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MEDICAL CHOICES DURING PREGNANCY: WHOSE DECISION IS IT ANYWAY?

Susan Goldberg*

I. INTRODUCTION

Within the last two decades, technological developments¹ have led physicians to view the pregnant woman and the fetus within her as two separate patients,² rather than as a single patient.³ A concurrent rise in the technology available for treatment of the fetus *in utero* has contributed to the view that the fetus is a separate patient.⁴ When medical problems arise, the physician must decide who the patient is, what treatment, if any, should be implemented, and what the ramifications of such treatment will be on the "other" patient.⁵ This dilemma is further complicated by

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1. Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 J. A.M.A. 1060 (1988). Ultrasound, amniocentesis, fetal heart monitoring and *in utero* treatment of fetal abnormalities have all contributed to the perception that the fetus is a separate entity. "[M]edicine's enhanced ability to treat the fetus directly has profoundly affected, perhaps even created, physicians' perception of the fetus as a separate patient." *Id.* at 1060.

2. See J. PRITCHARD, P. MACDONALD & N. GANT, *WILLIAMS OBSTETRICS* 139 (17th ed. 1985). For a discussion of whether there is a moral obligation to treat the fetus, see Murray, *Moral Obligations to the Not-Yet Born: The Fetus as Patient*, 14 *CLINICS PERINATOLOGY* 329 (1987).

3. A more traditional definition of obstetrics focused on "the care of women during pregnancy, labor and the puerperium." See Rothman, *When a Pregnant Woman Endangers Her Fetus*, *HASTINGS CENTER REP.*, Feb. 1986, at 25.

In the past, when the only way to treat the fetus was to treat the woman as the sole patient, the hope was that corollary benefits would accrue to the fetus. Nelson & Milliken, *supra* note 1.

4. See Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 *J. LEGAL MED.* 333 (1982) [hereinafter Robertson, *The Right to Procreate*]; Robertson, *Legal Issues in Fetal Therapy*, 9 *SEMINARS PERINATOLOGY* 136 (1985); Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 *VA. L. REV.* 405 (1983) [hereinafter Robertson, *Procreative Liberty*].

5. Early cesareans and difficult obstructed labors often posed "the spectre of tragic choices between mother and child." Rhoden, *The Judge in The Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 *CALIF. L. REV.* 1951, 1954 (1986).

the inherent difficulty of defining when the fetus becomes a separate patient—an issue on which theologians and physicians disagree, and as to which medical technology provides no definitive answers. These problems are compounded when the treatment the doctor believes to be in the best interest of the fetus is refused by the pregnant woman.⁶ Access to the fetus necessarily involves invasion of the woman's person. This "geography of pregnancy"⁷ has spawned a genuine controversy over whether a pregnant woman has the right to refuse treatment deemed beneficial to her fetus.⁸ Arenas of conflict which have come to the fore in the past few years include maternal lifestyle choices thought to endanger the fetus,⁹ failure to obtain prenatal screening,¹⁰ expo-

A recent New York Times article indicated that some researchers were discussing treating pregnant women infected with AIDS with the drug AZT in the hope of obtaining better outcomes for children born with AIDS. Problems may arise because not all adults can tolerate the drug, and only about 40% of infants born of AIDS infected mothers have been found to become infected. N.Y. Times, May 24, 1988, § C (Medical Science), at 3.

6. Refusal often stems from religious objection to treatment. See, e.g., *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981); *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983). Other motivations for refusal have included fear of effects of treatment, irrational beliefs and, on occasion, trivial objections.

7. See Gallagher, *Fetus as Patient*, in *REPRODUCTIVE LAWS FOR THE 1990s* 155 (N. Taub & S. Cohen 1988).

8. See generally Nelson & Milliken, *supra* note 1; Robertson, *supra* note 4. According to a national study conducted in 1986 and published in the *New England Journal of Medicine*, court orders have been obtained since 1981. The majority of court orders sought were for cesarean sections; three orders were sought for hospital detentions, and three orders were sought for intrauterine transfusions. Kolder, Gallagher, & Parsons, *Court-Ordered Obstetrical Interventions*, 316 *NEW ENG. J. MED.* 1192, 1192-93 (1987). For a discussion of these cases, see Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 *HARV. WOMEN'S L.J.* 9 (1987).

9. See *Reyes v. Superior Ct.*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977) (heroin user charged with endangering fetus during pregnancy, but court held statute applicable only to existing children); *In re Baby X*, 97 Mich. App. 111, 116, 293 N.W.2d 736, 739 (1980). For a discussion of the widely publicized case of charges brought against Pamela Rae Stewart for alleged prenatal injuries inflicted due to use of amphetamines and failure to follow physician's orders, see Note, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 *S. CAL. L. REV.* 1209 (1987).

For a discussion of possible "lifestyle" choices creating potential liability for prenatal harm, see Note, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 *YALE L.J.* 599, 606-07 and notes (1986). Among the suspect activities are poor prenatal nutrition, use of both prescription and non-prescription drugs, smoking, drinking alcohol, and engaging in immoderate exercise or sexual intercourse. *Id.*

10. The increasing prevalence, availability and affordability of prenatal screening devices such as ultrasound and amniocentesis conceivably may create liability hazards for a

sure to workplace hazards,¹¹ fetal treatment *in utero* via the mother,¹² fetal surgery¹³ and, most common, forced cesarean sections.¹⁴ In a number of court cases,¹⁵ doctors have sought to override the refusal of pregnant women to submit to treatment.

In arguing that the woman's refusal is not determinative, some physicians, commentators and courts have indicated the belief that the traditional notion of autonomous decision-making by competent adults¹⁶ must be balanced against "fetal rights."¹⁷ While at common law the fetus was not treated as an entity separate from the mother,¹⁸ recent trends in tort and criminal law in-

pregnant woman who fails to obtain such testing when it is suggested by her physician or generally recommended for women in her age or risk category, and complications ensue.

11. Exposure to chemicals in the workplace has, in some industries, led to the practice of excluding women of childbearing years from certain jobs. See Marshall, *An Excuse for Workplace Hazard*, 244 THE NATION 532 (1987). If a woman exposed herself to a hazardous substance in the course of her work, she might incur liability for any resulting harm to her fetus.

12. See S. ELIAS & G. ANNAS, *REPRODUCTIVE GENETICS AND THE LAW*, ch. 10 (1987) [hereinafter ELIAS & ANNAS]; L. ANDREWS, *MEDICAL GENETICS, A LEGAL FRONTIER*, ch. 9 (1987); Robertson, *supra* note 4; Note, *A Maternal Duty to Protect Fetal Health?* 58 IND. L.J. 531 (1983). Such treatments can include blood transfusions, vitamin and hormonal therapies and drug therapies. *Id.* at 531-34.

13. See Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 AM. J.L. & MED. 1 (1983). Current surgical techniques performed on the fetus include operations to remove obstructions to the ureter, and the placement of shunts to drain fluids accumulated on the brain (hydrocephalus). See generally ELIAS & ANNAS, *supra* note 12.

14. See § III 2. See Kolder, Gallagher & Parsons, *supra* note 8; Nelson & Milliken, *supra* note 1; Rhoden, *supra* note 5; Gallagher, *Fetus as Patient*, *supra* note 7; Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REP., June-July 1982, at 16; ELIAS & ANNAS, *supra* note 12.

15. See, e.g., *In re A.C.*, 533 A.2d 611 (D.C. 1987), *vacated and remanded for reh'g en banc*, 539 A.2d 203 (D.C. 1988); *Taft v. Taft*, 446 N.E.2d 395 (Mass. 1983); *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

16. One of the most vocal of the fetal rights advocates among legal commentators, John Robertson, would impose liability on women for any injuries negligently inflicted upon the fetus *in utero*. The proposed basis for these actions is "contingent legal personhood" status for the fetus. Robertson, *The Right to Procreate*, *supra* note 4, at 352; Robertson, *Procreative Liberty*, *supra* note 4.

17. I use the term "fetal rights" in quotes because nomenclature is often determinative in our society, and the term itself may result in according greater rights to the fetus than may be due. Conversation with Jonathan Krinick, Esq. (June 30, 1988) See discussion, § III B, on "State's Interests" and "Fetal Rights?"

18. See § III B 2. Under traditional property law rules, while a fetus could be named as a remainder or an heir, no rights vested until issue was born alive. See generally 1 W. BLACKSTONE, *COMMENTARIES* 130; Doudera, *Fetal Rights? It Depends.*, 18 TRIAL 38, 39 (1982).

Under tort law, no recovery was available for prenatal harms. See W. KEETON, D. DOBBS,

dicating an expansion of some of the rights granted to unborn beings.¹⁹

Decisions to override maternal refusal of treatment, or the imposition of liability for failure to conform to physician orders,²⁰ directly conflict with the competent woman's right to decide whether or not to receive treatment.²¹ While the state may have an interest in protecting and preserving the "potentiality of life,"²² even after the state's interests become compelling late in pregnancy, they must give way to the constitutional rights of the mother.²³ Any treatment of the fetus necessarily entails a physical invasion of the mother. Compelling such treatment would radically diminish a pregnant woman's rights since there is no parallel duty of physical subordination owed by a mother to her already

R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 55, at 367 (5th ed. 1984). Later, tort liability began to attach for prenatal injuries if the fetus was subsequently born alive. See *Bonbrest v. Kotz*, 65 F. Supp. 138 (D.D.C. 1946). In criminal law, unless a live birth occurred after prenatal injuries, and the infant later died, no charges would be filed. See W. LAFAVE & A. SCOTT, CRIMINAL LAW § 7.1, at 607 (2d ed. 1986).

19. Liability of third parties who inflict harm on the fetus has expanded to the point that some jurisdictions have dropped the requirement that a fetus be viable prior to recovering for prenatal harms. See Comment, *Maternal Liability: Courts Strive to Keep Doors Open to Fetal Protection—But Can They Succeed?*, 20 J. MARSHALL L. REV. 747, 751-52 n.40 (1987) (listing cases where jurisdictions have abrogated viability requirement). See also Note, *A Century of Change: Liability for Prenatal Injuries*, 22 WASHBURN L.J. 268, 270-78 (1983).

