score reflected some fetal distress, the second score was in the range of normal for a newborn. The woman, on the other hand, suffered from delayed healing of the incision wound (Jordan & Irwin, 1989:15).

Los Angeles, California (1981)

> In Los Angeles in 1981, the wishes of a pregnant woman were overridden. A pregnant woman with terminal cancer wanted her doctors to attempt to resuscitate her first if she went into cardiac arrest as a result of chemotherapy and if a choice had to be made

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[114] Case #79-JN83, Denver Juvenile Court (1979).

between saving her or the fetus. The ob/gyn staff urged that she be compelled to undergo a cesarean, a step that other doctors argued would result in her immediate death. The Department of Social Services filed a court petition charging the woman with neglect and being an unfit parent, asking that the fetus be named "a dependent child of the court" and that the woman's instructions be reversed. The court ultimately ruled in favor of the woman, but she died soon thereafter (Gallagher, 1984:134).

Atlanta, Georgia (1981)[115]

Jessie Mae Jefferson's doctors told a family-court judge in rural Butts County four days before her due date that because of a condition called "placenta previa"--the placenta's blocking the birth canal--there was "a 99 percent certainty" that the full-term fetus would not survive a natural birth. Jefferson and her husband, however, opposed the surgery, saying that "the Lord has healed her body" and "whatever happens to the child will be the Lord's will." Declaring the fetus to be "a deprived child without proper parental care," the judge authorized the surgery in an order upheld by the Georgia Supreme Court--the only final written appellate opinion on the issue so far. Jefferson didn't return to the hospital and later gave birth, by natural delivery, to a healthy baby. ("Georgia Supreme Court Orders Caesarean--Mother Nature Reverses on Appeal," read the headline in the state's medical journal.) (Jost, 1989:417; Gallagher, 1984:134).

Illinois (1982)

In this case a section was recommended because of three prior sections, maternal anemia, and cephalo-pelvic disproportion (in which the baby's head is too large to fit through the maternal pelvis). The woman refused a cesarean section for religious reasons, and her husband supported her decision. A juvenile court judge ruled that the fetus was suffering medical neglect and awarded temporary protective custody to a hospital lawyer along with the power to consent to a section and to other medical or surgical procedures. We do not know if a section was actually performed. After the birth of a six-pound baby, custody reverted to the parents (Jordan & Irwin, 1989:15).

Michigan (1982)

This woman had a diagnosis of placenta previa some weeks before the expected date of birth and, like the woman in Georgia, refused surgery on religious grounds. The hospital petitioned the county court, which, acting on the information that there was a 90 percent risk of fetal death, made the fetus a temporary ward of the court and ordered the woman to enter the hospital for necessary treatment. The woman went into hiding with her family and the police were unable to deliver the court order in spite of repeated attempts to locate her. She gave birth to a healthy baby vaginally three weeks later at another hospital (Jordan & Irwin, 1989:15).

Michigan (1983)

This case involved a West African woman whose first child was born vaginally after a section had been recommended and refused. In this particular labor, cesarean section was

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115 *Jefferson v. Griffin-Spalding Co. Hospital Authority* (1981).

advised four hours after admission because of secondary arrest [labor has stopped after it was well established] with failure to progress, based on a cervical dilation of 5 centimeters two and four hours after admission. Fetal heart tones were normal at the time, though earlier, late decelerations had been noted. The woman and her husband refused to consent to surgery. It appears that an administrator contacted a local circuit judge who expressed his willingness to order a section. During the legal process, the woman gave birth vaginally to a healthy child with Apgars of 8 and 9. The couple were unaware of the legal maneuvers at the time and, as far as we know, were never informed (Jordan & Irwin, 1989:15,16).

Chicago (1984)

When a Nigerian woman expecting triplets, along with her husband, rejected recommendations of doctors at a Chicago hospital for a Caesarean section, the hospital's attorneys obtained a court order granting the administrator temporary custody of the triplets and authorizing the surgery as soon as she went into labor. The woman resisted and had to be physically restrained with wrist and ankle cuffs before the anesthetic could be administered (Jost, 1989:417).

Michigan (1986)

A twenty-four-year-old, single, black woman, expecting her first baby, had had little prenatal care because she felt she was not getting proper attention at the prenatal clinic. She was admitted in early labor, but her contractions stopped and an induction was performed. After several hours, the woman was in great pain. Demerol was given, followed by an epidural (spinal anesthesia) several hours later, which apparently did not take. The patient was described as uncooperative and noncompliant, screaming with pain and thrashing about. A second epidural brought some relief, but "severe decelerations" in the fetal heart rate were noted in the chart. The woman was moved to the delivery room for a section, which she refused. At that time she was described as acting crazy, flailing her arms to keep the staff away. She was told that her baby could die or would have cerebral palsy, if it were born alive. The staff yelled at her and were ready to put her under when the hospital lawyers obtained a verbal okay from a local judge for the action. At that point, she was told that cerebral palsy meant mental retardation, and she is reported to have consented to the section with a whispered yes. Surgery resulted in the birth of a 7-pound, 15-ounce baby with Apgar scores of 8 and 9 (Jordan & Irwin, 1989:16, footnote omitted).

Washington, D.C. (1987)[116]

Angela Carder, terminally ill with cancer, was diagnosed by doctors as having only days to live; her 26 1/2-week-old fetus was deemed viable. To try to save the fetus, attorneys for George Washington University Hospital in Washington, D.C., obtained a court order authorizing a Caesarean section. The fetus died two hours after delivery; Carder died two days later. Although a panel of the District of Columbia Court of Appeals had upheld the

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116 *Re A.C.* (1990), 573 A. 2d 1235, 1237, 1253 (District of Columbia Court of Appeals, 1987).

order, the full court decided to review the case to try to settle the legal issue. The appeal was argued in September (Jost, 1989:417).

The case was decided in 1989 (reported in 1990)--the court overruled the decision (see Sherman, 1989).

Belleville, Ontario (1987)[117]

On April 3, 1987, an Ontario provincial court ruled a 38-week-old fetus (full term is approximately 40 weeks) to be a child in need of protection and made the fetus a ward of a Children's Aid Society. In this case the pregnant woman refused all appeals that she obtain medical treatment and planned to give birth in the underground parking garage she made her home.

The Children's Aid Society asked the court for a protection order under Ontario's Child and Family Services Act, on the concern that the fetus might be dead or at serious risk of infection and fatal pneumonia.

At the first of two hearings the judge said that he had the authority to find a fetus a child in need of protection, but refused to take further action based on what he called hearsay evidence. A week later Judge Kirkland made the fetus a ward of the CAS after hearing new medical evidence, and also ordered the mother to undergo psychiatric assessment in hospital (Eichler, 1987:375; Bala, et al., 1991:36-37).

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[117] *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249 (Ont. Prov. Ct. Fam. Div.)

APPENDIX II

LIST OF COURT CASES BY LEGAL CITATION

Re A.C. (1990), 573 A. 2d 1235, 1237, 1253 (District of Columbia Court of Appeals, 1987). [x-ref Rogers, 1990].

Re Baby R (1987), 9 R.F.L. (3d) 415 (B.C. Provincial Court, Family Division). [x-ref Davis, 1987].

Re Baby R (1988), 15 R.F.L. (3d) 225 (B.C.S.C.). [x-ref Macdonell, 1988].

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* Court decisions are listed by author, i.e., name of court judge, and also cross referenced by legal case citation, e.g., (Davis, 1987) [x-ref *Re Baby R*, 1987]; for a list of court cases by legal citation see Appendix 11.

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