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Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest"‡

By LAWRENCE J. NELSON,*
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For reasons ranging from fear of surgery to religious belief, competent pregnant women sometimes refuse medical treatment that a physician considers beneficial to the woman, the fetus, or both.¹ If the woman intends to bring the fetus to term, the attending physician and other health care practitioners involved in the woman's care may find her refusal odd and inconsistent with the desire to deliver a healthy baby.

† "Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest." Mill, On Liberty, in 43 GREAT BOOKS OF THE WESTERN WORLD 271 (R. Hutchins ed. 1952).
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¹ In this context, "competent" has the meaning it usually has in cases involving adults refusing medical treatment, i.e., demonstrating an ability to understand the nature of one's medical condition and the consequences of refusing treatment. See Bartling v. Superior Court, 163 Cal. App. 3d 186, 193, 209 Cal. Rptr. 220, 223-24 (1984) (patient knew removal of ventilator would result in death); Lane v. Candura, 6 Mass. App. Ct. 377, 384, 376 N.E.2d 1232, 1236 (1978) (patient rejected amputation with full appreciation of the consequences); State Dep't of Human Servs. v. Northern, 563 S.W.2d 197, 209-10 (Tenn. Ct. App. 1978) (though lucid generally, patient lacked comprehension of seriousness of her medical condition).

The analysis presented in this Article assumes that the mother is legally competent. An incompetent pregnant woman should be given medically indicated treatment to prevent harm to herself and to her fetus despite her apparent objection. As with other incompetent adults, medical practitioners should not permit incompetent pregnant women to be harmed by refusing treatment that likely will benefit them. If the attending medical practitioners doubt the competency of a pregnant woman who is refusing treatment, they should immediately seek the advice of mental health professionals, an institutional ethics committee, and legal counsel. On occasion, a woman's competency may be so doubtful that it is reasonable for the practitioners involved to seek judicial guidance.
Moreover, if the treatment poses a relatively insignificant direct medical risk to the mother, while promising to be of significant benefit to the fetus, her refusal may seem even more puzzling. When a pregnant woman refuses treatment that will either directly or indirectly benefit her fetus, and perhaps even save its life, she confronts her physician and other involved practitioners with a dilemma rooted in conflicting loyalties to the woman and to the fetus. Do they honor the mother's refusal and leave the fetus to a possible fate of injury, disability, or death, or do they ignore the mother's wishes and treat her, despite her objections, for the sake of protecting the fetus?

If the physician chooses to treat the mother despite her refusal, he must not only ethically justify ignoring the woman's right to control her own body, but also must face the potential legal consequences of treating her against her will. On the other hand, if the physician respects her refusal, he seemingly has abandoned the fetus, arguably a patient separate from the mother to whom he owes an ethical and legal duty of care. To escape this dilemma, some physicians and hospitals have sought and obtained judicial orders compelling pregnant women to undergo the medically recommended treatment despite their previous refusal. Seeking judicial sanction for compelled treatment transfers the problem from the hospital to the courthouse, from the physician to the judge, but the same difficult question remains: should the pregnant woman be forced to accept medical treatment that she does not want?

This Article attempts to answer the formidable and serious question: when, if ever, is it ethically and legally permissible for a physician or a judge to compel a competent pregnant woman to undergo medical treatment for the sake of her fetus? Although the question arises rarely,

2. This Article sometimes refers to pregnant women as "mothers" and commonly refers to the unborn product of human conception as a "fetus" rather than an "unborn child" or an "unborn baby." The Article does not attempt to invoke any particular emotion or image by use of these terms but rather seeks to achieve verbal economy. The authors recognize the human status of the fetus and its obvious potential to develop into what we all recognize to be a person with full human rights. However, one does not have to deny the fetus all moral status or legal protection whatsoever in order to conclude that a competent pregnant woman's refusal of medical treatment should be respected, even if harm will then befall her fetus. The reasons supporting this conclusion are set forth in detail infra text accompanying notes 217-88.


5. There is no reliable method to estimate how often pregnant women refuse medical treatment that would benefit their fetuses, but the cases cited herein and the authors' professional experience indicate that it happens often enough to be a significant ethical and legal
when it does, it generates heated controversy and bitter conflict. This Article begins by discussing the various clinical situations in which maternal-fetal conflict may arise and the perceptions of clinicians faced with a maternal refusal of treatment. The Article then explores the ethical aspects of compelling a pregnant woman to undergo treatment for the benefit of her fetus. The Article next considers the legal status of the fetus and the legal interests of the pregnant woman. Finally, the Article discusses the problem of legally compelling pregnant women to live as seems good to their physicians, to the judiciary, or to society generally. Some legal commentators favor pervasive judicial intervention in the life of a pregnant woman who refuses treatment, others favor only limited intervention, and some favor no intervention at all. This Article argues that neither the medical profession nor the judiciary should force competent pregnant women to undergo medical treatment for the sake of preserving the life or health of their fetuses, regardless of the result. This conclusion ultimately rests not only on a view of the legal status of the fetus and the woman’s constitutional right of privacy, largely ignored by other commentators, but also on a conviction that it is profoundly unwise social policy for the law to use its coercive power to invade a per-


7. See, e.g., Robertson, The Right to Procreate and In Utero Fetal Therapy, 3 J. LEGAL MED. 333, 351-61 (1982) (Once the fetus is past the point of viability, the mother has a duty to produce a live and healthy infant.).

8. See, e.g., Mathieu, Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice, 8 HARV. J. LAW & PUB. POL'Y 19, 51-52 (1985) (advocates a balancing test in which relative weight of conflicting interests changes according to point in pregnancy at which they arise); Myers, supra note 4, at 65-71 (would erect a “presumption against intervention” and would require state to use “least restrictive means” when intervention necessary); Note, The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention, 14 FAC. L.J. 1065 (1983) (proposing that a mother’s choice regarding medical treatment of her fetus prevails unless the fetal therapy is a proven procedure that clearly would benefit the fetus, the use of such therapy would prevent significant and irreversible physical or mental impairment of the fetus, no less intrusive treatment is available, and the treatment will not result in serious harm to the mother); Note, Constitutional Limitations on State Intervention in Prenatal Care, 67 VA. L. REV. 1051, 1066-67 (1981) (asserting that state action regulating a pregnant woman’s behavior would be constitutional if it prevented serious harm to the fetus’ health, if no less intrusive means would achieve the same end, and if the woman were provided procedural protections when the state proposed to invade her bodily integrity).

9. See, e.g., Annas, supra note 4, at 16 (arguing that a pregnant woman has “a right to refuse surgery recommended for the sake of her fetus”).
son's body even for the benefit of what is arguably another person. This Article also argues that pregnant women should not be forced to alter their behavior in order to reduce or eliminate risk to their fetuses.

**Maternal-Fetal Conflicts in the Clinical Context**

An evaluation of whether a mother should be forced to accept treatment requires a general understanding of the clinical situations during pregnancy in which the interests of the mother and her fetus may conflict. Obviously, both the fetus and the mother face the medical risks of pregnancy itself. In addition, the fetus may suffer from various medical conditions that are amenable to direct therapy *in utero*. Moreover, a variety of maternal behaviors may adversely affect fetal health. If a mother takes physical risks during pregnancy or refuses medical treatment for herself or the fetus, a physician faces the dilemma of having two patients with competing interests. This section discusses the medical risks of pregnancy and examines those situations in which certain maternal behavior or maternal refusal of medical treatment may cause harm to the fetus.

**Inherent Medical Risks of Pregnancy**

The outcome for the mother in a normal spontaneous vaginal delivery is uniformly excellent. Postpartum morbidity—pain, discomfort, and disfigurement—is slight, and mortality from the normal birth process itself is exceedingly unusual. Delivery by Cesarean section, a surgical procedure opening the maternal abdomen and uterus to deliver the fetus, has more morbidity than does routine vaginal delivery, but the morbidity is similar to that from other abdominal operations and consists primarily of pain and discomfort related to the incision. Still, maternal mortality after Cesarean section is extremely low, less than one per thousand, and usually is due to blood clots, infections, or the complications of anesthesia.

Similarly, a normal vaginal delivery poses little risk to the fetus. Cesarean section by itself also poses a very small chance of harm to the fetus. Indeed, it is often performed to secure a rapid and controlled delivery in order to improve fetal outcome. For example, Cesarean section is indicated in most cases of placenta previa, a condition in which the placenta grows over the opening to the birth canal. If a vaginal delivery

11. Id. at 868-69.
is attempted past a placenta previa, profuse bleeding through the vagina can occur. In this situation, although both mother and fetus risk death from hemorrhage, the fetal risk is higher because the fetus is completely dependent for survival on the blood supply from the placenta. When the previa is complete, causing total blockage of the birth canal by the placenta, maternal as well as fetal survival may depend upon prompt control of the bleeding by removing the placenta through Cesarean section or, on occasion, hysterectomy.¹²

The case of Jefferson v. Griffin Spalding County Hospital Authority¹³ highlights this problem, and illustrates the limited ability of a physician to predict the outcome of pregnancy. Mrs. Jefferson’s obstetrician testified that she had a complete placenta previa and that, if a vaginal delivery were attempted, her infant had a ninety-nine percent chance of dying and she a fifty percent chance of dying. The court ordered Mrs. Jefferson to undergo an ultrasound examination, and if a complete placenta previa was still present, then to undergo Cesarean section. She refused to undergo Cesarean section on religious grounds, but did appear for the ordered ultrasound examination. A few days later, she uneventfully delivered a healthy child without surgical intervention.¹⁴

Cesarean section is also medically indicated for abruptio placentae.¹⁵ In this condition, the placenta detaches prematurely from the inner wall of the uterus, and the fetal blood supply can be quickly and severely impaired. Placental abruption poses somewhat less risk to the mother than does placenta previa because the bleeding is contained within the uterus and usually stops spontaneously. If spontaneous delivery of the fetus and placenta does not occur, however, Cesarean section is necessary not only to prevent further blood loss and clotting problems in the mother, both of which can be fatal, but also to secure live birth.¹⁶

¹² The perinatal mortality (death of the fetus shortly before, after, or during the birth process) rate for all cases of placenta previa is approximately 10%. Without Cesarean section, the fetal risk of death is much higher, but accurate data are not available. With modern obstetric care, maternal mortality is very low. See Hibbard, Placenta Previa, in 2 GYNECOLOGY & OBSTETRICS ch. 49 (1985). Obviously, if a woman refused either Cesarean section or other therapy designed to stop the bleeding, her risk of dying would be higher.


¹⁴ Annas, supra note 4, at 16.

¹⁵ WILLIAMS OBSTETRICS, supra note 10, at 402-03.

¹⁶ The perinatal mortality from abruptio placentae in the best of circumstances is from 30% to 60%. Without prompt Cesarean section, fetal death is almost certain. There are well-documented cases in which a fetus, alive at the time of admission to the hospital when abruption had already begun, died in utero while waiting for a vaginal delivery to occur. Maternal mortality is approximately 1% with prompt Cesarean section. If abruption is allowed to continue, however, the bleeding within the uterus can cause low blood pressure, clotting problems,
Cesarean section is also appropriate for the controlled delivery of extremely premature infants when fetal distress occurs during premature labor. Premature labor may occur when a fetus is at a very low weight (less than 750 grams) and at a gestational age that is on the border of viability outside the uterus (twenty-four to twenty-seven weeks). Less than one percent of all live births occur in this gestational age group. However, when premature labor cannot be stopped and fetal heart monitoring indicates fetal distress, then Cesarean section offers the best chance of delivering the fetus alive. A premature fetus has a higher chance of injury during labor and delivery than does a fetus delivered at term.

When labor has failed to progress, or when the fetus has physical dimensions prohibiting passage through the pelvis, Cesarean section is the preferred treatment. Delivery by Cesarean section is also indicated when the progress of labor has been unsatisfactory and there is evidence of fetal distress. Vaginal delivery in these situations will result in higher fetal and maternal morbidity and mortality than will delivery by Cesarean section.

Interruption of pregnancy either by induction of labor or by Cesarean section may be medically indicated in cases of eclampsia, a syndrome in which maternal high blood pressure and seizures injure both mother and fetus because of insufficient oxygen delivery to vital organs. Prompt cessation of labor by either vaginal delivery or Cesarean section greatly reduces both fetal and maternal morbidity and mortality.

17. Fetal distress is a term describing any situation during which the fetus receives insufficient blood supply from the placenta, and thus insufficient oxygen, and suffers some organ compromise as a result. This compromise is at the cellular level and results in an excess of acid in the fetus’ system. If the stress is severe, abnormal patterns can be seen with fetal heart rate monitoring. See WILLIAMS OBSTETRICS, supra note 10, at 286-91, 867. See the discussion of fetal heart monitoring infra note 38.


19. WILLIAMS OBSTETRICS, supra note 10, at 756-57.

20. Id.

21. Difficult labor, known as dystocia, can occur in several situations: 1) when the uterus is unable to contract in a forceful and coordinated manner sufficient to deliver the fetus; 2) when the fetus has a congenital anomaly, such as a large head from hydrocephalus, or lies within the uterus so that a shoulder would descend the birth canal first rather than the head (transverse lie); and 3) when pelvic abnormalities in the mother prevent passage of the fetus down the birth canal. In any of these situations, vaginal delivery probably would be unsuccessful and cause fetal death. See WILLIAMS OBSTETRICS, supra note 10, at 641-42, 657, 662-65.

22. Eclampsia is the most severe of several syndromes involving high blood pressure that
In situations of repeated third trimester miscarriage due to weakness of the cervix, the physician may recommend cerclage (suturing to close the cervix) in order to maintain the pregnancy. This procedure has no risk to the fetus and virtually none to the mother.\textsuperscript{23}

A deterioration in general maternal health may pose some risk to the fetus. For example, in one case, physicians sought a court order requiring a pregnant woman to receive blood transfusions because they feared she would suffer severe hemorrhaging prior to the end of her pregnancy.\textsuperscript{24} The mother had refused the blood transfusions for religious reasons. The court directed her to receive blood transfusions if medically necessary to save her life or the life of the fetus.\textsuperscript{25} While such transfusions pose very little risk to either the mother or the fetus, they rarely are medically indicated.

Medical Conditions Amenable to \textit{In Utero} Therapy

In recent years, several congenital conditions of the fetus have become subject to \textit{in utero} diagnosis and treatment. Physicians can diagnose these conditions either by ultrasound\textsuperscript{26} or by amniocentesis.\textsuperscript{27} Some conditions require that drugs be administered to the mother in order to

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\textsuperscript{23}  In one case, a husband unsuccessfully sought a court order to require his pregnant wife to undergo this procedure after she refused it on religious grounds. Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983).


\textsuperscript{25}  Id. at 424, 201 A.2d at 538.

\textsuperscript{26}  Ultrasonography involves the transmission of radio waves into the body. These waves are reflected off body tissues and fluids and are detected by a transducer to create an image. There are no known risks or side effects from this purely diagnostic technique.

\textsuperscript{27}  Amniocentesis involves the insertion of a needle into the uterus with ultrasound guidance to sample the amniotic fluid surrounding the growing fetus. Cells obtained from the fluid are cultured and analyzed for evidence of chromosomal abnormalities, such as Down's syndrome. The procedure is very safe, with rare reports of premature labor, infection, and maternal or fetal bleeding. \textit{Williams Obstetrics}, supra note 10, at 268-69.
treat the fetus. Other examples involve direct intra-amniotic instillation of a drug or even blood transfusions into the peritoneal cavity of the fetus to treat a certain often fatal form of anemia called erythroblastosis fetalis. Intra-amniotic injections pose little risk to either fetus or mother. Direct fetal blood transfusions pose some risk of harm to the fetus, as the transfusion needle actually enters the fetal abdomen.