A court denied a mother's claim of immunity from suit by her child for prenatal injury in *Grodin v. Grodin*, 102 Mich. App. 396, 301 N.W.2d 869 (1981) (discolored teeth sustained due to mother's ingestion of tetracycline).

20. Robertson does not advocate compulsory commitment of women for treatment during the pregnancy. Rather, women might be subjected to criminal or civil liability *after* the pregnancy for acts or omissions that occurred during the pregnancy. Robertson, *supra* note 4.

21. The requirement of informed consent necessarily implies the right to refuse treatment. Both are derived from respect for the autonomy of the individual in decision-making, rights to bodily integrity and privacy. See Rhoden, *supra* note 5, at 1969-71. The competent adult's right to refuse treatment exists even if the refusal may result in her death. See *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986). For a discussion of *Roe v. Wade*, 410 U.S. 113 (1973), as a patient's rights case, see Gallagher, *Fetus as Patient*, *supra* note 7, at 170-72.

22. *Roe v. Wade*, 410 U.S. 113 (1973), discussed this state interest and found the state's interest became compelling at viability. *Id.* at 163-64.

23. Gallagher points out that this compelling state interest, according to the Court in *Roe*, does not supersede the life or health of the mother. Gallagher, *Fetus as Patient*, *supra* note 7, at 170-71. See also *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). In past cases, health has been broadly defined. *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

In addition, the right to privacy and autonomy in decision-making discussed in note 21, *supra*, must be respected.

born children.²⁴ Finally, the practical realities of the doctor-patient relationship advise against the imposition of unwanted treatment on the pregnant woman for the benefit of the fetus.²⁵

After outlining the current scope of the conflicts and existing case law, I plan to examine the District of Columbia Court of Appeals decision in *In re A.C.*²⁶ A competent woman, terminally ill with cancer, was forced by court order to undergo a cesarean section, in order to attempt to save her 26 week-old fetus. The woman, her husband and her parents had all objected to the surgery.²⁷ After receiving widespread publicity, and petitions for rehearing, the D.C. Court of Appeals vacated the judgment of the three judge panel that had approved the trial court's order, and remanded the case for rehearing en banc.²⁸ The *In re A.C.* decision is important because it illustrates the shortcomings of a balancing approach in resolving these conflicts. Any attempt at balancing impairs a competent individual's right to decline treatment and, in an effort to protect an unborn fetus, invades the autonomous decision-making of a living woman. While the consequences of respecting a woman's right to refuse treatment may sometimes yield tragic consequences for the fetus, the woman, or both, no alternative exists that does not diminish the autonomy of the woman and place pregnant women in a less protected status than other adults.

II. THE RIGHT TO REFUSE TREATMENT

The right to control one's destiny is a closely held fundamental

24. See Rhoden, *supra* note 5, at 1960-68, 1975-82. Our laws do not currently require parents to undergo surgical procedures to benefit their already born children. *Id.* Robertson, who advocates obligations to the fetus, would also require such actions for existing children. See Robertson, *Procreative Liberty*, *supra* note 4, at 456; Robertson, *The Right to Procreate*, *supra* note 4, at 351.

25. The vast majority of women will readily follow their physician's advice. The imposition of forced treatment and legal sanctions would radically alter the doctor-patient relationship in a counterproductive way. See Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 J. A.M.A. 1060, 1065 (1988). In addition, for some women who disregard doctors' orders, the threat of sanctions will be insufficient to alter their behavior (e.g., a heroin addict's need for a "fix" might override all other concerns at a given point in time). These considerations mandate that no penalties be imposed for failure to obtain recommended treatment or to refrain from certain activities.

26. 533 A.2d 611 (D.C. 1987).

27. *Id.* at 613.

28. *In re A.C.*, 539 A.2d 203 (D.C. 1988).

precept of American law.²⁹ "No right is held more sacred, [n]or is more carefully guarded . . . than the right of every individual to the possession and control of his own person, free from all restraint or interference of others"³⁰ This right to self-determination and bodily integrity includes decisions regarding medical treatment. A doctor must obtain consent before treating the patient or the unauthorized contact will be deemed a battery.³¹ "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"³² Recent cases have held that consent is not enough; decision-making must be informed in order for consent to be valid.³³ Information enables the patient to weigh the risks and benefits of the proposed treatment.³⁴

Informed consent, therefore, necessarily involves patient choice. Implicit in the concept of informed decision-making is the right to refuse treatment.³⁵ This right to refuse treatment extends even to decisions which will lead to a patient's death.³⁶ In *Bowvia v. Superior Court*, Elizabeth Bouvia sought to have removed a nasogastric tube used to forcibly feed her. The appellate court found that:

[T]he decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. . . . It is

29. *Union Pac. Ry. v. Botsford*, 141 U.S. 250 (1891). The right to refuse treatment based on autonomy and informed consent is conceptually distinct from constitutionally protected privacy rights. The doctrines have different analytical roots and have followed separate courses of development. However, the two theories have much in common, and both are sometimes classified under the right to privacy.

30. *Id.* at 251.

31. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

32. *Id.* at 129, 105 N.E. at 93. This right has been extended to incompetents via the substituted judgment standard. Under this standard, a guardian "substitutes" their judgment of what the incompetent would have decided. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). *But see In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981), where a best interests standard was used to determine whether treatment was deemed appropriate. It is important to note that the line between competence and incompetence is often indistinct and an individual can be deemed competent for one decision and incompetent for another.

33. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

34. *Id.*

35. See *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).

36. *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).

a moral and philosophical decision that, being a competent adult, is hers alone.³⁷

There are four countervailing state interests which must be considered when addressing the right to refuse medical treatment. The interests asserted by the state which have been recognized by the courts are: preserving life, preventing suicide, protecting innocent third parties and maintaining the integrity of the medical profession.³⁸ These interests usually will not override a competent adult's right to decline medical treatment.³⁹ However, in circumstances where the right to refuse treatment is asserted by a parent, for a living child, the state's interest in the protection of innocent third parties most often comes to the fore if the parental decision is deemed not to be in the best interests of the child.⁴⁰

III. CONSTITUTIONAL CLAIMS

A. *The Right of Privacy*

The right to autonomous decision-making is also grounded in the constitutional principle of privacy, as articulated in *Griswold v. Connecticut*.⁴¹ *Griswold* established the privacy right of a married couple to use contraception.⁴² The constitutional protection of autonomy in decision-making regarding intimate subjects has also included fundamental decisions regarding marriage,⁴³ procreation,⁴⁴ childrearing,⁴⁵ contraception⁴⁶ and abortion.⁴⁷ In all of

37. *Bowia*, 179 Cal. App. 3d at 1144, 225 Cal. Rptr. at 305.

38. See *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 431-33, 497 N.E.2d 626, 634 (1986); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).

39. See *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

40. The state interest, which in some cases has overridden the right to refuse medical treatment, is the protection of innocent third parties. In most cases, the third parties are children who would be the actual recipients of the treatment. See *Muhlenberg Hosp. v. Patterson*, 128 N.J. Super. 498 (Law Div.), 320 A.2d 518 (1974) (transfusion ordered for child despite parental refusal). But see *In re President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

41. 381 U.S. 479 (1965).

42. *Id.*

43. *Loving v. Virginia*, 388 U.S. 1 (1967).

44. *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

45. *Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

46. *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (extending *Griswold* right re contraception to the unmarried); *Carey v. Population Services Int'l*, 431 U.S. 678 (1977) (contraception for minors).

47. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983).

these decisions, the privacy right was derived from the penumbras emanating from the Bill of Rights.⁴⁸ The *Griswold* Court recognized that the marriage relationship was within a zone of privacy created and protected by several fundamental constitutional guarantees.⁴⁹ Interference with this right must only be to further a compelling state interest, and has to be narrowly tailored to avoid unnecessarily sweeping, overbroad intrusions.⁵⁰

In *Roe v. Wade*, the Supreme Court stated that the right of privacy protected a woman's right to decide whether or not to terminate a pregnancy.⁵¹ Despite continuous challenges, later cases have upheld this right. The right of privacy is a "central part" of liberty.⁵²

Our cases have long recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government. That promise extends to women as well as men. . . . Any other result, in our view, would protect inadequately a central part of the liberty that our law guarantees to all.⁵³

As the Court indicated in *Roe v. Wade*, the right to privacy is not absolute.⁵⁴ A compelling state interest is necessary to override the privacy right; any resulting limitations must be tailored to the least restrictive means necessary to achieve the state end.⁵⁵

B. *Countervailing Claims*

1. State's Interests

Under *Roe v. Wade*, the state's interest in preventing a woman from obtaining an abortion does not become compelling until the third trimester.⁵⁶ At viability, the state has a compelling interest

48. See *supra* notes 43-47. The amendments to the Constitution from which the penumbras emanate are the first, fourth, fifth, ninth and fourteenth. See *Roe*, 410 U.S. at 152-53.

49. *Griswold*, 381 U.S. 479, 484-86.

50. *Id.* at 485-86.

51. *Roe*, 410 U.S. at 153.

52. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 772 (1986).

53. *Id.*, quoted in Brief of Amici Curiae in Support of Appellant's Petition for Rehearing and Suggestion of Rehearing *En Banc*, *In re A.C.* (No. 87-609), at 4 (citations omitted).

54. *Roe*, 410 U.S. at 154.

55. See *Roe*, 410 U.S. at 155.

56. *Id.* at 163-64. During the second trimester the state does have an interest in regulating the abortion procedure to ensure the health of the woman, but because first trimester

in protecting potential life.⁵⁷ "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the womb."⁵⁸ Abortion can be proscribed during the third trimester (after viability) in furtherance of this state interest.⁵⁹ However, *Roe* clearly indicates that the state cannot prohibit third trimester abortions needed to protect the life or health of the woman.⁶⁰ Later cases have broadly defined health to include psychological, family and emotional factors.⁶¹ In addition, no trade-off between a woman's health and the state's interest in protecting potential life is permissible.⁶²

In the context of "maternal-fetal conflicts," the question arises as to whether the state's compelling interest in potential life during the third trimester gives the state the right to impose affirmative obligations on a woman who has not exercised her right to an abortion.⁶³ Can the state intervene in maternal conduct which may be detrimental to the fetus in the third trimester?⁶⁴ If so, does the state also have an interest in regulating a woman's con-

abortion is safer than pregnancy, the state's interest is not compelling during the first trimester. *Id.* at 149, 163-64.