Other conditions may require early delivery, often by Cesarean section, in order to achieve the best possible fetal outcome. For example, congenital hydronephrosis (blocked urine flow leading to progressive kidney dysfunction) and hydrocephalus (blockage of the flow of cerebrospinal fluid preventing normal brain development) would require surgical intervention and delivery much earlier than the normal end of pregnancy in order to protect normal fetal development. If the surgery involved only placement of a catheter through the mother's abdominal wall into the fetal bladder, this would pose little risk to the mother. Hysterotomy (actually opening the uterus to operate on the fetus), on the other hand, poses the same risk as a Cesarean section. If the fetus had congenital hydronephrosis, for example, and the mother refused any intervention, then at birth the infant would suffer complete kidney failure and would require kidney dialysis, which is difficult to perform in newborns. If congenital hydrocephalus were not corrected, fetal neurological handicaps, including mental retardation, would result.

Actual surgery on the fetus while in utero is still experimental, but researchers are accumulating experience with certain techniques. As

28. For example, to help maturation of the fetal lung, a physician may administer glucocorticoids to the mother.
29. One such drug would be thyroid hormone, used to treat congenital hypothyroidism.
30. Erythroblastosis fetalis is an often fatal form of hemolytic anemia in the fetus or neonate that is caused by the transplacental transmission of maternal antibodies that destroy the fetal red blood cells. It is caused by blood group incompatibility between the mother and fetus. In the fetus or newborn, this condition causes jaundice, enlargement of the liver and spleen, and anemia. If the anemia is severe enough, circulatory failure ensues, and the fetus or newborn dies. If the fetus dies in utero, this most severe form of anemia is called hydrops fetalis.

Direct fetal blood transfusions are performed only during the 23rd to 32nd weeks of gestation. About 50% of such transfusion attempts are successful. Attempts earlier in pregnancy are either unsuccessful or cause fetal injury because the fetus is so small. After the 30th week, delivery by Cesarean section with ex utero blood exchanges is technically much more successful. At this age, the infant can be more easily kept alive outside the uterus. If the anemia is severe enough to require either attempts at fetal blood transfusion or early delivery, and such therapy is refused by the mother, the fetus will almost certainly die. WILLIAMS OBSTETRICS, supra note 10, at 776-79.

32. As of May 15, 1985, 72 cases of obstructive uropathy (blockage of the normal flow of
more true surgical interventions on the fetus occur, the risk of fetal damage from the operative procedure itself and the chance of premature delivery may increase. The risks from direct fetal surgery are uniformly higher for the fetus than for the mother. No matter how small the risks to the mother, however, they may seem particularly significant in this unique situation because the mother receives no personal medical benefit from the intervention.

If a procedure requires hysterotomy, the mother faces a slight risk of harm from the surgical procedure itself, as well as a high risk of premature labor. If a premature delivery occurs, the life and health of the fetus would be at risk because its chances to survive and thrive increase with the time spent developing in utero. Although drug therapy exists to forestall premature delivery, it is neither totally effective nor completely safe for either the mother or the fetus.33

Medical Risks of Maternal Behavior to the Fetus

Maternal behavior and life-style can also directly affect fetal development. Adequate maternal nutrition is considered essential for fetal growth. Cigarette smoking slows fetal development and leads to smaller than normal infants. These infants have a higher death rate after birth than do infants born of nonsmoking mothers.34 Mothers whose diabetes mellitus is not well-controlled risk eclampsia and infection, and are more likely to give birth to large babies with an increased perinatal mortality.35

urine from the bladder into the amniotic fluid) in fetuses had been treated with placement of an in utero chronic vesico-amniotic shunt (a catheter placed into the fetal bladder to drain urine into the amniotic fluid). The best survival rate (80%) was seen in those cases with a posterior urethral valve as the only anomaly. Most other cases had other malformations as well, with an overall group survival of 42%. The procedural death rate was 4%, two deaths occurring after trauma from the procedure and one from premature delivery induced by infection from the procedure. Of those surviving, 93% had no long-term morbidity.

Thirty-two ventriculo-amniotic shunts were placed for obstructive hydrocephalus (blockage of the normal flow of cerebrospinal fluid around the brain and spinal cord) and 27 survived (85%). Four deaths (12.5%) were directly related to the procedure. Eleven infants (41% of those surviving) were normal at a mean follow-up period of eight months, the others exhibiting mild to severe neurologic handicaps. Manning, International Fetal Surgery Report (1985) (unpublished report on file with THE HASTINGS LAW JOURNAL); see also Harrison, Filly & Golbus, Fetal Treatment 1982, 307 NEW ENG. J. MED. 1651 (1982).

33. Drug therapy involves the use of tocolytic (from the Greek word "tokos," meaning childbirth) agents that slow and abolish premature uterine contractions. Ritodrine is the most effective such drug currently approved, but its side effects to the mother, and presumably the fetus, are potentially serious. These side effects include fever, decreased blood pressure, decreased serum potassium, acidosis, and cardiac failure. See WILLIAMS OBSTETRICS, supra note 10, at 752-53.
34. Id. at 258.
35. Id. at 600-01.
Maternal heroin use can result in fetal addiction. Narcotic withdrawal can be both prolonged and dangerous in an infant.\textsuperscript{36} Fetal alcohol syndrome may result from maternal alcoholism. Infants with this syndrome suffer from prenatal and postnatal growth retardation, mental retardation, and a constellation of cardiovascular, craniofacial, and limb deformities. Moreover, they face an increased chance of dying after birth.\textsuperscript{37}

\textbf{Dilemma of Medical Treatment}

Physicians understandably may be perplexed when a mother refuses a recommended therapy that poses some risk to her, but is intended to improve fetal survival. One report describes what one group of physicians thought to be the irrational refusal of a woman in labor to allow Cesarean section recommended because of fetal distress.\textsuperscript{38} The physi-

\textsuperscript{36} Id. at 788-89.
\textsuperscript{38} Bowes & Selgestad, \textit{Fetal Versus Maternal Rights: Medical and Legal Perspectives}, 58 Obstetrics & Gynecology 209, 209-11 (1981). In this case, Cesarean section occurred some eight hours after the fetal heart monitor disclosed patterns consistent with fetal distress and after the mother initially refused to consent to surgery. The infant was severely stressed at birth but then recovered uneventfully. After the severe lack of oxygen endured by the fetus during the long labor, concern would be appropriate for the child’s future intellectual development. Here, the fetal heart monitor accurately predicted significant fetal distress. Meconium, the first expelled fecal material of the fetus, had also stained the amniotic fluid three hours after the first abnormal fetal heart tracings, another reliable sign of fetal distress.

Contraction stress tests are performed near term in order to predict fetal well-being if the pregnancy is allowed to continue. The mother is brought to the hospital near term and oxytocin is administered to stimulate uterine contractions. Fetal heart rate monitoring is employed. If fetal distress patterns appear, then early termination of pregnancy by Cesarean section is considered. Such testing is occasionally performed when the mother has diabetes, hypertension, or is past her due date. These tests have an acceptable false-negative rate (0.5-1.0%), but a high false-positive rate. See Jarrell & Sokol, \textit{Clinical Use of Stressed and Nonstressed Monitoring Techniques}, in 2 Gynecology & Obstetrics, supra note 12, ch. 58.

Fetal heart rate monitoring is used more commonly during labor itself. Such continuous intrapartum fetal heart rate monitoring is standard in many delivery suites, especially when labor has not progressed satisfactorily. Although both external (ultrasound or phonocardiography) or internal (attaching an electrode directly to the fetus) systems can be used, the latter is more reliable technically. Various patterns of fetal heart rate decelerations are used to predict potential danger to the fetus if labor is allowed to continue. See D’Angelo & Sokol, \textit{Intrapartum Fetal Monitoring}, in 2 Gynecology & Obstetrics, supra note 12, ch. 59. No accurate data exist on the predictive accuracy of these tests, and notable exceptions to the predicted outcomes have occurred. One study showed a reduction in both the intrapartum and neonatal death rates when monitoring was applied. This was observed in both high-risk and low-risk pregnancies. See Erkkola, Gruunroos, Punnonen & Kiliku, \textit{Analysis of Intrapartum Fetal Deaths: Their Decline With Increasing Electronic Fetal Monitoring}, 63 Acta Obstetricia et Gynecologica Scandinavica 459, 459-61 (1984). In spite of its limitations, fetal heart monitoring may be considered the appropriate standard of care, at least in high-risk pregnancies. See Schifrin, Weissman & Wiley, \textit{Electronic Fetal Monitoring and Obstetrical Malpractice}, 13 Law Med. & Health Care 100 (1985).
cians hurriedly summoned attorneys and a juvenile court judge to the delivery room, where the judge ordered a Cesarean section over the mother's objections. The mother then became more cooperative, and the doctors ultimately achieved a successful delivery by Cesarean section.

One recent medical journal reported a more dramatic confrontation between a mother and her physician. In that case, abruptio placentae suddenly occurred during labor and presented an imminent threat to fetal survival. The attending physicians felt that immediate action was necessary to save the fetus and that no time could be lost in attempting to secure legal sanction for their plan. Despite the mother's repeated refusals to give consent for a Cesarean section, she did not actively resist when given general anesthesia. The physicians then delivered a severely stressed, but otherwise healthy infant by Cesarean section.

These cases outline the dimensions of the direct conflict that can occur upon the mother's choice to subordinate her fetus' interests to other values, values which often appear to the physician as a lack of concern for fetal well-being and as antagonistic to the physician's goal of providing the fetus with the maximum chance for survival and a normal life. The physician's dilemma is even sharper when the infant is otherwise normal and at term, as in the two examples described above. Physicians who treat pregnant women may reasonably assume that the mother views the interests of the fetus as at least equal to, if not more important than, her own.

Physicians generally assume that if the woman becomes pregnant and then carries the pregnancy toward term, she wants to deliver a healthy infant. Physicians may have a low tolerance for many patients' often unstated fears concerning minor medical problems or low-risk invasive procedures, such as Cesarean section. When an apparently competent mother decides on a course of action that clearly places her infant's life at risk, the confusion and possible anger of those who otherwise would do everything possible to save that infant is understandable. Those emotions, however, should not determine the response of physicians, or of the law, to maternal refusals of treatment.

In summary, a pregnant woman can refuse medical treatment in a variety of situations. Each case poses different risks and consequences for mother and fetus. Likewise, the reasons a pregnant woman might refuse treatment could vary greatly and may well have nothing to do with the relative medical risks of the treatment recommended by a physi-

cian. In fact, the reported cases suggest that the most common reason for refusal of treatment by pregnant women is religious belief.\footnote{40} Similarly, a pregnant woman can adopt a number of different life-styles or behaviors that pose some risk of harm to her fetus. Whatever the reasons for refusal and whatever the attendant medical risks, the question of whether a pregnant woman should be forced to undergo medical treatment against her will or to behave in ways she does not freely choose cannot be answered solely on the basis of whether the mother or fetus may suffer some physical detriment. The fundamental ethical, legal, and social values at stake must be taken into account as well. On balance, these values do not justify compelling a pregnant woman to accept medical treatment against her will.\footnote{41}

**Ethics and Maternal-Fetal Conflict**

**Moral Status of the Fetus**

Resolution of the moral conflict between a woman and the fetus she carries logically begins with an articulation of the moral status of the fetus. The debate concerning the moral status of the fetus has generally focused upon the question of whether it is a “person.” For, if the fetus is a person, then it is a being inherently worthy of respect and has rights which morally obligate all other persons to treat it with dignity and with consideration for its interests. Correspondingly, if the fetus is a person, it has a right to continue to exist, a “right to life.” Consequently, others would be morally obligated to refrain from actions that would deprive the fetus of its life, injure its health, or unjustifiably interfere with its development. In addition, they would be obligated, at least to some extent, to take actions that would benefit the fetus and enhance its prospects for life.

The determination of whether the fetus is a person is not made by scientific observation of facts. Rather, it is a philosophical matter involving arguments about moral values and moral principles that vary in their persuasiveness. A somewhat bewildering variety of arguments has been made about the moral values and principles that should guide an assessment of the moral status of the fetus and our consequent treatment of it. To complicate matters further, each of these arguments has profound


\footnote{41} See infra notes 217-88 & accompanying text.
implications for personal action and public policy. As a result, the moral status of the fetus is controversial and unsettled.

Many commentators have noted the ethical importance of identifying a point at which a person comes into being and becomes a bearer of rights and duties. Some believe that from the moment a human ovum is fertilized with human sperm, a separate person exists who possesses the same ethical rights and is owed the same treatment as any live-born man or woman. Others contend that the fetus is, at most, a potential person, lacking full ethical status until it is born alive and lives independently outside the mother's body. According to this view, the fetus need not be treated as if it were a person, although it is not necessarily a being without any moral status whatsoever. Still others have asserted that the fetus becomes a person at the moment of its first heartbeat, when it starts to kick in the womb or is "quick," or when it reaches the point of viability and is able to maintain its life outside the womb.

In short, there is no consensus about when the fetus becomes a person and when we must treat it accordingly. The multiplicity of views about the fetus' moral status is as disquieting as it is puzzling, perhaps because each view has but part of the truth. It is reasonable to claim that a fetus has human moral value and significance: it possesses the potential to develop into what is unarguably a human person, it develops markedly human physical characteristics at an early stage in its growth, and it is genetically and organically distinct from its mother. Yet, it is also reasonable to claim that this potential is not equivalent to the actual, that the recently fertilized egg is simply not the same kind of moral being as a live-born human, and that the death of a fertilized egg in the course of attempting in vitro fertilization is hardly the moral equivalent of mur-

44. See, e.g., Fletcher, Fetal Research: An Ethical Appraisal, in THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, RESEARCH ON THE FETUS 3, 3 (1975).
45. While conceding that the fetus is not a person, one reasonably could maintain that the fetus' potential personhood is sufficient to prohibit others from engaging in fetal experimentation that would cause it pain. Similarly, one could reasonably maintain that, although it is not necessarily immoral for a woman to choose an abortion, such a choice remains a very serious moral matter.
46. For a definition of "quick," see infra note 123.
48. In vitro fertilization is a process in which ova are harvested from a woman at the time in the menstrual cycle when they can be fertilized by donor sperm, either from the husband or another donor. The actual fertilization occurs in the laboratory (in vitro) and not in the wo-
der. Those who adhere to this view believe that, at least until the fetus can or actually does live outside of the womb, the mother should have the prerogative to terminate her pregnancy for good reason.

Given the wide variety of sincerely held and plausible moral arguments about the status of the fetus, it seems pointless to rest resolution of conflicting maternal-fetal medical treatment interests upon the somewhat abstract issue of the fetus' moral status. Instead, an ethical analysis of the particular context of obstetric medical treatment may be more helpful in illuminating maternal-fetal conflict.

Moral Dilemma of the Medical Practitioner

In the case of a wanted pregnancy, the identity of interest between the mother and the fetus rarely presents the physician providing prenatal care with ethical obligations to the fetus that are distinct from those to the mother. A woman who intends to bring her pregnancy to term typically wants what is best for her fetus and seeks and accepts medical treatment accordingly. The physician's job is to ascertain which treatments are medically necessary to produce both a healthy infant and mother. For all practical purposes, then, the physician encounters but one patient who is the subject of medical treatment.

When caring for a woman who wants to bring her fetus to term, the physician is morally obligated to render the best possible care to achieve the mother's goal of the birth of a healthy baby. The physician's personal views about the moral status of the fetus should have no bearing on his professional conduct. In fact, a physician who intentionally renders less than the best possible obstetrical care during the course of a wanted pregnancy because he views the fetus as a nonperson until birth would be subject to the same moral condemnation as a physician who intentionally renders inferior medical care on the basis of a patient's race or economic status.