57. *Id.* at 160-64. The Court said viability occurs somewhere about 28 weeks. *Id.* at 160.

58. *Id.* at 163. The Court noted that, in some cases, viability could occur as early as 24 weeks. *Id.* at 160 (citing L. HELLMAN AND J. PRITCHARD, *WILLIAMS OBSTETRICS* 493 (14th ed. 1971)); *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 1689 (24th ed. 1965). Despite technological advances since the *Roe* decision, viability has not been pushed back significantly beyond the 24 week time period.

59. *Id.* at 163-64. For general discussion of the state's interests see Rush, *Prenatal Care-taking: Limits of State Intervention With and Without Roe*, 39 U. FLA. L. REV. 55 (1987).

60. *Roe*, 410 U.S. at 164.

61. See *Doe v. Bolton*, 410 U.S. 179, 192; *Colautti v. Franklin*, 439 U.S. 379 (1979). See also Gallagher, *Fetus as Patient*, *supra* note 7, at 171, and accompanying notes.

62. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986). The *Thornburgh* Court upheld the Circuit Court's view that the statute was unconstitutional because it "failed to require that maternal health be the physician's paramount consideration." *Id.*, citing *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979).

63. See Robertson, *Procreative Liberty*, *supra* note 4, at 437, for the view that once a woman "waives" her right to an abortion, she bears an affirmative obligation to make sure she does no harm to the fetus. However, there is some question as to whether a woman ever waives her right to an abortion. For a waiver to be effective, it must be knowing, voluntary and specific to the situation. Merely failing to obtain an abortion does not amount to an affirmative decision to waive the right. Abortions are available during the first two trimesters, and, if maternal health is at stake, during the third trimester as well. See *Roe*, 410 U.S. at 164-65.

64. See Note, *Developing Maternal Liability Standards for Prenatal Injuries*, 61 ST. JOHN'S L. REV. 592, 610 (1987); Robertson, *Procreative Liberty*, *supra* note 4, at 437.

duct prior to the third trimester if the woman is not seeking an abortion?⁶⁵ These questions are posed, in part, because of asserted state interests in potential life and because, according to some, the fetus has independent rights.⁶⁶

2. Fetal Rights?

At common law, the fetus was accorded some interests, but it did not have the full legal rights of a person.⁶⁷ For some purposes, in property law, a fetus was deemed to be a "life in being" as of conception.⁶⁸ While a fetus could be named an heir,⁶⁹ and was a "life in being" for purposes of the Rule Against Perpetuities,⁷⁰ actual inheritance was contingent upon live birth.⁷¹ The purpose of these rules was to give effect to the testator's intent, rather than to create legal rights for the fetus.⁷²

For actions in tort, at common law, no recovery for *in utero* injuries was allowed.⁷³ Later, the rule was changed to allow recovery for prenatal injuries if the fetus was born alive.⁷⁴

In most jurisdictions today, prenatal injury does provide a cause of action if the fetus was viable at the time of injury.⁷⁵ In addition, in some jurisdictions, the common law requirement that a live birth occur has been eroded, and suit may be brought regardless of whether or not a child is born alive.⁷⁶ When live birth

65. See Comment, *Unborn Child: Can You Be Protected?*, 22 U. RICH. L. REV. 285, 288.

66. See, e.g., Robertson, *Procreative Liberty*, *supra* note 4; Comment, *Maternal Liability: Courts Strive to Keep Doors Open to Fetal Protection—But Can They Succeed?*, 20 J. MARSHALL L. REV. 747 (1987); Note, *Standards for Prenatal Injuries*, *supra* note 64.

67. See 1 W. BLACKSTONE COMMENTARIES 130.

68. *Id.*

69. See generally 1 W. BLACKSTONE COMMENTARIES 130.

70. Leach, *Perpetuities in a Nutshell*, 51 HARV. L. REV. 638, 640 (1938).

71. 1 W. BLACKSTONE COMMENTARIES 130.

72. Doudera, *Fetal Rights? It Depends*, 18 TRIAL 38, 39 (1982); *Unborn Child*, *supra* note 65, at 749.

73. *Dietrick v. City of Northampton*, 138 Mass. 14 (1884) (no recovery allowed for fetal death because fetus is not an entity separate from the mother). See PROSSER & KEETON ON THE LAW OF TORTS, *supra* note 18, § 55, at 367.

74. *Bonbrest v. Kotz*, 65 F. Supp. 138 (D.D.C. 1946). A live birth is also required in most jurisdictions in order to bring criminal charges. See W. LAFAVE & A. SCOTT, CRIMINAL LAW, *supra* note 18. In a few jurisdictions a fetus may be the victim of murder. See *People v. Apadoca*, 76 Cal. App. 3d 479, 142 Cal. Rptr. 830 (1978).

75. See Beal, "Can I Sue Mommy?" *An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive*, 21 SAN DIEGO L. REV. 325, 331-32 (1984); Note, *Standards for Prenatal Injuries*, *supra* note 64.

76. *Id.*

is required, a *person* is suing for earlier injuries. Allowing suits for prenatal injury to be brought regardless of whether or not a live birth occurs does not necessarily indicate that legal rights are bestowed upon the fetus. Many would argue that allowing the suit is a recognition of the loss the *parents* have suffered, regardless of the status of the fetus.⁷⁷

Under *Roe v. Wade*, the fetus is not a person as the term is used in the fourteenth amendment and, hence, does not have legally protectable interests under the amendment.⁷⁸ However, some commentators argue that *Roe* does not prevent legal rights from being accorded to the fetus.⁷⁹

While in most cases the legal status of the fetus involves complex issues and may vary according to the type of right (if any) to be conferred, some commentators believe that discussions of fetal status

distract attention from the central legal question posed by treatment refusals during pregnancy. The question is really whether doctors or the government may usurp patients' decision-making rights and appropriate or invade their bodies to advance what is perceived to be in the therapeutic interests of a second patient, the fetus.⁸⁰

IV. ARENAS OF CONFLICT

A. *Lifestyle Decisions*

As we learn more about substances and activities which are potentially harmful to a developing fetus, the problem of coping with non-compliant patients has taken on a new meaning. Scientific studies in the past decades have indicated that, in addition to obviously detrimental substances such as illicit drugs,⁸¹ alco-

77. *Id.* See also *Dunn v. Roseway*, 333 N.W.2d 830 (Iowa 1983); Gallagher, *Fetus as Patient*, *supra* note 7, at 41 n.162. *But see Grodin v. Grodin*, 102 Mich. App. 396, 301 N.W.2d 869 (1980); *Smith v. Brennan*, 31 N.J. 353, 157 A.2d 497 (1960).

78. *Roe v. Wade*, 410 U.S. 113, 157-58 (1973). The Court comes to this conclusion by analyzing the historical interpretation of the fourteenth amendment, abortion statutes which provided exceptions to abortion proscriptions, and abortion cases decided by lower courts.

79. See *supra* note 19. See generally Robertson, *Procreative Liberty*, *supra* note 4.

80. Kolder, Gallagher & Parsons, *supra* note 8, at 1194.

81. Heroin and cocaine use during pregnancy often result in the birth of addicted infants, who suffer from withdrawal symptoms as neonates. See Note, *Parental Liability for Prenatal Injury*, 14 COLUM. J.L. & SOC. PROBS. 47, 173-74 (1978).

hol⁸² and tobacco,⁸³ some over-the-counter and prescription drugs,⁸⁴ and certain food additives⁸⁵ also may be harmful to an embryo growing within the womb. In addition, certain maternal physical activities may adversely affect the fetus.⁸⁶

Of the few reported cases in this area, most involve pregnant women using illicit drugs. A few courts have held that heroin use during pregnancy involved prohibited conduct within the scope of the state's child neglect laws, and removed the newborn infants from their mothers.⁸⁷ While no effort was made to force behavior changes by the mothers, conduct during the pregnancy was sanctioned by removing the newborn because of the effect her conduct had on the fetus.⁸⁸

In a case which received nationwide publicity, a California wo-

82. Because alcohol crosses the placenta, consumption during pregnancy can affect the fetus. E. ABEL, *FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECTS* (1984). Infants born to heavy drinkers can suffer from fetal alcohol syndrome, which may cause growth retardation, depression of the central nervous system development and certain facial abnormalities. H. ROSETT & L. WEINER, *ALCOHOL AND THE FETUS* 6 (1984). For a discussion of the effects of fetal alcohol syndrome, see Note, *Maternal Substance Abuse*, *supra* note 9, at 1210-16. Current literature suggests that even low or moderate consumption of alcohol during pregnancy can affect fetal development. Little, *Moderate Alcohol Use During Pregnancy and Decreased Infant Birth Weight*, 67 AM. J. PUB. HEALTH 1154 (1977); Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. LEGAL MED. 63, 73 (1984).

83. Smoking has been associated with higher risk of premature delivery and low birth weights. Shino, Klebanoff and Rhoads, *Smoking and Drinking During Pregnancy: Their Effects on Preterm Birth*, 255 J. A.M.A. 82, 84 (1986).

84. The use of tetracycline during pregnancy can cause discoloration of tooth enamel. See *Grodin v. Grodin*, 102 Mich. App. 396, 301 N.W.2d 869 (1981). Studies indicate that aspirin may cause damage to the fetus or premature infant. A. GUTTMACHER, *PREGNANCY, BIRTH AND FAMILY PLANNING* 78 (1986).

85. Saccharines, nitrites and sulfites may fall into the category of additives which may have some effect on the fetus.

86. Sexual intercourse may be taboo for certain women at risk of miscarriage or hemorrhaging due to placenta previa.

87. See *In re Baby X*, 97 Mich. App. 111, 293 N.W.2d 736 (1980). It should be noted, however, that the Department of Social Services petitioned for custody only after the infant's birth, mooting the possible jurisdictional issue. See Note, *Maternal Substance Abuse*, *supra* note 9, at 1228. See also *In re Ruiz*, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (C.P. Wood County, Juv. Div. 1986). But see *Reyes v. Superior Ct.*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977) (appellate court reversed lower court conviction of neglect, finding that fetus was not a child under state's child abuse statute).

88. *Reyes v. Superior Ct.*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977). See also Note, *Standards for Prenatal Injury*, *supra* note 64, at 607-08.

In a recent decision by the District of Columbia Superior Court, a judge incarcerated a cocaine abusive pregnant woman convicted of theft. The court ordered that she not be released until the conclusion of her pregnancy because of concern for the defendant's inability to control her drug addiction. See *United States v. Vaughn*, Crim. No. F 2172-88 B (D.C. Super. Ct. 1988).

man was indicted for failing to follow her physician's orders which allegedly resulted in injury to the fetus.⁸⁹ Ms. Stewart was charged with a misdemeanor for willfully failing to provide prenatal care,⁹⁰ which allegedly resulted in birth of a brain-damaged infant.⁹¹ Ms. Stewart allegedly took amphetamines, failed to rest, and had sexual intercourse with her husband despite her doctor's advice to refrain from these activities.⁹²

In another case, alcohol abuse, the failure to undergo treatment for alcohol abuse and the failure to obtain prenatal care led a New York State court to find that the fetus was the equivalent of a child for purposes of child abuse laws.⁹³ The court found that the determination of child abuse could be based on the mother's conduct during her pregnancy.⁹⁴

In *Grodin v. Grodin*, the court allowed a child to bring a tort action for his mother's ingestion of tetracycline during her pregnancy, which led to discoloration of the child's teeth.⁹⁵ The Michigan court reasoned that the mother could be liable for tortious conduct in the same way a third person⁹⁶ would be for interfering with a child's "legal right to begin life with a sound mind and body."⁹⁷

These cases involving lifestyle choices only scratch the surface of a woman's potential liability for failure to conform her conduct to standards set by her physician. Increased knowledge about fetal development and environmental factors affecting development, could lead to restrictions on a woman's conduct during pregnancy in order to enhance chances of a healthy outcome for the fetus. Part of the danger with imposing liability in such cases

89. L.A. Times, Oct. 1, 1986, pt. II, at 1, col. 4. Charges were dismissed by the court on February 26, 1987. *Id.*, Feb. 27, 1987, pt. I, at 3, col. 3.

90. CAL. PENAL CODE § 270 (West 1988).

91. The infant died six weeks later. See ELIAS & ANNAS, *supra* note 12, at 261.

92. *Id.* See also Note, *Maternal Substance Abuse*, *supra* note 9.

93. *In re Smith*, 128 Misc. 2d 976, 492 N.Y.S.2d 331 (Fam. Ct. 1985).

94. *Id.* at 978, 492 N.Y.S.2d at 334. For a discussion of this issue, see Note, *Maternal Substance Abuse*, *supra* note 9, at 606-07.

95. 102 Mich. App. 396, 401, 301 N.W.2d 869, 871 (1980).

96. For an analysis of the propriety of equating maternal liability with third party liability, see Note, *Standards for Prenatal Injury*, *supra* note 64, 603-05.

97. 102 Mich. App. at 400, 301 N.W.2d 870, quoting *Smith v. Brennan*, 31 N.J. 353, 364-65, 157 A.2d 497, 503 (1960). While some commentators believe an infant has the "right" to begin life with a sound mind and body, others do not. Despite our technological advancements, perfect babies are not guaranteed; no infant has the right to demand what cannot be guaranteed.

is the insidious nature of the curtailment of the woman's autonomy. As Elias and Annas point out, the most "difficult questions are raised when the intervention poses no physical threat to the woman (such as taking a vitamin pill), but she still objects to it on religious or personal grounds."⁹⁸ While the invasion may be small, the ramification is of "great symbolic importance because it determines what value and how much respect we accord to the autonomy of a pregnant woman."⁹⁹

In addition, hindsight has shown that in certain instances failure to follow medical advice may have been the wisest course. The scenario described below took place in the 1960's, and illustrates how a woman's disregard of current medical wisdom might have been considered fetal abuse: "Janet M., a diabetic, refused her DES treatment, prescribed as especially important in the prevention of miscarriage among diabetics . . . she refused to limit her weight gain . . . to under thirteen pounds . . . and twice refused to show up for scheduled x-rays, citing a distrust of medications and radiation."¹⁰⁰ Given the changing nature of medical information, it seems that women should have the right to choose whether to accept a physician's recommendations. As such recommendations have sometimes proven to be faulty, women should not be subject to sanctions for refusing to follow their physicians' advice.¹⁰¹

B. *Fetal Therapies*

The second potential arena of conflict involves fetal therapies. Within this broad category three issues will be examined. First, as prenatal screening methods to uncover abnormalities in fetal de-

98. ELIAS & ANNAS, *supra* note 12, at 254. The authors also point out that, in most cases, women will do *whatever* their doctors recommend to ensure the health of their babies. *Id.*

99. *Id.* Of course, even a small invasion is a restriction on individual autonomy, decision-making and privacy, and therefore the importance is not merely symbolic.

100. Rothman, *When a Pregnant Woman Endangers her Fetus*, HASTINGS CENTER REP., Feb. 1986, at 25, *quoted in* Gallagher, *Prenatal Invasions*, *supra* note 9, at 55 n.238.

101. Elias and Annas believe that advice must remain exactly that: *advice* rather than a mandated course of action. "[P]hysicians are neither policemen nor seers." ELIAS & ANNAS, *supra* note 12 at 261. In *Roe v. Wade*, Justice Blackmun based his opinion on the state of medical technology, but since technology has its limitations, Blackmun's reasons for deference to the woman and her physician may be unhelpful in situations where predictions of fetal complications are involved. Because of the uncertainty of such prognostications, an intrusion on the woman's privacy on that basis is especially difficult to justify. *See* Implications, § V.

velopment become more common, may a woman be held liable for failure to utilize available screening mechanisms? Second, must the woman accept therapies deemed useful for the fetus such as transfusions and injections which can be accomplished with only "minor" invasions of the mother's body? The final issue within this arena of potential conflict involves fetal surgery to correct defects while the fetus is *in utero*, involving major invasions of the woman's body.

1. Prenatal Screening and Diagnosis

John Robertson has aptly characterized one approach in analyzing the category of prenatal screenings and diagnosis as "whether the mother's failure to seek a test was negligent in light of the risks that the test posed to her and the fetus and the probability that the test would uncover a correctable defect."¹⁰²

Prenatal diagnosis and screening is becoming more prevalent as our technology improves.¹⁰³ Current diagnostic tools include amniocentesis,¹⁰⁴ useful for the diagnosis of chromosomal abnormalities,¹⁰⁵ and ultrasound,¹⁰⁶ useful in visualizing the fetus and diagnosing some skeletal abnormalities.¹⁰⁷ Additional diagnostic methods which show great promise for use in determining hereditary disorders¹⁰⁸ and neural tube defects¹⁰⁹ are growing in use as testing methods become more refined. A new testing method, chorionic villi biopsy, holds great promise because it provides much of the information currently obtained via amniocentesis, but during the first trimester.¹¹⁰

102. Robertson, *Procreative Liberty*, *supra* note 4, at 437, 448.

103. Blank, *Emerging Notions of Women's Rights and Responsibilities During Gestation*, 7 J. LEGAL MED. 441, 452 (1986).

104. *Id.* at 452-53 and accompanying notes. Amniocentesis is now believed to be accurate and reliable, with little risk to mother or fetus. Golbus, Loughman, Epstein, Halbasch, Stephens & Hall, *Prenatal Genetic Diagnosis in 3000 Amniocentesis*, 300 NEW ENG. J. MED. 157 (1979).

105. As more women over 35 are having children, the use of amniocentesis is increasing. Women over 35 have an increased risk of carrying children with chromosomal abnormalities. Blank, *supra* note 103, at 454.

106. See *Id.* at 455. While ultrasound has been in use for only about 15 years, most studies have shown no harmful effects to the fetus.

107. *Id.*

108. Fetoscopy permits the viewing of the fetus *in utero*. *Id.* at 456.

109. *Id.* at 457.

110. *Id.* at 458 (citing Elias, Simpson, Martin, Sabbagha & Gerbie, *Chronic Villus Sampling for First-Trimester Prenatal Diagnosis: Northwestern University Program*, 152 AM. J. OBSTETRICS & GYNECOLOGY 204 (1985)). The importance of providing diagnostic testing

As diagnostic testing becomes more routine, the question of whether failure to obtain testing is actionable will arise with increasing frequency.

2. Fetal Therapy Given Via the Mother

In the past, treatments given to the mother were intended to improve maternal health, and were hoped to have the corollary benefit of improving fetal health. Today, some therapies have been developed which, although given via the woman, are primarily intended to benefit the fetus.¹¹¹ Therapy is given during the pregnancy under the theory that treatment after delivery will be less effective or totally ineffective.¹¹² However, a problem arises when a treatment deemed beneficial to the fetus is refused by the mother.

In one of the earliest of the forced treatment cases, *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,¹¹³ the New Jersey Supreme Court granted a hospital's request to force blood transfusions on a pregnant woman who refused the treatment for religious reasons.¹¹⁴ The transfusions were deemed necessary because there was a probability that the woman would hemorrhage at some point and both she and the viable fetus would be at risk without the transfusions.¹¹⁵

Treatment for certain metabolic diseases¹¹⁶ can be provided by

in the first trimester is that early screening allows for treatment at the earliest possible time and preserves the option of abortion if treatment is unavailable and the parents decide to terminate the pregnancy.

111. For a general description of medical therapies, see ELIAS & ANNAS, *supra* note 12, at 262-74.

112. *Id.* at 263.

113. 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

114. *Id.* at 423, 201 A.2d at 538.

115. *Id.* The court reasoned that it had a duty to protect the unborn child. *Id.* Many commentators have criticized later courts' reliance on *Raleigh Fitkin*. See, e.g., ELIAS & ANNAS, *supra* note 12, at 256. *Raleigh Fitkin* was decided prior to the Supreme Court's decision in *Roe v. Wade* which established privacy rights and the right to refuse treatment. In addition, since the woman had already left the hospital, the issue was moot. Little time was spent on policy considerations.