When a woman either does not want to continue her pregnancy or has decided for her own reasons not to submit to medical treatment recommended to protect or preserve the life of the fetus, however, the physician's views on the moral status of the fetus—and those of the mother, for that matter—become critical. A physician who believes that the fetus is a person from the moment of its conception may feel morally bound

man (in vivo). After fertilization has taken place, the embryo is implanted through the cervix into the woman's uterus. Often, several embryos are implanted at once. The odds of successfully achieving pregnancy by this method are no better than ten to twenty percent. See Acosta & Garcia, Extracorporeal Fertilization and Embryo Transfer, in J. Aiman, INFERTILITY: Diagnosis and Management 215 (1984).
not to carry out the mother’s desire to terminate her pregnancy or not to acquiesce in her refusal of treatment. A physician who thinks the fetus achieves personhood at some point after conception, but prior to birth, would feel similarly morally bound if the mother desired the abortion or refused the treatment after the “moment” the fetus became a person. Only the physician who believes the fetus is a person only after birth would feel morally free to accept the mother’s desires. Yet, it is likely that even this physician would experience moral qualms if the mother were refusing treatment that could benefit the fetus greatly by, for example, saving it from severe mental retardation or even death at little or no risk to herself.

Arguably, as medicine has developed and physicians have acquired the skill and knowledge to treat the fetus directly, the fetus has become a patient separate from its mother. In this sense, a “patient” would be defined as a human organism that can benefit from direct medical intervention. Today, medical intervention can not only preserve the life of certain fetuses that would otherwise die, but it can also maintain or enhance fetal health by preventing some dysfunction, pain, or disfigurement that the fetus would otherwise suffer. Precisely because fetuses can benefit from medical treatment directed at them rather than at their mothers, they can be viewed as having an increased moral claim to their physicians’ medical ministrations, given the physician’s general obligation to help, or at least not to harm, his patients.49

A woman who believes she is morally justified in seeking an abortion poses little problem for the physician who finds such conduct morally unacceptable. He can simply refuse to perform the abortion, perhaps attempt to change the woman’s mind, or perhaps refer her to someone who views abortion differently. In addition, the physician could forcibly keep the woman from any abortifacient and confine her involuntarily until she delivers. However, this alternative seems morally unacceptable as an extreme and unwarranted intrusion on the woman’s freedom.

A physician who finds a mother’s refusal of treatment morally unacceptable because it infringes on the fetus’ rights faces a strikingly similar set of options. First, the physician can terminate his professional relationship with the pregnant woman. This will be morally permissible, however, only if the woman does not need medical care or if another physician is willing to assume immediate responsibility for the medical

49. See generally Nelson, Primum Utilis Esse: The Primacy of Usefulness in Medicine, 51 YALE J. BIOLOGY & MED. 655 (1978) (arguing that there are historical and philosophical reasons for replacing the first principle of medical ethics, “Do no harm,” with “Above all, be useful”).
care of the woman. Second, the physician can try to change the mother's mind, a morally acceptable course of action at least on its face. Indeed, a physician who ascribes personhood to the fetus at the time of the mother's refusal will probably feel morally obligated to try to convince her to change her mind.

However, persuasion may become unethical if it turns into coercion through the use of threats or misrepresentations. A physician faced with a pregnant woman's refusal of treatment might overemphasize, or misrepresent outright, her personal risks in refusing treatment in an effort to induce her to consent to the treatment. In addition, the physician might threaten the woman with legal action if she fails to consent. For example, the physician might tell the woman that he and the hospital can and will get a court order that will force her to accept the treatment unless she relents and accepts the treatment. A woman in this situation might grudgingly accept the treatment under the belief that she really has no choice in the matter.

For someone who firmly believes that the fetus has a moral status that gives it a right to life, threatening the mother with legal compulsion or lying to her may seem morally justified, perhaps even praiseworthy. Nonetheless, whatever one's perspective of the fetus' moral status, endorsing a physician's use of threats, lies, or misleading representations to bend a patient's will about the treatment decision is, at the very least, a morally dangerous professional ethic. The physician-patient relationship is founded upon trust and honesty, not deceit and coercion. As a competent, autonomous adult, the pregnant woman is ethically entitled to an honest explanation of her own and her fetus' medical situation and the limits of the medical knowledge about her case. If the facts that support treatment are as compelling as the physician believes them to be, the woman may well change her mind. The physician's moral obligation to the mother as a patient and a fellow human being require full and fair disclosure of her situation and forbid deceit intended to curtail her freedom.

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50. Abandoning the woman and leaving her without medical attendance is not unlike imprisoning the woman intending to abort: ethically, it is too extreme a response to a pregnant woman's refusal of treatment and looks too much like retribution. Moreover, a physician could be liable for malpractice if a woman suffered harm for lack of medical attendance.

51. Naturally, this type of conduct is difficult to document, but the authors have knowledge that this has happened on more than one occasion.

52. Those who believe that bombing abortion clinics is morally justified to protect fetal life, for example, are unlikely to have qualms about lying to, or threatening, a woman who is refusing treatment thought necessary to save the life or preserve the health of the fetus.

53. See S. Bok, LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE 238-42 (1978) (calling for respect and truthfulness from physicians to patients).
On some occasions, to be sure, there is too little time for the physician to remonstrate with the woman and still perform the treatment needed to protect the fetus. If this is the case, the physician’s choice is either to honor the woman’s refusal or to force treatment upon her. Although in one reported case a team of physicians took it upon themselves to force a pregnant woman to undergo treatment,\textsuperscript{54} such a choice is ethically questionable. First, by refusing treatment, the pregnant woman has chosen to put her interests or other values above the interests of the fetus. Given the lack of consensus about the moral status of the fetus and the proper resolution of the maternal-fetal conflict of interests, it is arbitrary to claim that the physician’s decision to protect the fetus, rather than to honor the pregnant woman’s decision to refuse treatment, is the morally correct choice. Forced treatment ignores the mother’s right to self-determination. It intrudes upon her bodily integrity and thus violates the fundamental moral principle that no one should invade or attack the body of another without consent—whether it is with a fist, a bullet, a drug, or a scalpel.

In addition, one who forces treatment upon an unconsenting adult is placing his judgment about this most intimate and personal matter above that of another, and is enforcing it with physical might. This course of action is morally presumptuous, if not perilous. Is it morally justifiable for someone to kidnap a dear friend who he fervently believes is about to enter into a disastrous and destructive marriage? Is it morally justifiable to stand in front of a movie theater which is showing pornography and physically prevent adults from entering, even to the point of assaulting them? These tactics are unacceptable, mainly because the use of physical power to enforce one’s moral convictions is too invasive of the rights of others and out of proportion to the “harm” that may be caused by the objectionable behavior. Moreover, the trust and confidence reposed in physicians by patients who may be weaker and vulnerable undermines any moral justification for the use of coercion or force.

A pregnant woman is in a unique situation. If a woman refusing medical treatment were not pregnant, only her interests would be directly at stake. During pregnancy, however, the woman literally encloses another being, the fetus, to which she is directly, physically, and intimately attached. What she does or fails to do can have an immediate physical effect on this other being in a manner truly singular in human experience.\textsuperscript{55} As long as the fetus remains within her, the pregnant wo-

\textsuperscript{54} See Jurow & Paul, supra note 39, at 597.
\textsuperscript{55} This is not to deny that what one person does can significantly affect another. A suicide can profoundly affect the deceased’s loved ones, even physically. Yet, no one other
man is connected to that being in a way that no other person is connected to any living person. In contrast, after the fetus is born and the two are separated, the mother could refuse life-saving treatment and leave the baby motherless, but she would not take her child to the grave with her.56

The unique physical relationship between a pregnant woman and her fetus complicates any resolution of the conflict between them. As the fetus' claim to receive medical treatment necessarily requires the invasion of the mother's body, the conflict between the two intensifies, and the consequences of resolving the conflict become much more serious. This same problem is not present when a parent refuses treatment of a living child.

Also, as in the few reported cases, the woman who refuses treatment often does so in the course of what otherwise appears to be a wanted pregnancy. This may lead the attending practitioners to question her motives. They might label her a "bad mother," or assert that she is being abusive of her "child," or is acting contrary to the natural bonds of affection between a mother and her soon-to-be-born child. A woman in this situation is likely to be viewed with suspicion and to be treated unsympathetically.

One might argue that, rather than imposing treatment pursuant to his own moral views, the physician should attempt to evaluate the woman's reasons for refusal and to determine whether they are sufficiently reasonable or weighty to prevail. Under this approach, however, it can be very difficult to distinguish a "good" reason from a "bad" one, or a "rational" choice from an "irrational" choice.57 More importantly, if the

than a pregnant woman (except, perhaps, Siamese twins) can, for example, drink poison and have that same poison directly cause the demise of another being. In short, although all human beings are connected to each other by emotional and spiritual bonds, a pregnant woman and her fetus are physically connected in a most intimate and unique fashion.

56. Once a fetus is born alive, its moral and physical relationship with its mother clearly changes. Medical treatment of a live-born infant no longer requires invasion of the mother's body, although treatment of the infant could still be performed against her will. The ethics of treating a live-born infant against its mother's wishes are significantly different than treating a pregnant woman's own body against her wishes. For a discussion elsewhere in this symposium of issues involved in withholding treatment from seriously impaired newborns, see Shapiro & Barthel, Infant Care Review Committees: A More Effective Approach, 37 HASTINGS L.J. 827 (1986); Smith, Disabled Newborns and the Federal Child Abuse Amendments: Tenuous Protection, 37 HASTINGS L.J. 765 (1986).

57. For example, how would one go about evaluating whether a Jehovah's Witness' refusal of a blood transfusion was rational or sensible? Jehovah's Witnesses believe that the Scriptures forbid "drinking blood" and that receiving a transfusion is the equivalent of "drinking blood." See Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 RUTGERS L. REV. 228 n.2 (1973); Ford, Refusal of
moral right of a competent adult to self-determination is to have any meaning, her reasons for choosing as she does must prevail over the opinion of someone else who views those reasons as insufficient or irrational. In short, it is not the nature of the woman’s reasons that should determine whether others must respect her ethical entitlement to choose or to reject treatment for herself and her fetus. Rather, it is the exercise of a competent adult’s freedom of choice that others should respect.

Deference to a pregnant woman’s choice regarding treatment is, in the end, less morally troubling than forced treatment against her will. Allowing the mother to prevail respects her personal dignity, preserves her bodily integrity, and allows her full exercise of her freedom of choice, although it potentially may entail harm to the fetus. Upholding the woman’s refusal avoids the hopeless and unprincipled task of deciding whether her refusal of treatment is “reasonable” or “acceptable” to the attending physician or to someone else. Finally, respecting the woman’s refusal not only avoids imposing a particular view of the moral status of the fetus in the face of profound moral uncertainty about that status, but also precludes the possibility that the woman will be treated prejudicially because of her perceived “callousness” toward the fetus.

Legal Dilemma of the Medical Practitioner

In addition to honoring the pregnant woman’s refusal of treatment or forcing treatment upon her, the attending physician and others involved in her care have a third option: they may seek a court order to compel the woman to undergo the treatment recommended to protect the fetus. As there is no affirmative legal duty to seek or obtain such an order, the decision to invoke the legal process must be made on other grounds. If a medical practitioner involved in a pregnant woman’s care firmly believes that her refusal is morally wrong, he may well feel morally compelled to seek a treatment order. The order, if granted, may avoid harm to the fetus and would provide legal protection for the practitioner administering treatment.

A court order avoids the legal risks inherent in performing the treatment over the pregnant woman’s objections and precludes a private individual from making the critical decision about forced treatment.

Blood Transfusions by Jehovah’s Witnesses, 10 CATH. LAW. 212, 213 (1964). There is no meaningful way to evaluate the reasonableness or merit of a belief in the authority of the Scriptures or of a judgment that receiving a blood transfusion is the equivalent of an activity prohibited by the Scriptures. For an excellent example of the intellectual morass awaiting a judge who attempts to analyze this belief of Jehovah’s Witnesses, see In re Clark, 21 Ohio Op. 2d 86, 89, 185 N.E.2d 128, 132 (C.P. Lucas County 1962).

58. See infra text accompanying notes 69-70.
However, it does not evade the ethical issues involved. The very decision to seek a court order implicates important moral values. If a physician or hospital seeks a judicial order compelling treatment, the pregnant woman's privacy will be invaded and her expectation of confidentiality about her medical treatment disregarded because the facts of her case will be disclosed, at least to the judge and his staff and perhaps to the general public as well.\(^{59}\) In addition, the patient would be thrust involuntarily into the legal system, required to obtain legal counsel if she is to be properly represented in any related legal proceeding, and forced to defend her choice at a time when she may be physically ill-disposed to do so as a result of her medical condition. Moreover, the litigation might have to be resolved within hours, not within years as with most other lawsuits.

Nevertheless, if the law arguably supports judicial compulsion of medical treatment in certain situations, it is difficult to characterize the choice to seek a judicial order as morally objectionable. One who sincerely believes a pregnant woman's refusal of treatment is tantamount to direct harm of another person may feel ethically obligated to use socially sanctioned means to prevent that harm. It is a serious matter for anyone to attempt to use the coercive power of the state to force his moral beliefs upon others, but in our society, the law frequently enforces morality.\(^{60}\)

In any event, the choice to seek a judicial order certainly involves competing moral values. These same moral values are at stake in, for example, the abortion decision, and in the very controversy that constitutes the subject of this article. The same lack of consensus that surrounds the moral status of the fetus and that supports a pregnant woman's right to

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59. The judicial proceeding challenging the woman's decisions could be held in camera or conducted pseudonymously in order to protect her identity from public discovery and to maintain the confidentiality of her medical situation. \textit{Cf.} Bossier City Medical Suite, Inc. v. City of Bossier City, 483 F. Supp. 633, 644 (W.D. La. 1980) ("The chilling effect of publicly airing so private a matter as the decision to terminate a pregnancy may well preclude a woman from seeking vindication of her constitutional rights. . . ." (citations omitted)). But it may become a public matter if the judge denies a request to protect the identities of the parties. Compare the proposal elsewhere in this symposium for the application of an invasion of privacy tort to private parties seeking to compel treatment of seriously impaired newborns in Vitiello, \textit{Baby Jane Doe: Stating a Cause of Action Against the Officious Intermeddler}, 37 HASTINGS L.J. 863 (1986).

60. See, e.g., Commonwealth v. Stowell, 389 Mass. 171, 449 N.E.2d 357 (1983) (constitutional right of privacy does not bar the criminal prosecution of consenting adults who commit adultery in private). \textsc{cal. penal code} § 227 (West Supp. 1986) (making fighting a duel and sending or accepting a challenge to fight a duel a crime); \textit{id.} § 597 (making cruelty to animals a crime); \textit{id.} § 647(c) (prohibiting persons from accosting someone in any public place for the purpose of begging or soliciting alms).
choose her interests over those of her fetus arguably supports the right of those who favor the fetus' interests to plead their case to a court of law.

In the final analysis, however, the controversy generated by a pregnant woman's refusal of treatment beneficial to her fetus, and perhaps critical to the fetus' life, is rarely going to be resolved as a "pure" moral decision. In practice, few physicians will force treatment on a competent pregnant woman in light of the serious legal consequences of such an act. Forcing a woman to undergo medical treatment, such as a Cesarean section, for the sake of the fetus would be a civilly actionable battery. Because battery is an intentional tort, the attending physician and any others who participated in treating the woman would be liable in compensatory damages for all harm proximately caused by the treatment, regardless of whether they intended the harm or performed the treatment in a nonnegligent manner. They would face the possibility of punitive damages as well. Furthermore, the physician's medical malpractice insurer may not be obligated to defend the physician or to pay any damages assessed because battery is an intentional, rather than a negligent, act. Consequently, any compensatory or punitive damages assessed could be the personal responsibility of the physician.

In addition to a battery action, the attending physician and others involved in compelling the treatment could be subject to civil actions for professional negligence, breach of confidentiality, invasion of privacy, or intentional infliction of emotional distress. If the pregnant woman were treated in a public hospital, the woman also might have a civil rights action against the physician, the hospital, and others involved in her care. Finally, it is not inconceivable that criminal battery charges

could be brought against the attending physician.66

In summary, the legal consequences of treating a competent adult pregnant woman against her will without a court order are so serious that a cautious attorney advising the physician or hospital could hardly recommend facing them. In light of these risks, it is not likely that many physicians or hospitals would treat a pregnant woman over her objection without judicial authorization, notwithstanding their moral beliefs. Consequently, as a practical matter, the maternal-fetal conflict probably will be resolved in one of two ways—either the physician will honor the pregnant woman’s wishes or the judicial system will determine whether to compel treatment.

The Law and Forced Treatment of Pregnant Women

Because of the serious risk of legal liability, few physicians or other health care practitioners will treat a competent pregnant woman against her will without a court order. A critical question arises as to whether the law supports the issuance of an order compelling a pregnant woman to undergo treatment for the sake of her fetus. If a physician can obtain such a judicial order, he presumably would be immune from civil or criminal liability for properly performing the authorized treatment.68 Although no court order absolutely immunizes the physician or other practitioners from any liability, it provides much greater legal protection than if the physician or other practitioners acted without such an order.

Because no statute, regulation, or judicial decision places an affirma-

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66. Assume a competent nonpregnant adult refused surgical amputation of a gangrenous limb after being properly informed of the risks of such a choice, and a surgeon who sincerely believed that the patient had made a wrong and irrational choice wheeled the protesting patient to the operating room, physically restrained the patient, placed her under general anesthesia, and cut off the diseased limb. Assume also that the disease had not endangered the patient’s life, but that it possibly might do so at some point in the future. This kind of interference with the person of another, though probably well-intentioned, seems to be the type of conduct that the criminal law generally is meant to deter and punish. There is no theoretical bar to bringing criminal battery charges against the surgeon in this hypothetical case or even homicide charges if the patient died as a result of the general anesthesia. A competent adult pregnant woman should not be denied the protection of the criminal law simply because she is carrying a fetus.

67. Clinicians face a different situation with a pregnant minor. If the minor is so young or immature that she cannot give or withhold informed consent to treatment, then she should be treated as if she were an incompetent adult. See supra note 1. However, if she is mature enough to understand the nature and consequences of her decisions regarding medical treatment, she may have the legal right to control her own medical fate. See CAL. CIV. CODE § 34.5 (West 1982) (minor has ability to consent to treatment for pregnancy on her own).

68. A physician may enjoy immunity from legal liability for actions taken pursuant to a court order, provided that he is not negligent in implementing the order. See In re Spring, 380 Mass. 629, 638-39, 405 N.E.2d 115, 122 (1980).
tive duty on physicians or other practitioners to seek a court order that would override the wishes of any competent adult patient, including a pregnant woman, it is unlikely that a practitioner could be held legally liable for honoring a pregnant woman's informed refusal of treatment.\textsuperscript{69} There is no reported case imposing civil damages or criminal penalties on any physician for failing to seek judicial review of a competent adult's refusal of treatment. In fact, courts have flatly rejected the notion that a physician could be held civilly or criminally liable for honoring a competent adult's refusal of medical treatment.\textsuperscript{70}

This section begins with the threshold question of when, if ever, courts have jurisdiction to consider a petition filed by a physician, a hospital, or some third party seeking a judicial order compelling treatment. Next, it analyzes the legal status of the fetus and the interests of the state in protecting the fetus. Finally, this section examines the legal interests of the pregnant woman who has refused treatment that may benefit her fetus.

### Jurisdiction

No state has a statute expressly granting any court jurisdiction over disputes concerning a pregnant woman's refusal of treatment when the refusal puts her fetus at risk of injury or death. All states, however, have statutes prohibiting child abuse and neglect.\textsuperscript{71} While definitions of child abuse and neglect vary among the states,\textsuperscript{72} parental failure to provide adequate medical care can constitute neglect.\textsuperscript{73} In addition, all states have statutes authorizing the state to assume the custody and control of a minor whose parents or guardian have endangered the minor's welfare

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\textsuperscript{69} To avoid possible malpractice liability, the attending physician must inform the patient of the risks and consequences of refusing treatment. Truman v. Thomas, 27 Cal. 3d 285, 292, 611 P.2d 902, 905, 165 Cal. Rptr. 308, 312 (1980).


\textsuperscript{71} For a complete list and analysis of these statutes, see Katz, Howe & McGrath, Child Neglect Laws in America, 9 Fam. L.Q. 1 (1975).

\textsuperscript{72} See, e.g., CAL. PENAL CODE § 11165(c)(2) (West Supp. 1986) ("general neglect" defined as failure of parent to make an informed and appropriate medical decision regarding a child's care after consultation with a physician who has examined the child); NEV. REV. STAT. § 201.090(3) (1983) (neglected child is any person under 18 years of age not provided with the necessities of life by its parents).

\textsuperscript{73} See, e.g., CAL. PENAL CODE § 270 (West Supp. 1986) (failure to furnish necessary medical attendance or other remedial care without lawful excuse is a crime); id. § 11165(c)(2) (child who does not receive specified medical treatment for religious reasons is not for that reason alone a neglected child).
by neglect or commission. Statutes allowing the state to assume custody and control of an endangered minor have been used as the jurisdictional basis for judicial orders compelling a pregnant woman to submit to treatment for the sake of her fetus.

The critical question with respect to child neglect statutes as a jurisdictional basis for judicial action in a case of maternal-fetal conflict is whether the fetus is a "child" within the meaning of the applicable statute. While child neglect statutes are intended to protect live-born children under the specified age of majority, only one expressly defines the term "child" to include a fetus. In all likelihood, legislators were not considering fetuses when they drafted child neglect statutes.

The lack of express legislative intent has led two appellate courts to conclude that fetuses are not within the scope of child neglect statutes. In In re Steven S., a California court of appeal held that an unborn fetus is not a "person" within the meaning of the statute conferring jurisdiction on the juvenile court to adjudge any "person under the age of 18 years" a dependent child of the court on certain specified grounds. While the mother was in the process of challenging her confinement in a psychiatric facility, the county sought to have her fetus declared a dependent child. The district attorney informed the juvenile court that, because of insufficient evidence that she was mentally ill, it would not attempt to keep the mother confined. The court then ordered the fetus, and hence the mother, detained pending its adjudication on the merits of the dependent child petition. Subsequently, the juvenile court sustained


77. Even those who tend to favor judicial intervention to protect the fetus admit this. See Myers, supra note 4, at 26.


79. Id. at 28-30, 178 Cal. Rptr. at 527-28; CAL. WELF. & INST. CODE § 300 (West Supp. 1986) ("Any person under the age of 18 years who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge that person to be a dependent child of the court: . . . Who is in need of proper and effective parental care or control."). Section 300 has been used as a jurisdictional basis for the state's challenge to a parent's refusal to consent to medical treatment of a child. In re Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979).

80. In Los Angeles, the Office of the County Counsel handles dependent child petitions, while the District Attorney's office litigates mental health cases.
the petition, and the mother's detention continued until she gave birth. At that time, she was released, the child was placed in a foster home, and the mother disappeared.

The court of appeal reversed and explained its holding by noting that previous decisions had not found fetuses to be "persons" within the meaning of various statutes and that when the legislature intended statutes to include fetuses, it said so explicitly. In light of these facts, the court declined to construe "section 300 to expand the meaning of the term 'person' to include an 'unborn fetus,'" and thus found the order of the juvenile court asserting jurisdiction over the unborn fetus lacking in statutory authority. The court also disapproved of the use of the juvenile proceedings to detain the mother for two months in circumvention of the state's mental health laws.

Similarly, in *In re Dittrick Infant*, a Michigan court of appeals held that the state juvenile code did not apply to unborn fetuses. In that case, a woman became pregnant while a proceeding against her for physical and sexual abuse of her children was pending. Prior to the birth, the probate court directed a state agency to take custody of the fetus pursuant to the juvenile code. The appellate court recognized that the word "child" could be "read as applying even to unborn persons," yet ultimately concluded "that the Legislature did not intend application of these provisions to unborn children."

In contrast, the Supreme Court of Georgia affirmed a juvenile court order giving a county social welfare agency temporary custody of a fetus as a "deprived child without proper parental care necessary for his or her physical health" after its mother refused a Cesarean section. Interest-
ingly, one justice noted in a concurring opinion that he believed “the legislature intended that the juvenile courts exercise jurisdiction only where a child has seen the light of day. I am aware of no ‘child deprivation’ proceeding wherein the ‘child’ was unborn.”88 Nonetheless, the justice found the trial court’s action to be a “proper exercise of its equitable jurisdiction with respect to both the mother and the fetus.”89

Irrespective of the applicability of the pertinent child neglect statute, a petitioner seeking compulsory treatment might simply invoke the court’s general equity jurisdiction. The equitable powers of the courts are commonly considered to be aimed at effecting justice among the parties and ordering that which in good conscience ought to be done to settle the dispute.90 In addition, equity is intended to grapple with novel cases and conditions.91 Accordingly, it would seem that many courts would be receptive to an appeal to their equity jurisdiction in order to hear the merits of a claim that a pregnant woman should be forced to accept medical treatment. In one reported decision, the court did not even directly address the jurisdictional question. It simply stated, “We are satisfied that the unborn child is entitled to the law’s protection. . . .”92

In addition, a petitioner could claim that a court has jurisdiction because of the state’s interest in the fetus pursuant to its parens patriae power.93 Parens patriae has been described as a “prerogative . . . inherent in the supreme power of every State. . . . [I]t is a most beneficent function, and often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves.”94 While the parens patriae power extends to the protection of

89. Id. at 92, 274 S.E.2d at 462 (citing Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (per curiam), cert. denied, 377 U.S. 985 (1964)). Raleigh Fitkin is discussed infra text accompanying note 92.
90. Times-Mirror Co. v. Superior Court, 3 Cal. 2d 309, 331, 44 P.2d 547, 557 (1935) (“Equity . . . will assert itself in those situations where right and justice would be defeated but for its intervention.”).
91. Id. (“Equity does not wait upon precedent which exactly squares with the facts in controversy. . . .”).
93. See generally Myers, supra note 4, at 22-23 (describing parens patriae power).
94. Mormon Church v. United States, 136 U.S. 1, 57 (1890).
live-born children, the question remains whether it also extends to the fetus.

In summary, a particular state’s child neglect law may or may not provide a jurisdictional basis for a petition seeking to compel a pregnant woman to undergo treatment, depending upon the court’s interpretation of the application of the law to fetuses. Irrespective of the child neglect law, a court may well find that general equity or parens patriae jurisdiction exists. In short, jurisdiction for petitions to compel treatment remains an open question, even in states such as California and Michigan. Furthermore, it is unlikely that many judges would dismiss a petition for compelled treatment on jurisdictional grounds without at least reviewing the merits of the dispute, particularly if it is characterized as a “life-or-death” matter by the petitioner’s counsel. Finally, the urgency of the situation may also lead judges to rule on the merits of a petition seeking compelled treatment even though the pregnant woman may be unrepresented and no true adversary hearing is held.

95. See Prince v. Massachusetts, 321 U.S. 158, 166-67 (1944) (state may pass child welfare laws even if such laws interfere with parental authority).

96. In light of the arguments set forth in this Article, the parens patriae power should be understood not to encompass unborn fetuses.

97. Some commentators have argued strongly that these laws should apply to fetuses. See, e.g., Myers, supra note 4, at 26-31. The major problem with this position is that legislatures most probably did not intend these statutes to pertain to fetuses. Id. at 26. Moreover, there is a critical difference between a fetus and a live-born child: to address the “abuse or neglect” of the former, the state must invade the mother’s body and liberty.

98. The trial court in In re Unborn Baby Wilson, No. 81-108 AV (Calhoun County P. Ct. Feb. 3, 1981), aff’d, No. 81-108 AV (Calhoun County P. Ct. Mar. 9, 1981), leave to appeal denied, No. 57436 (Mich. Ct. App. July 28, 1981), avoided In re Dittrick Infant, 80 Mich. App. 219, 263 N.W.2d 37 (1977), by distinguishing it in a less than convincing manner. The authors are aware by way of anecdote that at least one juvenile court in southern California has ruled, in spite of In re Stephen S., 126 Cal. App. 3d 23, 198 Cal. Rptr. 525 (1981), that an unborn fetus can be made a ward of the court under CAL. WELF. & INST. CODE § 300 (West Supp. 1986) and the mother can be forced to undergo treatment. The local child protective services agency apparently was instrumental in obtaining the juvenile court’s order in this case.

99. In an apparent emergency, with the fetus’ life and health at stake, and perhaps the mother’s as well, judges may be inclined to act quickly, though not necessarily correctly. “Judges are not terribly good at making emergency decisions.... It is inappropriate for judges to act impulsively, without benefit of reflection on past precedent and the likely future impact of their opinions.” Annas, supra note 4, at 17.

100. It is a violation of procedural due process for a court to order a pregnant woman to undergo treatment before a full and fair adversary hearing on the matter. See Boddie v. Connecticut, 401 U.S. 371, 374 (1971) (“Perhaps no characteristic of an organized and cohesive society is more fundamental than its erection and enforcement of a system of rules defining the various rights and duties of its members, enabling them to govern their affairs and definitively settle their differences in an orderly, predictable manner.”). As Professor Tribe has stated: [E]ven the most awful tortures, it must be remembered, can be cloaked with such clockwork logic that many become persuaded of their perverse justice. Turning square corners, then, must never become a substitute for respecting the humanity of
Legal Status of the Fetus Under the Common Law

For quite some time, the common law recognized fetuses as beings with certain legal rights or protections, particularly in the areas of property, criminal, and tort law. Blackstone noted that an "infant in ventre sa mere, or in the mother's womb, is supposed in law to be born for many purposes." At common law, a fetus could be named an heir to a decedent's estate, yet a fetus' property rights only vested upon live birth and if the inheritance inured to its benefit. This tradition has been maintained in modern American cases and in the Uniform Probate Code. Thus, property law does not confer the full rights of personhood upon the fetus. Instead, it creates a means of fulfilling the intentions of testators by protecting the right of a fetus to inherit property upon live birth.

Similarly, the criminal law did not give full legal recognition to the fetus. Historically, the criminal law did not recognize the killing of an unborn fetus as a homicide, considering the fetus to be a homicide victim only if it had been born alive. This rule has been adopted by

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*1 W. BLACKSTONE, COMMENTARIES *130; see Myers, supra note 4, at 4-6.

*2 1 W. BLACKSTONE, supra note 101, at *130 n.7.

*3 See, e.g., In re Peabody, 5 N.Y.2d 541, 547, 158 N.E.2d 841, 845, 186 N.Y.S.2d 265, 270 (1959) ("[A] child in ventre sa mere is not regarded as a person until it sees the light of day."); see also Roe v. Wade, 410 U.S. 113, 162 (1973).

*4 Relatives of the decedent conceived before his death but born thereafter inherit as if they had been born in the lifetime of the decedent." UNIFORM PROBATE CODE § 2-108 (1983).


*6 "Since at least the fourteenth century, the common law has been that the destruction of a fetus in utero is not a homicide . . . . The rule has been accepted as the established common law in every American jurisdiction that has considered the question." Commonwealth v. Cass, 467 N.E.2d 1324, 1328 (Mass. 1984) (citations omitted) (departing from the accepted rule and holding that viable fetus is a "person" for purposes of vehicular homicide statute).