116. Elias and Annas describe these metabolic diseases: methylmalonic acidemia: "a rare disorder characterized clinically by recurrent vomiting, failure to thrive, developmental retardation, hepatomegaly (enlarged liver), intermittent neutropenia (abnormal decrease in number of neutrophil cells in the blood) and thrombocytopenia (abnormal decrease in the number of platelets);" multiple carboxylase deficiency: "a rare autosomal recessively inherited inborn error of metabolism;" congenital adrenal hyperplasia: "a deficiency of the enzyme 21-hydroxylase." ELIAS & ANNAS, *supra* note 12, at 263-65.

giving large doses of specific vitamins to the mother.¹¹⁷ Drugs to halt premature labor may also be administered to benefit the fetus.¹¹⁸ Alternatively, when a premature delivery is likely, doctors may give the mother glucocorticoids, drugs designed to assist in the maturation of the fetus's lungs, in the hope that chances of fetal survival will be enhanced.¹¹⁹

While many of these therapies are not in wide use today, given the pace of technological development, the possibility of expanded use of such medical treatments exists, and leads to increasing possibilities of conflict.

3. Fetal Surgery

While diagnostic tools have for some time existed to identify fetal disorders, few treatments were available until recently to correct any discovered abnormalities.¹²⁰ As medical technology advances, the option of fetal surgery to correct certain defects *in utero* may become far more prevalent. While in most cases the "interests of the mother and the fetus are likely to be congruent, in some cases their interests will be in conflict."¹²¹

Surgical developments since the early 1980's include the placement of a shunt to allow for drainage in cases of fetal hydrocephalus.¹²² Ultrasound is used to guide the placement of the shunt.¹²³ While this procedure was viewed as a useful development, results of clinical trials were less successful than had been hoped for, and many hospitals have abandoned testing of the procedure.¹²⁴

Catheters have been inserted to alleviate urinary tract obstructions by allowing drainage of urine into the amniotic fluid.¹²⁵ In

117. For example, methylmalonic acidemia is treated by giving massive doses of vitamin B12 to the mother. Multiple carboxylase deficiency is treated with biotin and congenital adrenal hyperplasia is treated with dexamethasone. *Id.*

118. ELIAS & ANNAS, *supra* note 12, at 262.

119. *Id.*

120. Blank, *supra* note 103, at 461. The author notes that formerly the choice was exclusively between abortion and carrying the impaired fetus to term.

121. *Id.*

122. ELIAS & ANNAS, *supra* note 12, at 245-46. See also Depp, Sabbagha, Brown, Tamura & Reedy, *Fetal Surgery for Hydrocephalus: Successful In Utero Ventriculoamniotic Shunt for Dandy-Walker Syndrome*, 61 *OBSTETRICS & GYNECOLOGY* 710 (1983).

123. ELIAS & ANNAS, *supra* note 12, at 245-46.

124. *Id.*

125. *Id.* at 246-48. Without adequate drainage of urine, damage to the kidneys, facial deformities, hydroureter, and abdominal wall problems are likely to develop.

one case, the lower portion of the fetus was removed from the uterus while the surgery was performed. After the surgery was completed, the fetus was returned to the womb, the amniotic fluid replaced and the incision closed.¹²⁶ Apparently, in selected cases, surgery for fetal urinary tract obstructions has been successful in correcting or alleviating abnormalities.¹²⁷

Elias and Annas believe *in utero* surgery may ultimately prove useful in treating a number of other fetal abnormalities, including diaphragmatic hernias, spina bifida, gastroschisis and allogenic bone transplants.¹²⁸ While the possibilities for improving fetal survival rates may be enhanced as fetal surgical techniques are refined, the problems of potential conflict may escalate. As surgery on the fetus can only be conducted by surgery on the mother, difficulties may arise if the woman refuses to consent to the intervention.

C. *Surgical Interventions*

Judicial intervention has been sought most often in cases where physicians viewed surgery as being in the best interests of the fetus but the mother opposed the operation. In some cases, the surgery has also been viewed as necessary for maternal health.

1. Cerclage¹²⁹

In *Taft v. Taft*,¹³⁰ a court order was sought to force a pregnant woman to undergo a surgical procedure to sew closed her cervix to prevent a probable miscarriage.¹³¹ While the woman wanted the pregnancy to continue, she objected to the cerclage operation on religious grounds.¹³² The Supreme Court of Massachusetts vacated a lower court ruling ordering the surgery.¹³³ The high court

126. *Id.* at 246. See also Blank, *supra* note 103, at 463. The surgery was deemed a success, but the infant died a few months after birth from complications arising from underdeveloped lungs. Blank, *supra* note 103, at 463.

127. For a description of results, see ELIAS & ANNAS, *supra* note 12, at 247-48. The authors point out that conclusions about the efficacy of the surgery will depend on prognosis survival rates. *Id.*

128. See ELIAS & ANNAS, *supra* note 12, at 248-50.

129. Cerclage, also known as a "purse string operation," involves suturings to the cervix to hold a pregnancy that might otherwise be lost due to an incompetent cervix. *Id.*

130. 388 Mass. 331, 446 N.E.2d 395 (1983).

131. *Id.* at 332, 446 N.E.2d at 396.

132. *Id.* at 333, 446 N.E.2d at 396.

133. *Id.* at 331, 446 N.E.2d at 395.

stated that no state interest had been presented which justified curtailing the wife's constitutional right of privacy.¹³⁴

2. Forced Cesareans

a. Procedural Problems

According to one commentator, there have been at least eleven instances where cesareans were ordered by a court after the woman refused to consent to the operation.¹³⁵ Unfortunately, most of these decisions are unpublished.¹³⁶ The cases usually arise and

134. *Id.* at 334, 446 N.E.2d at 397. The court first commented on the paucity of the record. No transcript of proceedings below existed and no testimony was introduced before the lower court judge. In recognizing the woman's constitutional right of privacy, the court relied on *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). The court distinguished *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964) and *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981) (*per curiam*), as cases dealing with a viable fetus; while a fetus in the fourth month, as in this case, would not be viable. 338 Mass. at 334, 446 N.E.2d at 397 n.4. For a discussion of the *Jefferson* case, see Section IV C and accompanying notes.

135. Gallagher, *Prenatal Invasions*, *supra* note 8, at 11 & n.16. According to Gallagher, the cases are: *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981); *In re Madyun Fetus*, Daily Wash. Law Rep., Oct. 29, 1986, at 2233, col. 3 (D.C. July 26, 1986); a Colorado case described in Bowes & Selgestad, 58 OBSTETRICS & GYNECOLOGY 209 (1981); a New York City case described to me by New York City Judge Margaret Taylor and subsequently cited in Gallagher, *The Fetus and the Law: Whose Life Is It Anyway?*, 13 Ms., Sept. 1984, at 62, 134-35; *In re Ann Miller*, Supreme Ct. Special Term (Onondaga County, July 3, 1982) (on file at HARV. WOMEN'S L.J.); a 1982 Chicago case described in *Custodian Appointed to Protest Viable Unborn Child's Life*, National Right to Life News, March 11, 1982; a 1984 Washington State case related by attorney Daniel M. Arnold, letter from Daniel Arnold to Janet Gallagher (May 26, 1984) (discussing Case No. 84-7-50006-0, Sup. Ct. of Wash., Juv. Div.) (on file at HARV. WOMEN'S L.J.); a case involving an African woman in the United States, *Medical Ethics Case Conference: Ethical and Legal Issues in a Court Ordered Caesarean Section*, MEDICAL HUMANITIES REPORT issued by the Medical Humanities Program, Michigan State University (Winter 1984); a case in which doctors proceeded to operate on a nonconsenting woman *without* judicial authority, reported in Jurov & Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 OBSTETRICS & GYNECOLOGY 596 (1984); a 1984 Chicago case described in Kolder, *Women's Health Law, A Feminist Perspective* 1-2 (Aug. 1985) (unpublished manuscript on file at the HARV. WOMEN'S L.J.); a 1982 Michigan case outlined in correspondence with Ellen M. Tickner, Clinical Assistant Professor of Law University of Michigan Law School (May 31, 1983) (on file at the HARV. WOMEN'S L.J.). In addition, since the Gallagher article was published, at least one other court has upheld the order of a forced cesarean on a competent, unconsenting woman dying of cancer. *In re A.C.*, 533 A.2d 611 (D.C. 1987), *vacated and remanded for reh' en banc*, 539 A.2d 203 (D.C. 1988). See Section IV C for a discussion of *In re A.C.*

136. See Gallagher, *Prenatal Invasions*, *supra* note 8, at 11-12 n.16; Rhoden, *supra* note 5, at 1951 & n.4.

are resolved in phenomenally short periods of time.¹³⁷ Court orders are sought by telephone,¹³⁸ counsel is appointed but given little or no opportunity to prepare,¹³⁹ and hearings are often held in patients' rooms.¹⁴⁰ Janet Gallagher argues that these cases are "of highly dubious authority" as precedent¹⁴¹ since they are insulated from appellate review due to the time constraints and resultant shortcuts, the fact that losing parties are "seldom motivated or situated to fully brief or argue the complicated women's rights or fetal status issues, mootness, or the losing party's disinterest in (and practical inability to pursue) full scale litigation"¹⁴² Gallagher states, "the procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves"¹⁴³ Without adequate procedural due process, it is difficult to conceive of the resulting decisions as thoughtful, principled, reasoned responses to fully aired and adequately researched legal disputes.¹⁴⁴

b. The Cases

(1) *Jefferson v. Griffin Spalding County Hospital Authority*

The only reported appellate court decision prior to *In re A.C.* in which a cesarean section was ordered is *Jefferson v. Griffin*

137. In a Colorado case described in the medical literature, the time between admission of the patient in labor and the birth of the baby (including the request for hearing, the hearing itself, the decision and the delivery) was 11 hours. Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 *OBSTETRICS & GYNECOLOGY* 209, 209-10 (1981). One commentary indicated that reports of court-ordered cesareans involved timespans of 12-24 hours, which the authors considered to be "sufficient time to solicit legal intervention." Jurow and Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 *OBSTETRICS & GYNECOLOGY* 596 (1984). While it may be sufficient time to seek legal assistance, it seems that adequate procedural safeguards would entail longer periods of time. See Gallagher, *Prenatal Invasions*, *supra* note 8, at 48-54. Time limitations in one California case were allegedly far more severe. When the mother refused to consent to the surgery, the physicians, *without* court intervention, performed a cesarean less than two hours after she was admitted. Jurow and Paul, *supra*, at 597.

138. See Kolder, Gallagher & Parsons, *supra* note 8, at 1195.

139. *Id.* As Gallagher points out, counsel is usually a court appointee selected at the last minute, if there is counsel at all. Gallagher, *Prenatal Invasions*, *supra* note 8, at 48-49. See also Rhoden, *supra* note 137, at 2025 n.374.

140. Bowes & Selgestad, *supra* note 137.

141. Gallagher, *Prenatal Invasions*, *supra* note 8, at 48-49.

142. *Id.* at 49.

143. *Id.*

144. *Id.*

Spalding County Hospital Authority.¹⁴⁵ Jefferson, a woman in her thirty-ninth week of pregnancy, was diagnosed as having complete placenta previa, a condition in which the placenta blocks the birth canal.¹⁴⁶ Doctors estimated survival chances for the fetus at 1% and at 50% for the mother if the cesarean was not performed.¹⁴⁷ Because Jefferson refused the cesarean section on religious grounds,¹⁴⁸ the hospital sought a court order to perform the surgery. The court granted the hospital's request, holding that if Jefferson returned to the hospital, the surgery could be performed, even against her wishes.¹⁴⁹ Without elaborating on the basis for its decision, the court held that the state's interest in the potential life of the "unborn, living human being" overrides the mother's religious beliefs.¹⁵⁰

Medical technology, while advanced, is still not perfect. Jefferson had a healthy child after a normal labor and delivery away from the hospital.¹⁵¹

Numerous commentators have criticized the *Jefferson* decision.¹⁵² First, the court limited its holding by only making its order effective if the woman voluntarily presented herself at the hospital. Second, the court did not adequately explain its rationale. Third, the court misinterpreted *Roe v. Wade*.¹⁵³ While *Roe* indicates that the state has an interest in potential life, the life and health of the mother are not to be superseded by the state's interests.¹⁵⁴ Perhaps even more importantly, *Roe* does not speak

145. 247 Ga. 86, 274 S.E.2d 457 (1981).

146. *Id.* at 86, 274 S.E.2d at 458.

147. *Id.*

148. Jefferson and her husband believed that the Lord had healed her body and that whatever happened to the child would be the Lord's will. *Id.* at 88, 274 S.E.2d at 459.

149. *Id.* at 87, 274 S.E.2d at 460. While an order to permit the cesarean prior to the time natural childbirth began was requested, the court refused to grant the request. *Id.* at 87, 274 S.E.2d at 459.

150. *Id.* The court stressed the fact that the fetus was viable: "a human being fully capable of sustaining life independent of the mother." *Id.* at 88, 274 S.E.2d at 459. Given the facts of this case, the state may also have had an interest in protecting maternal health.

151. Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REP., June-July 1982, at 16. Commentators have reported that in six recent cases in which court ordered cesareans were sought, the doctor's predictions of harm to the fetus were inaccurate. Kolder, Gallagher & Parsons, *supra* note 8, at 1195.

152. See, e.g., Annas, *supra* note 151; ELIAS & ANNAS, *supra* note 12, at 254-55; Gallagher, *Fetus as Patient*, *supra* note 7, at 46-54; Nelson & Milliken, *supra* note 1, at 1061-63; Rhoden, *supra* note 5, at 1965-68.

153. 410 U.S. 113 (1973). See Nelson & Milliken, *supra* note 1, at 1062.

154. *Roe*, 410 U.S. at 164; Thornburgh v. American College of Obstetricians and Gynecologists, 458 U.S. 422 (1982).

of affirmative obligations of a woman to her fetus. *Roe* discusses the ability of the state to limit a woman's right to end a pregnancy. It goes no further.

A cesarean section is an extremely intrusive procedure, it is *surgery*, with all the attendant risks. When a competent adult refuses surgery, that decision must be respected.¹⁵⁵ The *Jefferson* decision to force a woman to undergo surgery was untenable because such "balancing" was proscribed by *Roe*, and as Rhoden points out, no comparable physical intrusion can be required of parents to benefit living children.¹⁵⁶

(2) Lower Court Decisions

In a lower court case decided in Colorado, a cesarean section was ordered on a non-consenting, competent, obese woman who had refused to consent because she was afraid of surgery.¹⁵⁷ Doctors were concerned about the results of fetal monitoring and sought judicial intervention. After an emergency hearing held in the patient's room, the fetus was found to be a dependent and neglected child and the cesarean section was ordered.¹⁵⁸ After the surgery, doctors were surprised that the child was healthy. The monitoring done eleven hours earlier had indicated fetal distress and doctors had expected a poor outcome.¹⁵⁹

In reaching its decision, the court incorrectly interpreted existing law. While the fetus has traditionally been granted some rights, it has never been afforded the full legal status of an already born human being.¹⁶⁰ *Roe* limits the state's compelling in-

cologists, 476 U.S. 747, 768-69 (1986). The health of the woman is to be broadly defined, including psychological and emotional attendant circumstances. *Colautti v. Franklin*, 439 U.S. 379, 394 (1979). See also *United States v. Voitch*, 402 U.S. 62, 71-72 (1971); *Doe v. Bolton*, 410 U.S. 179, 191-92 (1973). In my reading of *Roe*, *Colautti* and *Thornburgh*, the *Jefferson* case was wrongly decided. It could be argued, however, that the earlier cases are distinguishable because the abortion decision is different than treatment decisions after viability when the abortion option has not been exercised.

155. See *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

156. Rhoden, *supra* note 5, at 1975-82. Cf. *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (C.P. 1978) (individual not required to donate bone marrow despite the fact that refusal to donate would lead to cousin's death).

157. *Bowes & Selgestad*, *supra* note 137.

158. *Id.* See also *ELIAS & ANNAS*, *supra* note 12, at 255-56.

159. *Bowes & Selgestad*, *supra* note 137, at 211. The surprisingly good outcome serves to "underscore [] the limitations of continuous fetal heart monitoring as a means of predicting neonatal outcome." *Id.*

160. See § III B, discussing the state's interests and the concept of fetal rights.

terest after viability by recognizing that the state may not prohibit abortions necessary to preserve the life or health of the mother.¹⁶¹ Any cesarean surgery involves some health risks,¹⁶² and obese patients are generally at greater risk from both anesthesia and surgery.¹⁶³

Other cases of court-ordered cesareans have occurred in ten states and the District of Columbia.¹⁶⁴ In Michigan, a court ordered a pregnant woman who had refused surgery on religious grounds to report to the hospital or be forcibly brought there by the police.¹⁶⁵ In an Illinois case, a woman who had been hospitalized during the final period of her pregnancy (with triplets) refused a cesarean.¹⁶⁶ A court order permitting the cesarean was sought and granted, but the patient was not informed of this action.¹⁶⁷ When finally informed of the plan, the woman became angry, and was then forcibly restrained and subjected to the surgery.¹⁶⁸ Finally, in a California case, when doctors believed a fetus was in imminent danger and the woman refused to consent to a cesarean, the doctors performed the surgery without her consent and without court order.¹⁶⁹ In New York, a judge declined to order a cesarean section after a mother of ten children refused surgery on religious grounds.¹⁷⁰

161. *Roe v. Wade*, 410 U.S. 113, 163-64 (1973).

162. J. PRITCHARD, P. MACDONALD & N. GANT, *WILLIAMS OBSTETRICS* 867-71 (1985). For a discussion of the additional risks associated with cesareans, see Gallagher, *Prenatal Invasions*, *supra* note 8, at 50-53. See also *In re A.C.*, 533 A.2d 611, 617 & n.5 (D.C. 1987) (death rate associated with cesareans is between 0.1 percent and 1 percent, significantly higher than that associated with vaginal birth).

163. Bowes & Selgestad, *supra* note 137, at 211.

164. In addition to the Colorado case, court orders for cesareans have been given in Georgia, Hawaii, Illinois, Michigan, Minnesota, Ohio, Pennsylvania, South Carolina, Tennessee, Texas and the District of Columbia. See Gallagher, *Prenatal Invasions*, *supra* note 8, at 46-47; Kolder, Gallagher & Parsons, *supra* note 8, at 1194. A court order was denied in a New York case. See ELIAS & ANNAS, *supra* note 12, at 255.

165. See Gallagher, *Prenatal Invasions*, *supra* note 8, at 47. "Actual brute force proved unnecessary because the woman fled into hiding with her entire family. She gave uncomplicated vaginal birth to a healthy, nine pound, two ounce baby boy approximately two weeks later." *Id.*

166. ELIAS & ANNAS, *supra* note 12, at 255; Gallagher, *Prenatal Invasions*, *supra* note 8, at 9.

167. Gallagher, *supra* note 8, at 9.

168. Gallagher, *supra* note 8, at 10.

169. Jurow & Paul, *supra* note 137. The authors indicated that "[a]lthough the patient verbally . . . refuse[d] to consent to the surgery, no physical force was necessary to anesthetize the patient." *Id.* at 597.

170. Gallagher, *The Fetus and the Law—Whose Life Is It Anyway?*, Ms., Sept. 1984, at 62, 134-35.

These cases, decided in haste by the courts (if decided by the courts at all) and lacking explanations of the rationales used to support the decisions, set the stage for the most recent of the forced cesarean cases, *In re A.C.*¹⁷¹

(3) *In re A.C.*

A.C. had battled cancer since she was thirteen years old.¹⁷² After she had been in remission for three years, she married and became pregnant. During her twenty-sixth week, she was diagnosed as having a tumor in her lung. She was given at most only a few weeks to live.¹⁷³ After discussion with her doctors and family, A.C. agreed to accept treatment that might extend her life at least until the time the fetus was twenty-eight weeks.¹⁷⁴ At that point, the doctors believed, the chances of the fetus being viable would be greater.¹⁷⁵ In agreeing to the treatment, A.C. stated that her care and comfort were to be ensured by the doctors before that of her fetus.¹⁷⁶ Her husband, parents and attending physicians agreed with this course of action. When this plan was communicated to the George Washington University Hospital administration, advice was sought from counsel for the university. This counsel sought a court order for a cesarean section.¹⁷⁷

Within six hours, the trial court had appointed attorneys to represent A.C. and the fetus, and had held a hearing at the hospital.¹⁷⁸ Expert testimony from a physician who had not examined

171. 533 A.2d 611 (D.C. 1987), *vacated and remanded for reh'g en banc*, 539 A.2d 203 (D.C. 1988).