*7 See, e.g., People v. Greer, 79 Ill. 2d 103, 111, 402 N.E.2d 203, 207 (1980) (A fetus is the victim of murder only if it is born alive and subsequently dies of the injuries inflicted by the assailant.); Hollis v. Commonwealth, 652 S.W.2d 61, 62 (Ky. Ct. App. 1983) (same).
the Model Penal Code as well.\textsuperscript{108} In a few jurisdictions, however, a fetus can be the victim of manslaughter\textsuperscript{109} or vehicular homicide.\textsuperscript{110}

The evolution of California’s criminal law regarding the killing of a fetus is a paradigm of the amorphous and unsettled legal status of the fetus. In \textit{Keeler v. Superior Court},\textsuperscript{111} the California Supreme Court decided that a viable fetus, though stillborn as the result of an assault upon its mother, was not a “human being” for purposes of the murder statute.\textsuperscript{112} Shortly after \textit{Keeler}, the California legislature amended this murder statute by adding “a fetus” to the list of possible murder victims.\textsuperscript{113} The omission of a legislative definition of a “fetus” was apparently intended to avoid political difficulties.\textsuperscript{114} However, the legislature did specify that the statute would not apply when death of a fetus resulted from an act “solicited, aided, abetted, or consented to by the mother of the fetus.”\textsuperscript{115} This provision differs dramatically from the traditional rule that consent is not a defense to murder.\textsuperscript{116}

Six years after \textit{Keeler} and the amendment of section 187, a California court of appeal interpreted the term “fetus” in the statute to refer only to a “viable unborn child” in \textit{People v. Smith}.\textsuperscript{117} The prosecution had unsuccessfully urged the court to interpret the term “fetus” to include any product of conception old enough to be correctly called a fetus rather than an embryo.\textsuperscript{118} The court declined to adopt this position:

Legally and factually, a non-viable fetus does not possess the capability for independent existence and has not attained the status of independent human life. Logically, one cannot destroy independent human life prior to the time it has come into existence. Until the capability for independent human life is attained, there is only the expectancy and potentiality for human life.\textsuperscript{119}

\textsuperscript{108} \textit{MODEL PENAL CODE} § 210.1(1) (1980).
\textsuperscript{109} See, e.g., State v. Willis, 457 So. 2d 959 (Miss. 1984) (willful killing of unborn quick child is chargeable as manslaughter, willful killing of mother is chargeable as murder, and charges do not merge).
\textsuperscript{111} 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970).
\textsuperscript{112} Id. at 631, 470 P.2d at 624, 87 Cal. Rptr. at 488.
\textsuperscript{113} \textit{CAL. PENAL CODE} § 187(a) (West Supp. 1986).
\textsuperscript{114} “The legislative history of the 1970 amendment ... suggests the term ‘fetus’ was left undefined and open to construction in order to ensure passage of the amendment in the face of divided legislative views about its meaning and intended purpose.” \textit{People v. Smith}, 59 Cal. App. 3d 751, 756, 129 Cal. Rptr. 498, 501 (1976) (citation omitted).
\textsuperscript{115} \textit{CAL. PENAL CODE} § 187(b)(3) (West Supp. 1986).
\textsuperscript{116} W. \textsc{LaFave} & A. \textsc{Scott}, \textit{HANDBOOK ON CRIMINAL LAW} 408 (1972).
\textsuperscript{118} The prosecution argued that a product of conception older than 12 weeks is a fetus. \textit{Id.} at 755, 129 Cal. Rptr. at 502-03.
\textsuperscript{119} \textit{Id.} at 756, 129 Cal. Rptr. at 502 (citing \textit{Roe v. Wade}, 410 U.S. 113, 162 (1973)).
Smith followed Roe v. Wade by defining "viability" as "capability for independent existence." The court read Roe v. Wade to rest on the rationale that "until viability is reached, human life in the legal sense has not come into existence. Implicit in Wade is the conclusion that as a matter of constitutional law the destruction of a nonviable fetus is not a taking of human life."

At common law, inducing the abortion of a "quick" fetus was a misdemeanor unless the operation was necessary to save the woman's life. If performed before quickening, an abortion was not a crime at common law for either the mother or the abortionist. A homicide was committed only if the quickened fetus was born alive and subsequently died of its prenatal injuries. Under an 1828 New York statute, aborting a prequick fetus was a misdemeanor, while aborting a quickened fetus could be punished as manslaughter. According to Roe v. Wade, a majority of states by the 1950s had banned all abortions regardless of whether the fetus was quick. Wade fundamentally changed the criminal law regarding abortions by preventing states from prohibiting the abortions of fetuses that had not yet reached the point of viability.

Changes in tort law over the last century have granted fetuses more extensive rights. Over one hundred years ago, the Massachusetts Supreme Judicial Court in Dietrich v. Inhabitants of Northampton denied recovery for the death of a four- to five-month-old fetus caused by

120. 410 U.S. 113 (1973).
122. 59 Cal. App. 3d at 757, 129 Cal. Rptr. at 502. Interestingly, in 1985 the California Legislature amended the Penal Code adding, five years to the sentence of a felon who, during the commission or attempted commission of a felony, injures a woman whom he knew or reasonably should have known to be pregnant and this injury results in the death of the fetus. CAL. PENAL CODE § 12022.9 (West Supp. 1986).
123. R. PERKINS & R. BOYCE, CRIMINAL LAW 188 (3d ed. 1982). The term "quickening" is defined as "[t]he signs of life felt by the mother as a result of the fetal movements, usually noted first in the fourth or fifth month of pregnancy." T. STEDMAN, STEDMAN'S ILLUSTRATED MEDICAL DICTIONARY 1183 (5th ed. 1982).
125. Id. at 426-28.
126. Id. at 441-53.
128. See Lenow, supra note 105, at 5-10.
injuries sustained when its mother slipped and fell. Justice Holmes noted that "as the unborn child was a part of the mother at the time of the injury, any damage to it which was not too remote to be recovered for at all was recoverable by [the mother]." The Dietrich rule provided the basis for a generally accepted rule that denied recovery for fetal injuries and conditioned recovery in a wrongful death action on the live birth of the fetus.

The Dietrich rule was uniformly followed for over half a century, until a federal district court in Bonbrest v. Kotz held that there may be recovery for tortious injury to a viable fetus subsequently born alive. Later cases discarded viability as a factor limiting liability for prenatal injuries and awarded damages for injuries incurred at any point in gestation if the fetus was born alive. Prosser noted that the demise of the Dietrich rule was "up till that time the most spectacular abrupt reversal of a well settled rule in the whole history of the law of torts."

Judicial recognition of a live-born child's right to recover damages for tortious prenatal injury does not mean that courts recognize unborn fetuses as persons with full legal rights. Instead, this practice focuses on the need for compensation of a living person wrongfully injured rather than on the legal status of the fetus. One commentator has explained this approach:

The fact that courts permit live born infants to recover damages for prenatal injuries does not mean that courts view the unborn as 'persons.' Instead, the courts are interested in protecting the interests of the damaged live born person. The courts are not compensating fetuses but are instead compensating children who need special medical treatment, schooling, or other services because of the acts of some tortfeasor. The point in the pregnancy when those acts occur does not serve to deflect the courts from their rightful goal of compensating the injured child. This is most strongly indicated by those courts that permit recovery for preconception wrongful acts.

130. Id. at 15.
131. Id. at 17.
132. Summerfield v. Superior Court, 144 Ariz. 467, 474, 698 P.2d 712, 719 (1985) (en banc); Myers, supra note 4, at 6-7.
134. Id. at 142.
136. PROSSER & KEETON, supra note 62, at 368.
Decisions recognizing this "rightful goal" of compensating the live-born child have been misinterpreted as granting a fetus broad rights it does not, and should not, possess. For example, when the New Jersey Supreme Court in *Smith v. Brennan*\(^{138}\) recognized a child's cause of action for negligently inflicted prenatal injury,\(^{139}\) the court stated:

There is no question that conception sets in motion biological processes which if undisturbed will produce what every one will concede to be a person in being. If in the meanwhile those processes can be disrupted resulting in harm *to the child when born*, it is immaterial whether before birth the child is considered a person in being. And regardless of analogies to other areas of the law, justice requires that the principle be recognized that a child *has a legal right to begin life with a sound mind and body*.\(^{140}\)

The Michigan Court of Appeals has echoed the statement that "a child has the right to begin life with a sound mind and body."\(^{141}\)

One commentator has attributed this same "right" to fetuses and suggested that it justifies state intervention to protect fetuses who might be harmed by maternal "abuse" or "neglect," for example, by a refusal of medical treatment beneficial to the fetus.\(^{142}\) One state trial court has re-


\(^{139}\) *Id.* at 364-68, 157 A.2d at 503-05.

\(^{140}\) *Id.* at 364, 157 A.2d at 503 (emphasis added).

\(^{141}\) Grodin v. Grodin, 102 Mich. App. 396, 400, 301 N.W.2d 869, 870 (1981) (permitting a son to proceed in a negligence action against his mother for prenatal injury); see Womack v. Buchhorn, 384 Mich. 718, 725, 187 N.W.2d 218, 222 (1971) (permitting negligence action by eight-year-old against third party for prenatal injury). At least one court has refused to recognize any right to begin life with a sound mind and body. Becker v. Schwartz, 46 N.Y.2d 401, 411, 386 N.E.2d 807, 812, 413 N.Y.S.2d 895, 900 (1978) ("There is no precedent for recognition . . . of 'the fundamental right to be born as a whole, functional human being'. . .") (quoting Park v. Chessin, 60 A.D.2d 80, 88, 400 N.Y.S.2d 110, 114 (1977)). Other cases have utilized the purported "right" of a child to begin life "with a sound mind and body" in contexts other than damage claims for personal injuries. See *In re Baby X*, 97 Mich. App. 111, 115, 293 N.W.2d 736, 738-39 (1980) (prenatal conduct of mother detrimental to fetus relevant in child neglect proceeding); Hoener v. Bertinato, 67 N.J. Super. 517, 525, 171 A.2d 140, 144 (Juv. & Dom. Rel. Ct. 1961) (prospectively authorizing blood transfusions to be administered to a child after birth despite religious objections from the parents); *In re Sampson*, 65 Misc. 2d 658, 669, 317 N.Y.S.2d 641, 652 (N.Y. Fam. Ct. 1970) (authorizing surgery for a minor whose mother opposed administration of blood transfusions incident to the surgery); *In re Clark*, 21 Ohio Op. 2d 86, 89, 185 N.E.2d 128, 132 (C.P. Lucas County 1962) (authorizing three-month-old infant suffering from burns to receive blood transfusions over the parents' religious objections). These cases are subject to the same criticism that there is no such right in the literal sense. Nonetheless, one commentator has claimed that these cases support the proposition that a fetus possesses a right to gestation undisturbed by wrongful injury. Myers, *supra* note 4, at 60.

\(^{142}\) Myers, *supra* note 4, at 60, 64.
lied on this purported right to justify compelling a diabetic woman to accept all medical treatment, including insulin by injection, necessary in the judgment of her physician to protect the fetus from harm.\(^\text{143}\) This court found that the fetus was a "child," for jurisdictional and substantive purposes, within the meaning of Michigan's child abuse and neglect statute. The decision was "most compelled by the legal premise... that a child has a legal right to begin life with a sound mind and body" and ordered that the mother accept medical treatment for the benefit of the fetus.\(^\text{144}\)

The *Smith v. Brennan* decision, often considered the source of the purported "right" of a fetus to "begin life with a sound mind and body," plainly does not establish such a literal right. Rather, *Smith* recognized that a live-born child has a right to recover damages for injuries wrongfully inflicted upon it prior to birth.\(^\text{145}\) This holding does not mean that a *fetus* has any particular rights. Faced with an injured, live-born child, the *Smith* court expressly recognized that it was "immaterial whether before birth the child is considered a person in being" that would have legal rights that could be violated.\(^\text{146}\) To claim that *Smith* stands for the proposition that everyone owes a duty to a fetus to ensure that it is born "with a sound mind and body" is to stretch the holding beyond recognition.\(^\text{147}\) *Smith* clearly did not intend to expand dramatically the rights of

\[\text{143. In re Unborn Baby Wilson, No. 81-108 AV (Calhoun County P. Ct. Feb. 3, 1981), aff'd, No. 81-108 AV (Calhoun County P. Ct. Mar. 9, 1981), leave to appeal denied, No. 57436 (Mich. Ct. App. July 28, 1981). Although the basis for the court's ruling is unclear, another Michigan trial court has apparently followed *Wilson*'s rationale and ordered a woman to undergo Cesarean section for the benefit of her fetus. In re Baby Jeffries, No. 14004 (Jackson County P. Ct. May 24, 1982). *Jeffries* is a notable case for two reasons. First, Judge Sill ordered the local police to transport Mrs. Jeffries to a hospital and ordered her to admit herself to the hospital. Id. slip op. at 1. Second, the Jeffries family fled the state the day after the order was issued, and Mrs. Jeffries delivered a healthy baby vaginally without incident some three weeks later. Detroit Free Press, June 29, 1982, at A3, col. 3.}


\[\text{146. Smith, 31 N.J. at 364, 157 A.2d at 503.}

\[\text{147. Nonetheless, Professor Robertson has suggested that the law is not precluded from imposing on the woman who foregoes an abortion "a duty to assure that the fetus is born as healthy as possible." Robertson, supra note 7, at 352. He supports this suggestion by postulating that general principles of civil and criminal liability could permit damage actions and criminal prosecutions against a mother who chooses to forego treatment beneficial to her fetus. Id. at 352-33. No reported case, however, holds that a mother or father has "a duty to assure that the fetus is born as healthy as possible." The criminal law typically has rejected the proposition that a woman can be criminally prosecuted on the ground that she either failed to}
a fetus in such a fashion.

Furthermore, there is no historical or precedential basis for granting a fetus a legally enforceable right to begin life physically and mentally intact. There is no case which holds that a live-born person, much less a fetus, has a right to be healthy or to receive health care from the state or from any private party. Moreover, simply asserting that a fetus has a "right" to be born healthy is an insufficient reason for forcing a mother to receive medical treatment against her will and in derogation of her rights to bodily integrity, privacy, self-determination, and perhaps to religious freedom as well. These rights of the mother are far better grounded in both common and constitutional law than any supposed right of a fetus to be born healthy.

As in personal injury tort law, the rights of a fetus under wrongful death statutes have evolved over the years. At one time, virtually all jurisdictions required live birth as a prerequisite to recovery in an action for the injury or wrongful death of a fetus.148 Two justifications for this rule emerge from the cases. First, the defendant could owe no duty of
care to a person who was not in existence at the time of his conduct. Second, causation between conduct and injury was too difficult to prove. At present, the majority rule followed in thirty-one states and the District of Columbia recognizes a cause of action for wrongful death when a viable fetus is stillborn as a result of a wrongful act. A minority of states allow such an action only if the fetus is live-born. The Arizona Supreme Court has explained the majority view:

The majority rule... acknowledges that the common law has evolved to the point that the word "person" [as found in a wrongful death statute] does usually include a fetus capable of extrauterine life.

The majority finds no logic in the premise that if the viable infant dies immediately before birth it is not a "person" but that if it dies immediately after birth it is a "person."
The United States Supreme Court in *Roe v. Wade* implied that its holding was not inconsistent with the majority rule\(^{153}\) because of its view of the purpose of wrongful death actions involving a fetus. *Wade* characterized the aim of wrongful death actions for prenatal injuries as "vindicat[ing] the parents' interest [rather than the fetus', which is] consistent with the view that the fetus, at most, represents only the potentiality of life,"\(^{154}\) and is not a person in the whole sense.

Based on the law of property, crimes, and torts, several conclusions can be drawn about the fetus. First, and most important, a fetus is not a person under the law.\(^{155}\) Nonetheless, the law undeniably recognizes that the fetus has certain rights, such as inheritance, and is entitled to certain protections, such as a right of recovery, if born alive, for prenatal injury.\(^{156}\) Yet the recognition of some legal protections does not transform a fetus into a person with full legal rights, just as the limited legal protections extended to animals and human corpses do not transform them into persons.\(^{157}\)

Second, the legal status of the fetus is determined largely by the purposes of the particular law in question, rather than by a particular philosophical view of fetal "personhood." Accordingly, the legal capacity of an unborn fetus, if born alive, to inherit property is better understood as a way to fulfill the intentions of the testator, a goal of inheritance law, than as recognition of fetal personhood. Similarly, treatment of the unborn by the common law of crimes "reflects a judgment that the society of the time considered the killing of a fetus to be less blameworthy than the killing of a man, and the killing of a fetus that had not yet displayed a separate personality within the mother to be less blameworthy than the killing of one which had."\(^{158}\) Modern society has made similar judgments about the significance of killing a fetus. A fetus usually cannot be

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154. *Id.* at 162.
156. "For some purposes, the fetus is a person. For some, it is not. The stage at which it is granted personhood varies from one area of law to another." Baron, *If You Prick Us, Do We Not Bleed?*: Of Shylock, Fetuses, and the Concept of Person in the Law, 11 LAW MED. & HEALTH CARE 52, 55 (1983). It seems more accurate to say that the law does not recognize fetuses as persons but does grant them certain protections than to say that for some legal purposes it is a person and for other purposes it is not.
157. *See*, e.g., CAL. HEALTH & SAFETY CODE § 7052 (West 1982) (mutilating, disinterring, or removing from the place of interment any human remains is a crime); CAL. PENAL CODE § 597 (West 1982) (making cruelty to animals a crime); *Id.* § 642 (making theft of any article of value from a dead human body a crime). It is implausible to claim that these protections make animals or human corpses "persons."
the victim of a homicide unless it is born alive. In jurisdictions in which it is a criminal act to kill a fetus, the punishment is less than that for killing a live-born person. In some states, if the mother aids in or consents to the killing, no murder is committed. In the context of tortious conduct, the law attempts to compensate the innocent victims of injury. To serve this purpose, it is logical to allow a live-born fetus to recover damages for prenatal tortious injuries, or to allow the parents to recover if deprived of a child they wanted.