172. 533 A.2d at 612.

173. *Id.* Within a very short period of time it became apparent that A.C. was unlikely to live the two weeks doctors had initially believed.

174. Although in some cases, borderline viability can occur as early as twenty-four weeks, given the nature of the chemotherapy and A.C.'s cancer, the attending physicians believed that the fetus' chances for survival at twenty-six weeks were "grim." *Id.*

175. *Id.*

176. *Id.* at 613.

177. *Id.*

178. See Annas, *She's Going to Die: The Case of Angela C.*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 23. An expert testified that the likelihood of fetal viability at twenty-six weeks was 50-60 percent and the risk of serious handicap was less than 20 percent. *Id.* The appointment of a fetal advocate raises interesting questions. While the analogy to the state's interest in protecting children's rights via the appointment of a child advocate may be useful, particular state statutes may or may not provide jurisdiction to appoint a fetal advocate. In addition, under *Roe*, the fetus is not a child, and not all of the safeguards enacted to protect children are appropriate. Questions arise as to what standards are to be used in appointing an advocate, and as to what standards should be applied in guiding the

A.C. indicated that, in theory, a twenty-six week old fetus was viable.¹⁷⁹ The court found that the fetus was viable and that there was a state interest in protecting the potential life of the fetus.¹⁸⁰ The judge's oral delivery of his opinion relied on a single earlier trial court decision.¹⁸¹

After being informed of the trial court's decision, A.C. agreed to the procedure. However, a few minutes later, she stated: "I don't want it done."¹⁸² When the surgery was scheduled, a telephone appeal was made for a stay. "There was no time to have the transcript read or to do effective research. The atypical nature of the appellate hearing included our hearing directly from one of the physicians."¹⁸³ The court denied the request for a stay and surgeons performed the cesarean section that evening.

The fetus was not viable and survived for only two hours after the surgery. A.C. died two days later.¹⁸⁴

advocate. Furthermore, the gestational age at which appointment becomes appropriate or necessary is difficult to determine. In family law matters, the child advocate is often given great deference because of state interests in protecting the child's interests. Such deference, however, seems inappropriate toward the fetal advocate because protecting "fetal interests" necessarily involves invading maternal rights. The potentially zero-sum nature of the interaction, whereby assisting the fetus involves invading the mother and possibly jeopardizing her health, and the difference in the legal status between a fetus and a child may necessitate either different standards for appointment of a fetal advocate or a different role for the advocate. In addition, when a child advocate is appointed, protecting the best interests of the child are the advocate's mandate. In the case of a fetal advocate, whose interests are to be advocated? The assumption seems to be that the advocate is to assert the fetus's interest in life which, as discussed earlier, is really the state's interest in protecting potential life. While advocating the state's interest under *parens patriae* may be the correct stance for already born children, it does not seem appropriate when a fetus is involved. The deference generally given to the advocate as a result of his role in the system may skew the decision. See § III B.

179. Annas, *supra* note 151, at 23. In *Colautti*, the Court indicated that viability was determined by the attending physician based on the "particular facts of the case." "Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or . . . any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus." *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979).

180. Annas notes that A.C.'s terminal condition and the state's interest in protecting the fetus' "opportunity to live" were determinative for the court. Annas, *supra* note 151, at 24.

181. *Id.* In *re* A.C., 533 A.2d 611, 613 (D.C. 1987). In *re* Madyun, 114 Daily Wash. L. Rep. 2233 (D.C. Super. Ct. July 26, 1986), upon which the *In re* A.C. trial judge relied, was an unreported decision involving a woman's refusal to consent to a cesarean despite danger to the fetus from continued labor.

182. A.C., 533 A.2d at 613.

183. *Id.*

184. See Brief of *Amici Curiae* in Support of Appellant's Petition for Rehearing and

The court issued a written opinion five months after the stay was denied.¹⁸⁵ After recognizing that "we well know that we may have shortened A.C.'s life span by a few hours,"¹⁸⁶ it attempted to support its decision by discussing the importance of balancing between the individual's right to bodily integrity against the state's interest in potential human life.¹⁸⁷

This approach taken by the court of appeals was incorrect. First, the court assumed that there were two interests of equal magnitude at stake. While the state has a compelling interest in preserving potential life after viability, a fetus is not a person under *Roe v. Wade*.¹⁸⁸ *Roe* and its successors clearly indicate that, when maternal health is involved, no balancing is acceptable.¹⁸⁹

The court of appeals distinguished A.C. from *Colautti v. Franklin* by stating that "[t]his case does not present facts indicating that A.C.'s good health was being sacrificed to save her child's life, although her condition was clearly affected."¹⁹⁰ Later the opinion stated that the "cesarean section would not significantly affect A.C.'s condition because she had, at best, two days left of sedated life."¹⁹¹ The court seems to be saying that *Colautti* is inapplicable because A.C. was already in poor health. Yet the court did not indicate how healthy a pregnant woman would have to be before her autonomy became significant. As the Brief of *Amici Curiae* in Support of Appellant's Petition for Rehearing *En Banc* states, the court is equating terminal illness with non-

Suggestion for Rehearing *En Banc* at 2 (No. 87-609). See also A.C., 533 A.2d at 612.

185. After offering condolences "to those who lost the mother and child" the court acknowledged that its opinion, written after the fact, might "reasonably" be construed as "self-justifying." A.C., 533 A.2d at 613. The court recognized that its opinion was technically moot, but wrote "to assist others and to test this court's decision with analysis of precedent . . ." *Id.* at 611.

186. A.C., 533 A.2d at 613-14.

187. *Id.* at 614-17.

188. *Roe v. Wade*, 410 U.S. 113, 158 (1973).

189. *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). See § V, Implications, for a discussion of how changes in the composition of the Supreme Court may affect future decisions in this area.

190. A.C., 533 A.2d at 615 n.4.

191. *Id.* at 617. While the court states that it is balancing the interests of the woman and the fetus, it concerns itself almost exclusively with A.C.'s medical condition. "The Panel thus reduced the full range of A.C.'s constitutional rights to life, conscience, bodily integrity and reproductive freedom to a single concern—the right against 'bodily invasion'—and narrowly construed that right to involve only physical health." Petition for Rehearing and Suggestion that Rehearing be *En Banc*, *In re A.C.*, at 3.

personhood.¹⁹² "Never before has a court suggested that there is an exception for the rights of people who are not in 'good health.'" ¹⁹³ The *amicus* brief makes clear that under *Roe*, exemptions from state proscriptions on abortions must be provided for a woman whose health is at stake.¹⁹⁴

George Annas, writing in the *Hastings Center Report*, argues that the court's logic, if extended to other situations, could lead to such clearly unacceptable results as, for example, allowing the involuntary harvesting of organs from terminally ill patients if the organ might help preserve the life of another.¹⁹⁵

The court of appeals stated that two situations analogous to the forced cesarean cases are an adult's right to refuse treatment and the medical treatment of children despite parental opposition. The court is right about the first analogy, and wrong about the second.

The right of a competent adult to refuse treatment derives from a respect for autonomy and bodily integrity.¹⁹⁶ This right exists even if refusal of treatment will result in the patient's death.¹⁹⁷ Competency is presumed; and A.C.'s competency was never at issue.¹⁹⁸ The right to refuse treatment is not extinguished by terminal illness, nor should it be extinguished by pregnancy.

The appellate court, however, reasoned that the trial court did not err in subordinating A.C.'s rights to the interests of her unborn child and of the state.¹⁹⁹ The court analogized the state's interest in potential human life to its interest in providing medi-

192. Brief of *Amici Curiae* at 6 (citing Appellant's Memorandum in Response to the Court's Order to be Informed of Further Developments in This Case, at 2-3). Thirty-three organizations including medical, women's, and religious groups supported the brief.

193. Brief of *Amici Curiae* at 6.

194. *Id.* at 6 n.5.

195. Annas, *She's Going to Die: The Case of Angela C.*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 23, 25. See also Petition for Rehearing and Suggestion that Rehearing be *En Banc*, *In re A.C.*, at 5.

196. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251-52, 257 (1891); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 1137-42, 225 Cal. Rptr. 297, 301-06 (1986).

197. See *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).

198. See Memorandum of *Amicus Curiae* Concern for Dying in Support of the Motion for Reconsideration *En Banc*, at 4 (citing, *inter alia*, *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 255 Cal. Rptr. 297 (1986)). The trial court made no attempt to ascertain A.C.'s wishes, despite the fact that this is the first step to be taken when the right to refuse treatment is at issue.

199. *A.C.*, 533 A.2d at 617.

cal treatment to children despite parental refusal.²⁰⁰ While the court stated that it recognized differences between born children and the unborn, its opinion does not reflect this recognition.²⁰¹ Ordering medical treatment for a child does not place the physical health of the parent at risk; nor does it entail an invasion of the parent's body. No legal authority requires that parents submit to surgery to assist their children, even in life-threatening situations.²⁰² While some parents might readily make this sacrifice, they have no legal obligation to do so.

This case is tragic for a number of reasons. A young woman and the fetus she had hoped to bring into the world both died. Ironically, the court-ordered operation probably eliminated any chance the fetus may have had of going to term, and it may have hastened A.C.'s death as well. She was deprived of her autonomy. A.C.'s family was unable to be with her in her last hours. Finally, the court's decision, which infringes a woman's right to autonomous decision-making, sets a dangerous precedent. Annas cogently captured the problems with the court's reasoning:

They treated a live woman as though she were already dead, forced her to undergo an abortion, and then justified their brutal and unprincipled opinion on the basis that she was almost dead and her fetus' interests in life outweighed any interest she might have in her own life or health.²⁰³

V. IMPLICATIONS

"Maternal-fetal conflicts" pose intractable dilemmas. While *Roe v. Wade* states that a fetus is not a person in the constitutional sense,²⁰⁴ the presence of potential human life raises difficult questions as to what extent a woman's autonomy may be limited to protect that potentiality. Efforts to protect the fetus may lead to an abrogation of the privacy and autonomy rights of the woman carrying the fetus. However, an absolute respect for the woman's right might sometimes lead to loss of the potential life

200. *Id.* at 616.