In short, the variable legal treatment of a fetus is explained and justified by the particular social policies underlying different areas of law. A corporation receives similar treatment; it is a "person" within the meaning of the equal protection clause of the fourteenth amendment, but not a "person" for purposes of the fifth amendment's prohibition against self-incrimination. Similarly, a fetus may or may not possess legal protections, depending on the legal context and the social policies at stake. Consequently, despite appearances, the inconsistency in the legal treatment of a fetus is not pernicious or arbitrary; it simply reflects social values and policies taken into account by lawmakers.

The Constitutional Status of the Fetus and the State's Interest in the Fetus

The Supreme Court's decision in Roe v. Wade is the fundamental source of the law governing not only the constitutional status of the fetus, but also the scope and limits of the state's interests in the fetus and the power of the state to intervene in a woman's choice to terminate her pregnancy. In Wade, the Court stated "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Following Wade, some lower federal courts held that a fetus is not a person with

159. See supra notes 106-27 & accompanying text.
160. See, e.g., State v. Willis, 457 So. 2d 959, 960 (Miss. 1984) (The killing of a mother with malice aforethought is murder, and the resulting fetal death is manslaughter.)
162. Baron, supra note 156, at 55.
164. Baron, supra note 156, at 53-56.
166. Id. at 158. The reason for so holding is that the contrary result might deny altogether the right of a pregnant woman to take her fetus' life by aborting it. "If this suggestion of personhood [for the fetus under the fourteenth amendment] is established, [the mother's] case,
standing to sue for deprivation of constitutional rights, privileges, and
immunities or for federal civil rights violations.\textsuperscript{167} One such federal dis-
trict court declared that, under \textit{Wade}, "fetal life has no constitutional
rights or protection."\textsuperscript{168} On the other hand, \textit{Wade} provides that a preg-
nant woman possesses a "right of privacy" that is "broad enough to en-
compass [her] decision whether or not to terminate her pregnancy."\textsuperscript{169} Although fundamental, this right is not absolute and unqualified and is
limited by certain state interests.\textsuperscript{170}

Despite its conclusion that a fetus is not a person for purposes of the
fourteenth amendment, the Court in \textit{Wade} held that the state nonetheless has an "important and legitimate interest in protecting the potential-
ity of human life" that is separate and distinct from the state's interest in
preserving and protecting the health of the pregnant woman.\textsuperscript{171} These
two state interests become "compelling" at different points during preg-
nancy: the latter at the end of the first trimester, at which point maternal
mortality in abortion may exceed that in normal childbirth, and the for-
mer at the end of the second trimester, at which point the fetus is pre-
sumed capable of "meaningful life" outside the womb.\textsuperscript{172}

Consequently, even though the fetus is not a person under the four-
teenth amendment and has only the "potential" for human life, the Con-
stitution permits a state to regulate and even forbid abortions after the
fetus becomes presumptively viable—except when abortion is "necessary

\textsuperscript{167} See, e.g., Harman v. Daniels, 525 F. Supp. 798, 800-01 (W.D. Va. 1981) (fetus not a
person within fourteenth amendment); Poole v. Endsley, 371 F. Supp. 1379, 1382 (N.D. Fla.
1974) (fetus not a person within fourteenth amendment), aff'd in part mem., 516 F.2d 898 (5th
Cir. 1975); McGarvey v. Magee-Womens Hosp., 340 F. Supp. 751, 754 (W.D. Pa. 1972) (de-
ferred question to legislature), aff'd, 474 F.2d 1339 (3d Cir. 1973). Contra Douglas v. Town
of Hartford, 542 F. Supp. 1267, 1270 (D. Conn. 1982) (citing expansion of state law rights of
viable fetus).


\textsuperscript{169} \textit{Wade}, 410 U.S. at 153.

\textsuperscript{170} Id. at 162-63.

\textsuperscript{171} Id. at 162.

\textsuperscript{172} The Court stated:

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 mother's womb. State regulation protec-
tive of fetal life after viability thus has both logical and biological justifications. If the
State is interested in protecting fetal life after viability, it may go so far as to pro-
scribe abortion during that period, except when it is necessary to preserve the life or
health of the mother.

\textit{Id.} at 163-64.
to preserve the life or health of the mother.”

Wade’s statement about the compelling interest of the state in protecting fetal life at the point of viability has been cited frequently as authority for compelling a pregnant woman to undergo medical treatment for the sake of her fetus. For example, the Georgia Supreme Court relied in part on Wade when it upheld a trial court’s order compelling a pregnant woman to submit, despite religious objections, to a Cesarean section to save the life of the fetus. This case, then, appears to reflect a judicial readiness to construe Wade as authorizing forced medical treatment to protect the potential life of a viable fetus. Commentators also have relied upon Wade to buttress arguments in favor of state intervention to protect the fetus. Professor Myers favors an expansive interpretation of Wade’s language regarding the state’s interest in protecting potential life:

While the fetus is not a ‘person’ entitled to fourteenth amendment protection, Wade makes clear that the state has substantial authority to protect fetal life.

The state’s interest in viable fetal life permits it to forbid abortion, an act designed to extinguish life. It follows from this that the state is empowered to proscribe other acts calculated or likely to lead to the same result. Furthermore, since the interest in preservation of fetal life authorizes intervention to prevent destructive acts, it should also authorize limited compulsion of action which is necessary to preserve fetal life. Since a failure to act can as surely lead to frustration of the state’s interest as an affirmative act, the underlying state interest must reach both cases.

Professor Robertson has noted that if a state has prohibited abortions after viability pursuant to Wade, a woman carrying a fetus with a congenital defect “might be required to have the in utero surgery [to correct the defect], or be subject to criminal and civil penalties for not employing a therapy that would prevent the birth of a dead or handicapped child.”

173. Id.
175. Myers, supra note 4, at 18 (footnotes omitted).
176. Robertson, supra note 7, at 350 (footnote omitted). In a footnote to this statement, Professor Robertson asserts, with no citation to authority or further analysis, that if such a woman refused the surgery and the fetus died, “she could be prosecuted under state feticide or abortion laws.” Id. at 350 n.82.
The fallacy in this reliance on \textit{Wade} is both fundamental and serious. While it is true that \textit{Wade} recognized the state's compelling interest in protecting fetal life by banning abortion after viability, \textit{Wade} also placed a critical limit on the exercise of this interest: "[The state] may go so far as to proscribe abortion during [the third trimester], \textit{except when it is necessary to preserve the life or health of the mother}.") As a matter of constitutional law, then, the state's interest in protecting fetal life is not so compelling as to be absolute. Rather, this interest is limited by the mother's right of privacy and by her own interests in the preservation of her own life and health. In other words, the state lacks the constitutional power to prohibit abortion of a viable fetus if abortion is "necessary to preserve [maternal] life or health." Consequently, it is simply wrong to assert that \textit{Wade} grants the state unqualified authority to protect the fetus or an unlimited power to prohibit abortions after viability.

\textit{Wade} itself does not fully explain this limitation on the state's interest in fetal life and on its ability to ban post-viability abortions. However, in \textit{United States v. Vuitch}, the Court rejected a vagueness challenge to a statutory requirement that an abortion must be "necessary

\begin{itemize}
\item \textit{Wade}, 410 U.S. at 163-64 (emphasis added); see Hollis v. Commonwealth, 652 S.W.2d 61 (Ky. 1983) (The killing of a viable fetus does not support a murder conviction unless the child dies after live birth.). The Hollis court stated:

\begin{quote}
Viewed in the context of \textit{Roe}, Kentucky has a "compelling" interest in the life of the fetus when it reaches the stage of viability sufficient to legislate legal sanctions punishing those who destroy it, subject to the limitations that such sanctions shall not apply where the life or the health of the mother is involved.
\end{quote}

\textit{Id.} at 63.
\item \textit{Wade}, 410 U.S. at 163-64. The number of post-viability abortions purportedly performed for the preservation of the mother's life or health as sanctioned by \textit{Wade} is unknown. Statistics from the Centers for Disease Control indicate that abortions in the latter stages of pregnancy are rare: in 1980, less than one percent of the 1.6 million abortions performed nationwide were done on women pregnant more than 21 weeks. N.Y. Times, Feb. 15, 1984, at B4, col. 5. There are a number of possible reasons that physicians avoid either performing abortions near or after viability or publicly discussing these abortions. First, the medical risks to the mother increase substantially as the pregnancy advances. Rhoden, \textit{The New Neonatal Dilemma: Live Births from Late Abortions}, 72 GEO. L.J. 1451, 1455 (1984). Second, although other methods of abortion commonly used near the point of viability are highly feticidal, the administration of the abortifacient prostaglandin can result in live births that raise a host of agonizing legal and ethical questions about treating the abortus. \textit{Id.} at 1454-61, 1466-90; N.Y. Times, Feb. 15, 1984, at B4, col. 1. Third, and perhaps of more significance, physicians are understandably reluctant to risk criminal prosecution for performing a post-viability abortion. This reluctance is particularly understandable given the lack of clarity about when such an abortion may be "necessary" to preserve the health of the mother. Cf. Commonwealth v. Edelin, 371 Mass. 497, 510-17, 359 N.E.2d 4, 11-14 (1976) (difficult factual issues of viability and live birth). In any event, physicians in fact do often avoid performing abortions near the point of viability. N.Y. Times, Feb. 15, 1984, at B4, col. 1.
\item 402 U.S. 62 (1971).
\end{itemize}
for the preservation of the mother's life or health." 180 Similarly, in Doe v. Bolton, 181 the companion case to Wade, the Court did not find unconstitutionally vague a statutory requirement that a physician determine on the basis of his "best clinical judgment" that an abortion is "necessary." 182 According to a later case, both of these challenges failed because these statutory requirements had been "interpreted to allow the physician to make his determination in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the [mother]." 183 In short, the state must leave the physician free to analyze a broad range of factors when determining whether an abortion during the third trimester is "necessary to preserve the life or health of the mother." As the Third Circuit has noted: "It is clear from the Supreme Court cases that 'health' is to be broadly defined." 184

Colautti v. Franklin 185 further illuminates the limits on the state's ability to regulate abortions after viability. There, the Court found section 5(a) of the Pennsylvania Abortion Control Act 186 unconstitutionally vague. 187 Section 5(a) required a physician performing an abortion to adopt the abortion technique providing "the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother." 188 The Court criticized this portion of the statute because it did not "clearly specify... that the woman's life and health must always prevail over the fetus' life and health when they conflict." 189 The Court disapproved of the use of the word "necessary" in the statute because it "suggest[ed] that a particular [abortion] technique must be indispensable to the woman's life or health—not merely desirable—before it may be adopted." 190 Citing Vuitch and Bolton, the Court also noted that the statute did not imply "that all factors relevant to the welfare of the wo-

180. Id. at 71-72.
182. Id. at 191-92.
183. Colautti v. Franklin, 439 U.S. 379, 394 (1979). Colautti expressly noted that the Court in Bolton "found it critical" that the physician's best clinical judgment "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." Id. at 387-88 (citing Bolton, 410 U.S. at 192).
188. See supra note 186.
189. Colautti, 439 U.S. at 400 (emphasis added).
190. Id.
man may be taken into account by the physician in making his decision" regarding abortion technique. Based upon this analysis, the Court concluded:

Consequently, it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties, that we do not address, lurk behind this ambiguity. We hold only that where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions.

Thus, Colautti suggested that the state is constitutionally barred from utilizing the criminal law to require a physician performing an abortion to place the interests of the fetus above those of the mother. The Colautti Court clearly stated that "the woman's life and health must always prevail over the fetus' life and health when they conflict" as a matter of constitutional law in the context of an abortion.

The Court in Colautti gave little attention to the "constitutional difficulties" lurking in the Pennsylvania abortion statute that appeared to require a physician to place the medical interests of the fetus above those of the mother. However, subsequent challenges to the constitutionality of the Pennsylvania abortion laws provided the federal courts with additional opportunities to resolve these difficulties. For example, in American College of Obstetricians & Gynecologists v. Thornburgh, the Third Circuit reviewed parts of Pennsylvania's amended Abortion Control Act, including section 3210(b), which required the use in post-viability abortions of the method most likely to result in the fetus being "aborted alive," unless that procedure would result in a "significantly greater" risk to the mother. Noting Colautti's holding that the former statute impermissibly required the physician to "make a 'trade-off' between the woman's health and . . . fetal survival," Thornburgh struck down section 3210(b) because it, "like the old [statute], failed to require that maternal health be the paramount consideration." Because it was not susceptible to a construction "that does not require the mother to bear an in-

191. Id.
192. Id. at 400-01 (emphasis added).
193. Id. at 400.
194. Id.
196. 18 PA. CONS. STAT. ANN. §§ 3201-3220 (Purdon 1983).
197. Thornburgh, 737 F.2d at 300 (quoting 18 PA. CONS. STAT. ANN. § 3210(b) (Purdon 1983)).
198. Thornburgh, 737 F.2d at 300 (emphasis added).
creased medical risk to save her viable fetus,” the court held section 3210(b) unconstitutional.199

In sum, Wade, as clarified by Vuitch, Bolton, and Colautti, stands for the proposition that a woman’s constitutional right of privacy requires a state to allow a physician to consider a wide range of factors when determining whether an abortion of a viable fetus is necessary to preserve maternal life or health. Underlying this rule is the assumption that, incident to her right of privacy, a woman’s interests in the preservation of her life and health are superior to the state’s compelling interest in preserving fetal life. Colautti and Thornburgh make this assumption explicit: a state is constitutionally required to frame its abortion laws so that the woman’s health is paramount over the fetus’ survival. Even though the state’s interest in protecting fetal life becomes compelling at viability, this interest is not sufficiently compelling under the Constitution to support a statutory requirement that the mother bear any increased risk to her health in order to save her viable fetus.

Accordingly, it is mistaken to claim that Wade recognizes a state’s interest in a viable fetus that permits it to force a pregnant woman to accept treatment for the sake of her fetus, at least when the treatment poses risks to the mother that she would not otherwise face. In fact, Wade and its progeny direct that the pregnant woman’s interest in her life and health “must always prevail” over that of the fetus when they conflict in the abortion context. In light of these holdings, if these interests directly conflict in a nonabortion context that implicates a woman’s constitutional right of privacy, the state would be constitutionally bound to place the woman’s life and health above that of the fetus. In fact, as discussed below, a woman’s constitutional right to privacy as well as other fundamental and important legal rights are at stake when she is faced with the prospect of state-compelled medical treatment for the sake of the fetus.

The Legal Rights of the Pregnant Woman

The common law has long recognized that each individual has the right to control his own person and a concomitant right to be free from nonconsensual invasions of bodily integrity. At ancient common law, the action of trespass was criminal in character and “directed at serious and forcible breaches of the King’s peace.”200 Later, courts began awarding damages in trespass to injured plaintiffs who did not need to prove either

199. Id.
200. PROSSER & KEETON, supra note 62, at 29.
actual damage or fault on the part of the defendant since "the invasion of
the plaintiff's rights was regarded as a tort in itself." Later, the tort of
battery was recognized as the means of vindicating the interest in free-
dom from intentional and unpermitted bodily contact. Like the ancient
action for trespass, "[p]roof of the technical invasion of the integrity of
the plaintiff's person by even an entirely harmless, but offensive, contact
entitle[d] the plaintiff to vindication of [his] legal right by an award of
nominal damages."

The rights to control one's own person and to be free from un-
wanted bodily invasions are fundamental to the structure of our political
and social system. "Under a free government, at least, the free citizen's
first and greatest right, which underlies all others—the right to the invio-
lability of his person; in other words the right to himself—is subject to
universal acquiescence ... ."

Almost one hundred years ago, the Supreme Court acknowledged the fundamental nature and importance of
these rights:

No right is held more sacred, or is more carefully guarded, by the
common law, than the right of every individual to the possession and
control of his own person, free from all restraint or interference of
others, unless by clear and unquestionable authority of law. As well
said by Judge Cooley, "The right to one's person may be said to be a
right of complete immunity: to be let alone."

This language is not hyperbole. Our political and social system is
founded upon the premises that the individual should have a great deal of
control over his person and that society should protect individuals from
unwanted physical assaults. The right to control one's body is, of course,
like all rights, subject to limitation by certain state interests.

The common-law right to bodily integrity underlies the doctrine of
informed consent to medical treatment. At common law, it was recog-
nized that every person "of adult years and sound mind has a right to
determine what should be done with his own body; and a surgeon who

201. Id. at 30.
202. Id. at 40.
203. Mohr v. Williams, 95 Minn. 261, 268, 104 N.W. 12, 14 (1905), overruled on other
grounds, Genzel v. Halvorson, 248 Minn. 527, 80 N.W.2d 854 (1957).
204. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891). Wade refers to Botsford as the
first in a line of cases in which "the Court has recognized that a right of personal privacy, or a
guarantee of certain areas or zones of privacy, does exist under the Constitution." Wade, 410
U.S. at 152.
205. "We recognize that under certain circumstances the common-law right [to bodily
integrity] may have to yield to superior State interests ... . The State has a legitimate interest
in protecting the lives of its citizens. It may require that they submit to medical procedures in
order to eliminate a health threat to the community." In re Storar, 52 N.Y.2d 363, 377, 420
performs an operation without his patient's consent commits an assault, for which he is liable in damages.\textsuperscript{206} Until modern times, however, there was no requirement that the physician inform the patient about the nature, risks, and consequences of the treatment for which his consent must be sought. Now, the patient must give an informed consent and so has the right to receive information about the proffered treatment, its risks and benefits, and alternatives to enable the patient to make a meaningful choice.\textsuperscript{207}

The United States Constitution, as well as the common law, protects the individual's right to bodily integrity. A number of courts have expressly recognized that the constitutional right of privacy protects the individual's bodily integrity. For example, in \textit{Superintendent of Belchertown State School v. Saikewicz},\textsuperscript{208} the Massachusetts Supreme Judicial Court stated:

Of even broader import [than the common law regarding bodily integrity], but arising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy . . . . As this constitutional guaranty reaches out to protect the freedom of a woman to terminate her pregnancy under certain conditions . . . , so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances.\textsuperscript{209}

The individual can "choose to reject, or refuse to consent to, intrusions of..."
his bodily integrity,” such as medical treatment. Additionally, the fourteenth amendment protects the “right to be free from . . . unjustified intrusions on personal security.” Furthermore, the fourth amendment protects “the individual’s legitimate expectations that in certain places and at certain times he has ‘the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.’” Accordingly, the function of the fourth amendment “is to protect personal privacy and dignity against unwarranted intrusion by the State.”

All of these constitutional protections for the right to bodily integrity have their limits. The right of privacy as exercised in a refusal of medical treatment may give way to state interests in the preservation of life, the prevention of suicide, the protection of innocent third parties, and maintaining the ethical integrity of the medical profession. The liberty interests secured by the fourteenth amendment can be reasonably restricted for the common good. The community’s interests in securing evidence of crime and in fairly and accurately determining guilt or innocence are of “great importance” and may outweigh the individual’s “personal privacy and bodily integrity.”

A competent pregnant woman who refuses treatment that may be medically necessary to preserve the life or health of the fetus she carries has a strong personal interest in her bodily integrity. She has the same common-law and constitutional rights as a nonpregnant competent wo-

213. Schmerber v. California, 384 U.S. 757, 767 (1966) (extraction of blood from drunk driving suspect against his will not a violation of fourth amendment when facts establish probable cause and there was no time to secure a search warrant); cf. Winston v. Lee, 105 S. Ct. 1611, 1615-16 (1985) (surgical removal of bullet from suspect’s chest violated his fourth amendment rights).
215. The Supreme Court has stated:
[T]he liberty secured by the Constitution . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly free from restraint. . . . “The possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority . . . essential to safety, health, peace, good order and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one’s will.” Jacobson v. Massachusetts, 197 U.S. 11, 26-27 (1905) (quoting Crowley v. Christensen, 137 U.S. 86, 89 (1890)).
man. Indeed, it is difficult to imagine a more direct intrusion on a woman's personal privacy and bodily integrity than to be forced to undergo medical treatment against her will. While the legal rights of the pregnant woman to maintain her bodily integrity by refusing treatment are strong, the question remains whether they are strong enough to withstand challenge when the treatment in question affects the life or health of her fetus.

The State, the Individual, and the Constitution: Competing Interests

The only possible justification for a court order requiring a direct intrusion into a woman's body against her will would be a court's judgment that the interests of the fetus outweigh the interests of the pregnant woman. The precedential value of Jefferson v. Griffin Spalding County Hospital Authority\(^\text{217}\) and other unreported cases notwithstanding, the law clearly does not, nor should it, support such a judgment.

First, Roe v. Wade\(^\text{218}\) held that a fetus is not a "person" for purposes of the fourteenth amendment.\(^\text{219}\) While this statement does not necessarily imply that the fetus is a nonperson in all other legal contexts,\(^\text{220}\) it does deny fetuses basic constitutional protection of life, liberty, and property. Despite the potential detriment to the fetus resulting from the pregnant woman's choice to refuse medical treatment, that choice should prevail. Her status under the Constitution is superior and her "personhood" is free from doubt, while the fetus' constitutional status is inferior and its legal status as a person is uncertain and amorphous.

Second, and more important, Wade, Colautti,\(^\text{221}\) and Thornburgh\(^\text{222}\) deny the state a compelling interest in the protection of fetal life when the fetus' and mother's interests in life and health conflict in the context of abortion.\(^\text{223}\) It surely follows that the state is constitutionally barred from forcing the mother to undergo medical treatment for the sake of the

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219. Id. at 158.

220. See Myers, supra note 4, at 14-17.


223. We recognize that this constitutional argument based on Wade, Colautti, and Thornburgh has an obvious limitation in that it would not apply if medical treatment would put the mother at less risk of physical harm than foregoing the recommended treatment or if the treatment put her at no risk in any event. Consequently, this Article's constitutional argument would not necessarily preclude the state from forcing the mother to accept treatment that
fetus if that treatment endangers her life or health in any way.\textsuperscript{224} As the \textit{Thornburgh} court stated, "maternal health must be the paramount consideration."\textsuperscript{225} Even if the treatment does not put the woman's life or health at risk, however, the other arguments against compelled treatment based upon the value of maintaining the woman's bodily integrity and the uncertain legal and ethical status of the fetus would still apply.\textsuperscript{226}

Third, a pregnant woman's right to bodily integrity is too fundamental to be pushed aside by a judicial order for the sake of a fetus who is, at best, a quasi-person under the law.\textsuperscript{227} The importance of bodily integrity to our political and social value system is not a matter of rhetoric; it is part of the foundation of a free society that respects the individual.\textsuperscript{228} In fact, no reported appellate case has upheld a lower court's

either was of no risk to her or put her at less risk than refusing. Nonetheless, all of the other arguments against compelling treatment would still apply.

\textsuperscript{224} Because almost all medical interventions that could benefit the fetus entail at least some risk to the mother's life and health, the state cannot constitutionally force the mother to be the subject of those interventions. The medical risks to the mother range from death (due to anesthesia, blood loss, or infection) to pain and disfigurement. However, in some situations, discussed supra text accompanying notes 23-25, 28-29, the treatment poses truly negligible medical risk to the mother yet promises to benefit the fetus greatly.\textsuperscript{225} \textit{Thornburgh}, 737 F.2d at 300.

\textsuperscript{226} In \textit{In re Application of Jamaica Hosp.}, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985), the court ordered a competent adult woman who was 18 weeks pregnant and who was suffering from internal bleeding to accept blood transfusions for the sake of her previable fetus. The patient, a Jehovah's Witness, had refused the blood transfusions on religious grounds. Citing \textit{Wade}, the court held that "the State has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds." Id. at 1008, 491 N.Y.S.2d at 899. As discussed above, \textit{Wade} does not stand for the proposition that the state has an interest in the previable fetus that can outweigh the mother's right of privacy and right to bodily integrity. Because the mother here could have legally aborted the fetus under \textit{Wade}, it is exceedingly difficult to understand how \textit{Wade} can grant the state a "highly significant interest" in the fetus that outweighs the mother's constitutional and common-law rights. Significantly, the New York court did not even mention the mother's constitutional right to privacy and did not hold an adversary hearing on the application.

\textsuperscript{227} One commentator has stated:

Neither arguments for potentiality nor interests in human life as such can give sufficient support for the status of the fetus as a moral object, much less as a moral subject, to justify restricting the free choice of women in [obtaining abortions]. Potential persons have only potential rights, and simply being human does not confer sufficient moral standing to constrain the freedom of women seeking abortions. Engelhardt, \textit{Introduction to Abortion and the Status of the Fetus} at xxiii (W. Bondeson, H. Engelhardt, Jr., S. Spicker & D. Winship eds. 1983). Similarly, the fetus does not have sufficient moral standing to constrain the freedom of women who refuse medical treatment or choose to live in a manner that might harm their fetuses.

\textsuperscript{228} See, e.g., Erickson v. Dilgard, 44 Misc. 2d 27, 28, 252 N.Y.S. 2d 705, 706 (N.Y. Sup. Ct. 1962) ("[I]t is the [competent adult] individual who is the subject of a medical decision who has the final say and... this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires.").
order that actually compelled a conscious, competent adult other than a prisoner to accept medical treatment against his will. As the Massachusetts Supreme Judicial Court has observed:

The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

The value of a pregnant woman's life and dignity is certainly diminished if she is forced by a court to give up her right to decide what is to be done to her own body.

Furthermore, the law traditionally has strongly disfavored compel-
ling bodily intrusions on persons without their consent. The courts, nonetheless, have not held that the right to bodily integrity is absolute. The state may, for example, legitimately require persons to undergo compulsory vaccination for the sake of public health, to be drafted into the military for the protection of the nation, or to be subjected to physically invasive searches for evidence of criminal activity. In addition, courts have ordered organs to be taken from incompetent persons without their consent and transplanted into their siblings.

Nevertheless, the cases that permit certain kinds of compelled invasions still recognize the high value our society places on the bodily integrity of the individual. Although Schmerber v. California recognized that the state, without violating the fourth amendment, may have a physician extract a blood sample from a criminal suspect without his consent, the Court also observed that the “integrity of the individual’s person is a cherished value of our society.” Similarly, in Winston v. Lee, the Court observed that personal privacy and dignity are values “basic to a free society” and can be of such magnitude that a compelled surgical procedure on a suspect’s body may be unreasonable and in violation of the fourth amendment even if likely to produce evidence of a crime.

The courts have proceeded slowly and cautiously in authorizing bodily intrusions by the state. Schmerber explicitly cautioned that its

234. See, e.g., United States v. Crowder, 543 F.2d 312, 316 (D.C. Cir. 1976) (en banc) (surgical removal of a bullet from a hospitalized suspect’s arm, following full procedural safeguards, not an unreasonable search under the fourth amendment), cert. denied, 429 U.S. 1062 (1977).
235. Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (1972); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969). Contra In re Richardson, 284 So. 2d 185 (La. Ct. App. 1973); Lausier v. Pescinski, 67 Wis. 2d 4, 226 N.W.2d 180 (1975). The two cases permitting organ “donation” in the absence of the “donor’s” consent, Strunk and Hart, can be readily and conclusively distinguished as inapplicable to the issue of forcing pregnant women to undergo treatment. First, such compelled organ donation has been justified by a purported showing that the incompetent would benefit from the “donation.” Strunk, 445 S.W.2d at 146-47. If only in her own estimation, if not also in fact, a pregnant woman will not benefit from forced treatment against her will. Second, the pregnant woman is actively opposing the treatment being offered to her, while the incompetent is neither acquiescing to nor resisting the surgery precisely because of his incompetence.
237. Id. at 772. The Court also based its result in part on its finding that “for most people the [blood test] procedure involves virtually no risk, trauma, or pain.” Id. at 771.
239. Id. at 1616 (quoting Wolf v. Colorado, 338 U.S. 25, 27 (1949)).
240. Winston, 105 S. Ct. at 1616.
holding "that the constitution does not forbid the states minor intrusions into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions." Along similar lines, Winston required that the reasonableness of surgical intrusions be determined on a case by case basis, weighing the individual's interests in privacy and security against society's interest in obtaining the evidence. Moreover, a number of courts have refused to order compulsory surgery if it would endanger the life or health of the suspect.

In sum, the cases permitting the state to compel some bodily intrusions do not strongly support the forced treatment of pregnant women for the sake of their fetuses. Most of the permitted intrusions are very minor in nature, intended to benefit society at large, or involve the sui generis situation of a prisoner in state custody. In contrast, many of the intrusions upon a pregnant woman's person or liberty thought necessary to protect the fetus are neither minor in nature nor designed to benefit society in any tangible manner, nor does her refusal of treatment affect any significant state interests.

The importance of freedom of choice also is reflected in the venerable common-law principle that an individual is not ordinarily obligated to volunteer aid to another who is in need of assistance, even if the failure to act proves fatal to the imperiled person and the aid necessary to avert the tragic outcome would have involved little inconvenience for the potential rescuer. This "Bad Samaritan" principle exists because the common law highly values the individual's interests both in freedom from physical invasion or involuntary physical activity and in freedom to

241. Schmerber, 384 U.S. at 772 (emphasis added).
243. E.g., United States v. Crowder, 543 F.2d 312, 316 (D.C. Cir. 1976) (en banc) (agreeing with district court that a surgical operation to remove a second bullet imbedded in the suspect's thigh would be unacceptable because the procedure might reduce the suspect's use of his leg); Bowden v. State, 256 Ark. 820, 824, 510 S.W.2d 879, 881 (1974) (removal of bullet near spine a "major intrusion" that would subject the suspect to trauma, pain, and "possible risk of life" even if performed properly); Adams v. State, 260 Ind. 663, 299 N.E.2d 834 (1973) (per se rule against surgery), cert. denied, 415 U.S. 935 (1974); People v. Smith, 80 Misc. 2d 210, 362 N.Y.S.2d 909 (N.Y. Sup. Ct. 1974) (removal of bullet under muscles in chest wall a major intrusion).
244. E.g., Schmerber, 384 U.S. 757 (blood sample); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (smallpox vaccination); United States v. Crowder, 543 F.2d 312 (D.C. Cir. 1976) (removal of bullet lying superficially beneath skin did not involve any harm or risk from surgery).
246. See supra notes 228-29.
247. PROSSER & KEETON, supra note 61, at 375.
refuse to subordinate one's preferences and needs to those of another.\footnote{248} As Professor Regan rightly observed, "If this freedom is important, it is as important for the pregnant woman as for anyone else."\footnote{249} The Bad Samaritan principle and the values upon which it rests further illuminate why pregnant women should not be compelled to receive medical treatment they do not want.