201. *Id.*

202. *See* Annas, *supra* note 195, at 25.

203. *Id.* Annas characterized the operation as a forced abortion based on a view of abortion as a pre-term delivery of a non-viable fetus. Conversation with George J. Annas, Utley Professor of Health Law and Chief, Health Law Section, Boston University Schools of Medicine and Public Health (Nov. 11, 1988).

204. *Roe v. Wade*, 410 U.S. 113, 156-58 (1973).

that the state may, depending on the phase of gestation, have a compelling interest in protecting.²⁰⁵

Roe v. Wade and subsequent cases have upheld a woman's right to privacy in decision-making in the abortion context. While this privacy right is not absolute,²⁰⁶ the state, before it can interfere, must have a compelling interest, and any action it takes must be narrowly tailored to meet state ends. Even after viability, when the state's interest in the potential human life becomes compelling, exemptions from state proscriptions on abortions are available for the health of the mother.²⁰⁷ Health has been broadly defined.²⁰⁸ Although the premise of *Roe* has been embraced by a majority of Justices in cases decided by the Supreme Court since 1973, continuing attacks on the decision and changes in the composition of the Court may lead to an effort to narrow or overrule *Roe*.²⁰⁹

Despite the holdings in *Roe* and its progeny, most of the post-viability "maternal-fetal conflict" cases decided by lower courts have subordinated women's privacy and autonomy rights to the state's interest in potential life. "Maternal-fetal conflict" may be viewed by some as an appropriate area to narrow women's privacy rights, in effect carving away at the *Roe* decision. There are strong reasons why these lower court decisions should not be seen as limiting *Roe* and why precedent should be adhered to in deciding maternal-fetal conflict issues. Justice Stevens, in his concurrence in *Thornburgh*, discussed the importance of precedent and *stare decisis*:

There is a strong public interest in stability, and in the orderly conduct of our affairs, that is served by a consistent course of constitutional adjudication. Acceptance of the fundamental premises that underlie *Roe v. Wade*, as well as the application of those premises in that case, places the primary responsibility for

205. Under *Roe*, the state's compelling interest arises only after viability. Technical advances may, however, eventually accelerate fetal viability to the middle or early portion of the second trimester.

206. *Roe*, 410 U.S. at 155. At some point in pregnancy, the state's interests in guarding maternal health, maintaining medical standards and protecting potential life become compelling. *Id.*

207. *Id.* at 139.

208. See *supra* notes 61 & 154.

209. There are currently four Justices on the Court who supported *Roe*, three who dissented and two new Justices on the Court who have not been involved in abortion decisions at the Supreme Court level.

decisions in matters of childbearing generally in the private sector of our society.²¹⁰

In the area of "maternal-fetal conflict," precedent derives from both the line of privacy cases discussed above and the cases concerning autonomy in medical decision-making.²¹¹ The privacy cases have long recognized that "the individual is primarily responsible for reproductive decisions."²¹²

Recognizing a woman's right to decide whether to accept treatment that may benefit her fetus is in keeping with a long line of cases that defer to the patient in the context of medical treatment.²¹³ In recent years, the right to decide has been solidified and this right extends to the refusal of life-sustaining treatments.²¹⁴ To carve out an exception for pregnant women, an exception having nothing to do with decisional competency, would relegate these women to a second class status. Competence and informed decision-making have always been the standard determinants in refusal of treatment cases.

Requiring women to undergo unwanted treatment for the sake of their fetuses would deprive women of the liberty of *choosing* a course of action, which choice is the crux of the informed consent decision. The right to decide necessarily implies the right to reject the doctor's advice.²¹⁵ "In the final analysis the holding in *Roe v. Wade* presumes that it is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny."²¹⁶

Curtailing a woman's autonomy in medical decision-making during pregnancy may have the effect of causing women to shun medical care for fear that their autonomy will be restricted and their instructions countermanded. Many health problems would escape detection and treatment if pregnant women avoided doctors, which would undermine the goal of those who seek to impose obligations on a pregnant woman: improved pre- and post-natal

210. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 780-81 (1986) (Stevens, J., concurring).

211. See §§ II and III and accompanying notes.

212. *Thornburgh*, 476 U.S. at 778 (Stevens, J., concurring) (citing *Skinner v. Oklahoma*, 316 U.S. 535 (1942) and *Roe v. Wade*, 410 U.S. 113 (1973)).

213. See *supra* notes 29-39.

214. See *supra* notes 35-36.

215. See *Application of President of Georgetown College*, 331 F.2d 1000, 1017 (D.C. Cir.) (Burger, J., dissenting), *cert. denied*, 337 U.S. 978 (1964).

216. *Thornburgh*, 476 U.S. at 778 (Stevens, J., concurring).

health of children.

Affirmative legal obligations toward the fetus are without precedent in American society. Parents are not required to submit to medical treatment or surgery for the sake of their existing children. To oblige a pregnant woman to undergo unwanted treatment to benefit her fetus would give the fetus greater rights than the woman and greater rights than are currently afforded to existing children.

If decision-making is taken away from the pregnant woman, the question arises as to who should make medical decisions for her. *Roe v. Wade* and subsequent decisions treat doctors deferentially, but the ultimate decision-making is always left to the woman; the physician's role is to provide advice.²¹⁷ In the past, doctors have not been free to override a patient's decision about a course of treatment.²¹⁸ Courts have been unwilling to take away the individual's decision-making authority and delegate unreviewed authority to the physician. Doctors are sometimes wrong, and our increasingly sophisticated medical technology does not enable doctors to guarantee a particular outcome.

If decision-making authority was delegated to physicians, numerous problems would arise. For example, how far and into what areas should the doctor's authority extend? While medical knowledge evolves and changes, an ever greater array of substances and activities is thought to influence the fetus. Therefore, the invasion into a woman's autonomy and everyday activity is potentially all-encompassing.

Delegation of decision-making to the doctor also presents problems when a course of action the doctor deems appropriate or necessary for the fetus is not desired by, or in the best interests of the woman. "The physician has a fiduciary duty to his patient, and in this instance there are two patients with competing interests: the woman who refuses the cesarean and the fetus whose health depends on it."²¹⁹ When such a conflict arises, the opinion

217. *Roe*, 410 U.S. at 166.

218. See, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914); *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). However, see *Jurow & Paul, Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 *OBSTETRICS & GYNECOLOGY* 596 (1984), for a discussion of a case where doctors performed a cesarean without maternal consent and without seeking a court order. The authors acknowledge that the surgery could constitute assault and battery. *Id.* at 598.

219. Raines, *Editorial Comment on Jurow and Paul*, *supra* note 218, at 599.

of a second doctor would be necessary.²²⁰ If the two disagreed, would a third doctor be required?

The costs of these additional consultations would become prohibitively expensive for many women. The costs to the state of providing such consultations for indigent women would be exorbitant. The doctor could become an adversary to the patient who sought out his care, leading the patient to withhold information. Assuming that delegation of primary decision-making was feasible, resort to the courts would inevitably be necessary whenever the woman refused to comply with the doctor's orders. Therefore, delegation to the doctor of a woman's right to decide is inappropriate.

Courts are equally unsuited to handling the decision-making required in cases of maternal-fetal conflict. First, the courts have consistently held that treatment decisions are best left to the individual. Decisions about medical care implicate issues of autonomy which are best resolved in the sphere of personal decision-making. Second, the courts lack the expertise to make decisions of this kind on a day-to-day basis. The courts have always relied on expert testimony from physicians in treatment cases, but this would be too time consuming and expensive for daily decision-making on a grand scale. In addition, the judicial process would be unduly intrusive for the patient. To ensure "fairness" in the process, courts would no doubt demand testimony from several physician-experts who would subject the patient to repeated, unwanted physical examinations.

It is one thing for a patient to agree that her physician may consult with another physician about her case. It is quite a different matter for the State to compulsorily impose on that physician-patient relationship, another layer or . . . still a third layer of physicians. The right of privacy—the right to care for one's health and to seek out a physician of one's own choice protected by the Fourteenth Amendment—becomes only a matter of theory, not a reality, when a multiple-physician approval system is mandated by the State.²²¹

220. An analogy to an attorney representing two clients with conflicting interests might be appropriate here. If there are conflicts between clients' interests, it is unethical for the attorney to juggle these conflicting interests. The same considerations may apply to doctors when the best interests of the fetus do not coincide with the best interests of the mother.

221. *Roe*, 410 U.S. at 219 (Douglas, J., concurring).

For the reasons stated above, neither physicians nor courts are suited to make primary decisions about the treatment of pregnant women. These decisions must be left to the woman.

V. CONCLUSION

The right to bodily integrity is firmly established in law, and competent adults have the right to refuse treatment, even if adverse consequences result. As *Roe v. Wade* established, where maternal health is at stake, no balancing of state interests against a woman's right to decide whether to bear a child or terminate the pregnancy is permissible.

There are a number of practical difficulties in imposing an obligation to adhere to medically specified standards of conduct. First, insurmountable problems arise in trying to determine what types of conduct create an unacceptable risk for the fetus. Second, medical assessments of risk are sometimes wrong. Third, imposing legal obligations upon a woman to do or refrain from certain activities to protect her fetus will have a tremendously chilling effect. Some women may avoid seeking needed prenatal care. For others, the doctor will appear as an adversary, and the woman may not divulge important medical information out of the fear of sanctions or loss of control.

Finally, there is great danger in overriding a competent individual's decision about treatment that affects her body. Society runs the risk of creating a new class—pregnant women—who are deemed incompetent to make decisions, while their peers, non-pregnant women and men, have the right to bodily integrity.

While there may be some tragic results when a choice is made, the decisions regarding treatment of a pregnant woman to benefit her fetus must be left to the woman.