Assume that a four-year-old girl is suffering from kidney disease and can no longer be maintained properly on chronic hemodialysis. Her mother, a medically suitable organ donor, refuses to undergo the transplantation surgery. Would a legal action by the daughter to compel her mother to donate her kidney be successful? In all likelihood, no.\footnote{250} The end result of not compelling the donation—the death of a young child—would be tragic. The mother's refusal to aid her child may well be morally indefensible to some. But any other outcome would be unprecedented in any court and would alter fundamentally the structure of our society, based as it is on the freedom of the individual.

There is but one case that confronts the question of compelling a competent adult to "donate" body tissue to another. In \textit{McFall v. Shimp},\footnote{251} a thirty-nine-year-old man terminally ill with aplastic anemia sought a state judicial order compelling his first cousin to undergo further testing for compatibility of tissue and to "donate" bone marrow for transplantation if sufficient compatibility were present. The transplantation procedure apparently offered the plaintiff at least some hope of sur-

\footnote{248}{See Regan, \textit{supra} note 230, at 1569-79. The conclusions in this Article have been heavily influenced by Regan's analysis of abortion as a problem in the law of "Samaritanism," that is, the law concerning obligations imposed on certain individuals to give aid to others. Regan refers to the established principle that one does not have to volunteer aid as the "Bad Samaritan" principle. \textit{Id.} at 1572. This Article uses the same term.}

\footnote{249}{\textit{Id.} at 1578.}

\footnote{250}{A number of commentators have referred recently to compulsory organ donation as an example of a practice "clearly beyond the pale." \textit{See id.} at 1585. This situation, in which it would be highly unlikely for any judge to force a mother to donate a part of her body, also demonstrates why the "special relationship" (here, parent-child) exception to the Bad Samaritan principle does not apply to the pregnant woman refusing treatment. \textit{See id.} at 1593-98. If the "special relationship" between parent and child does not justify compulsion of the mother to donate body tissue to her daughter, it would not appear to justify compulsion of a pregnant woman to undergo treatment for the sake of her fetus either. McFall v. Shimp, No. 78-17711 In Equity (C.P. Allegheny County, Pa. July 16, 1978), \textit{cited in Comment, Coerced Donation of Body Tissue: Can We Live with McFall v. Shimp?}, 40 \textit{Ohio St. L.J.} 409, 409 n.1 (1979), denies the existence of a duty to undergo invasive medical procedures to benefit a family member. \textit{See infra} notes 250-54 & accompanying text. One commentator, however, has stated that Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969), arguably supports the existence of such a duty. Mathieu, \textit{supra} note 8, at 44.}

\footnote{251}{No. 78-17711 (C.P. Allegheny County, Pa. July 16, 1978), \textit{cited in Comment, supra} note 250, at 409 n.1.}
vival, while the risk of harm to the unwilling donor was quite small. The trial court refused to issue the order, finding no duty on the part of the defendant to render assistance. In the court’s view, the absence of such a duty rested upon principles constituting the “very essence . . . of our society.”

Although the court opined that the refusal of the defendant to assist his relative was morally questionable, it stated that legally forcing him to submit to such a bodily intrusion “would change every concept and principle upon which our society is founded.” The court recognized the extraordinary significance of the relief sought and declined to force the defendant to submit to the medical procedures:

For a society, which respects the right of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forceable extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends.

The court also expressed concern about the effects of establishing a duty to undergo bodily invasion for the benefit of another. To find such a duty “would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.”

If our society will not compel someone to undergo a bodily invasion such as organ or tissue transplantation for the benefit of another, how can society view pregnant women refusing treatment any differently? The basic values at stake are the same: the freedom to choose one’s own destiny and to maintain one’s bodily integrity. These values should underlie both our refusal to require someone to bind up the wounds of a stranger who is bleeding to death and our refusal to compel a competent pregnant woman to receive medical treatment against her will. Compelled treatment cannot plausibly be justified by the need to save the fetus’ life; we do not legally compel others to save the lives of live-born persons, even when the action required is much less physically burdensome or invasive.

In light of the fetus’ dubious and unsettled legal and

252. McFall, No. 78-17711, slip op. at 2, quoted in Comment, supra note 249, at 413.
253. McFall, No. 78-17711, slip op. at 2, quoted in Comment, supra note 249, at 409.
254. McFall, No. 78-17711, slip op. at 2-3 (emphasis in original), quoted in Comment, supra note 249, at 413-14.
255. McFall, No. 78-17711, slip op. at 2, quoted in Comment, supra note 249, at 413.
256. E.g., Sidwell v. McVay, 282 P.2d 756 (Okla. 1955) (strangers under no duty to prevent minor from hammering a pipe containing explosives).
257. See Regan, supra note 231, at 1589.
moral status, it should lay less claim to the aid of others than live-born persons.

Furthermore, compelled treatment cannot be independently justified on the ground that there is an overriding state or public interest in protecting the fetus from harm. There is a "public interest" in protecting every person in need of aid and preserving his life that is "precisely analogous to the public interest in saving the fetus," yet we do not force other potential Samaritans to render aid. It would be utterly anomalous to rely on the state or public interest to preserve the fetus' life in the situation of a woman refusing medical treatment and yet ignore it in other situations.

Furthermore, compelling pregnant women to undergo medical treatment sets an unsavory precedent for further invasions of a woman's privacy and bodily integrity, the same problem faced by the court in *McFall.* Robertson has observed that if the result in *Jefferson* is correct, "then far-reaching intrusions on the mother's body and freedom of action for the benefit of the unborn child may legitimately follow." Such intrusions could include court orders prohibiting pregnant women from using alcohol, cigarettes, or other possibly harmful substances, forbidding them from continuing to work because of the presence of fetal toxins in the workplace, forcing them to take drugs or accept intrauterine blood transfusions, requiring pregnant anorexic teenagers to be force-fed, forcing women to undergo prenatal screening and diagnostic procedures such as amniocentesis, sonography, or fetoscopy, or mandating that women submit to *in utero* or extra-uterine surgery for the fetus. Robertson and others seem little troubled by the prospect of such intrusions: "Compulsory amniocentesis, *in utero* surgery, or cesarean section, while more invasive, still have support in other precedents." The prospect of courts literally managing the lives of pregnant women and extensively

258. Id. at 1607.
259. See supra notes 249-54 & accompanying text.
261. Robertson, supra note 7, at 307.
263. Robertson, supra note 7, at 360. Robertson apparently believes that such interventions are justified under *Roe v. Wade.*

The state is compelling significant bodily intrusions to protect a patient who is not yet fully a legal person and about whose moral worth a fierce controversy swirls. Yet the fetal status of the beneficiary of the intrusion does not mean that a bodily invasion is coerced for insubstantial or morally illegitimate reasons. If the fetus is near-term, or even post-viability, its status is close enough to personhood that overriding claims of bodily integrity is within the state's discretion under *Roe v. Wade.* If the
intruding into their daily activities is frightening and antithetical to the fundamental role that freedom of action plays in our society. Moreover, enforcement of such orders would be difficult, entangling the judiciary in women's private lives.

Finally, the state lacks an interest in fetal life sufficient to overcome a woman's rights of privacy and bodily integrity, and further lacks any other interest sufficient to justify compelling a pregnant woman to undergo treatment. In *Superintendent of Belchertown State School v. Saikewicz*, the court reviewed the cases regarding refusal of treatment and identified four countervailing state interests that could outweigh an individual's rights of privacy and bodily integrity when refusing treatment: first, the preservation of life; second, the protection of innocent third parties; third, the prevention of suicide; and fourth, maintaining the ethical integrity of the medical profession. When examined closely, it is apparent that none of these interests justifies the compelled treatment of pregnant women. In addition, the state's legitimate interest in preventing parents from refusing medical treatment for their live-born children does not justify compelling mothers to undergo treatment for their fetuses.

The state's interest in preserving life commonly is thought to be the most significant of the four potential state interests. It is questionable whether the state has anything but an abstract interest in preserving the life of a particular individual who has decided to refuse treatment. Such a general interest always should give way to a competent patient's far stronger interests in self-determination, bodily integrity, and privacy.

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mother has already foregone her right not to procreate by not aborting, then she no longer has a right to produce a dead or unhealthy baby.

*Id.* As discussed earlier, *see supra* notes 176-198 & accompanying text, *Roe v. Wade* does not permit the state to place the fetus' interests above those of the mother after the fetus becomes viable. *Roe v. Wade*, 410 U.S. 113, 163 (1973). Moreover, no woman "waives" her right to privacy and bodily integrity by not aborting the fetus prior to its becoming viable. *Roe v. Wade* permits her to have an abortion after viability if necessary to protect her life or health. *Id.* at 163-64.

265. *Id.* at 741, 370 N.E.2d at 425. Other courts have accepted this listing of the relevant state interests without further analysis of their origins or justification. *See, e.g.*, Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).
If the state's general interest does not give way to the competent patient's far stronger interests, the patient's right to refuse treatment would be eviscerated, and the state would be put into the anomalous situation of protecting a person who had competently decided not to protect himself. Existing case law supports a competent adult's right to refuse medical treatment.268

The state's interest in the protection of innocent third parties, particularly minor children, "from the emotional and financial damage which may occur as a result of the decision of a competent adult to refuse life-saving or life-prolonging treatment"269 is highly questionable both in origin and as a matter of intelligent public policy. The leading case for the existence and significance of this state interest is Application of the President & Directors of Georgetown College, Inc.270 In Georgetown, a twenty-five-year-old married mother of a seven-month-old baby was brought to the hospital by her husband after she had lost two-thirds of her blood supply from a ruptured ulcer. The woman and her husband were Jehovah's Witnesses, a religion that prohibits its members from receiving blood transfusions. Judge Wright found the woman "was not in a mental condition to make a decision" and signed an order permitting the hospital to administer the blood.271

Although the patient's incompetency was a sufficient reason to authorize the transfusion, Judge Wright proposed other grounds to justify his action:

The state, as parens patriae, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother.272

This assertion lacked any precedential foundation. Its primary weakness is its failure to recognize the mother's strong constitutional and common-law rights to privacy, bodily integrity, self-determination, and religious freedom. The state's interest in preventing the death of the mother of a


269. Saikewicz, 373 Mass. at 742, 370 N.E.2d at 426.


271. Id. at 1007.

272. Id. at 1008. The court cited no authority to support these assertions.
minor child, on the other hand, is quite attenuated. Although the patient’s child might suffer financial or emotional loss as a result of the patient’s death, it is difficult to see why the state’s interest in preventing this harm is sufficiently strong to force a competent adult to accept life on terms she finds unacceptable. Moreover, it is unclear why this purported interest of the state rises to a level of significance that could outweigh the constitutional rights of the patient.

While it is undesirable for a child to lose its mother for any reason, it is arguably less desirable to force competent adults to relinquish control over their lives and bodies and to undergo treatment they find repugnant. Furthermore, in the Georgetown case itself, no evidence indicated that the infant would be totally “abandoned” at the death of her mother, particularly because the child’s father was alive. In the unlikely case that a patient’s refusal of treatment would directly threaten the lives or health of others (for example, Typhoid Mary refuses treatment that would render her non-infectious), a superior state interest in the protection of innocent third parties makes sense. Outside this narrow situation, however, the state’s interest in protecting innocent third parties is exceedingly weak and amorphous when compared to the competent adult patient’s interests in refusing treatment.

Further, the state’s arguable interest in the protection of innocent third parties would only apply to a pregnant woman if she already had children or if the fetus itself were considered an “innocent third party.” The reasons that a fetus should not be considered a separate person whose interests may outweigh those of a pregnant woman were discussed above. Even if a pregnant mother of a minor child could potentially die from her refusal of treatment, neither Judge Wright’s novel “abandonment” theory in Georgetown nor that of any other case provides a persuasive reason why the mother’s rights and interests should be subordinated to the state’s interest in preventing abandonment of the child.

Like its interest in the preservation of life, the state’s interest in the

273. See In re Osborne, 294 A.2d 372 (D.C. 1972), in which the patient had provided for the financial welfare of his two minor children.

274. See supra notes 218-26 & accompanying text.

275. In In re Application of Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (N.Y. Sup. Ct. 1985), the court ordered a competent adult woman who was the mother of two infants to receive blood transfusions if, during surgery to remove kidney stones, they were necessary to preserve her life. The patient had refused the transfusions on religious grounds. While noting that “[c]ourts are generally without power to order compulsory medical treatment over a competent adult patient’s objection,” it nonetheless granted the order, citing Georgetown as authority for the proposition that the state may compel treatment to prevent a mother from “abandoning” her children. Id. at 804-05, 490 N.Y.S.2d at 996-97. For the
prevention of suicide has never sufficed to force a competent patient to accept treatment. According to Saikewicz, the state's interest is really in the "prevention of irrational self-destruction." This interest is not implicated in a competent adult's refusal of treatment because such an act does not constitute suicide. It is not suicide when "the patient may not have the specific intent to die, and, . . . even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death." If a pregnant woman knows what she is doing, the state's interest in preventing suicide should not prevent her wishes from being respected.

The fourth state interest, in maintaining the ethical integrity of the medical profession, is the oddest and least intelligible of the lot. Georgetown is often cited as the first case to explicate this interest, but the case did not mention this state interest. The court did note it was uncertain whether the patient had "authority" to put the hospital and physicians at risk of civil or criminal liability if they should let her die as a result of her refusal. Another case commonly cited for this same proposition alludes to the patient subjecting the practitioners to a risk of liability, but focuses on the asserted right of a hospital and health care practitioners to impose treatment on a patient as they see fit.

This supposed interest of the state should not outweigh a competent

reasons discussed earlier, see supra notes 268-73 & accompanying text, this is an insufficient justification for compelled treatment of competent adults.

276. No reported case has held that a competent patient must undergo medical treatment he has refused in order to vindicate the state's interest in the prevention of suicide.

277. Saikewicz, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11.

278. Id. Other cases have recognized a distinction between the self-infliction of deadly harm and a choice against accepting medical treatment. See, e.g., Bartling v. Superior Court, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 226 (1984).

279. A competent adult is, by definition, someone who is able to demonstrate that he understands the nature and consequences of his actions, and thus is not so mentally disordered as to be out of touch with his particular situation. See supra note 1. An adult can be depressed or confused to some extent, yet remain competent to refuse treatment. Bartling v. Superior Court, 163 Cal. App. 3d 186, 193, 209 Cal. Rptr. 220, 223-24 (1984); Lane v. Candura, 6 Mass. App. Ct. 377, 383-84, 376 N.E.2d 1232, 1235-36 (1979). On the other hand, an adult can be so out of touch with her medical condition and equivocal about accepting the likely fatal consequences of a refusal of treatment that she is incompetent to make a binding decision. Department of Human Servs. v. Northern, 563 S.W.2d 197, 207 (Tenn. Ct. App.), appeal dismissed as moot, 436 U.S. 923 (1978).

280. E.g., Saikewicz, 373 Mass. at 743, 370 N.E.2d at 426.

281. Georgetown, 331 F.2d at 1009.

282. John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 583, 279 A.2d 670, 673 (1971) ("When the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the
adult’s right to refuse treatment. First, if the medical profession could obtain judicial assistance because it found the physician’s acquiescence in the patient’s refusal of treatment to be “unethical,” the patient’s constitutional and common-law rights would be rendered meaningless. “[I]f the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient’s hospital and doctors.”

Second, physicians and hospitals have nothing to fear legally if they respect the wishes of a competent adult who refuses treatment. Thus, there is no benefit to the medical profession from the state’s protection but there is a high cost to the patient. Finally, it is entirely unclear why the state should have an interest in maintaining the ethics of the medical profession that is sufficiently compelling to overcome the strong constitutional and common-law rights of a competent adult. A patient refusing treatment is not asking the physician to perform an affirmative act that is harmful and therefore “unethical.” Rather, the patient is asking to be left alone.

In Crouse-Irving Memorial Hosp. v. Paddock, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985), the court ordered that a competent adult woman receive blood transfusions, if necessary, after undergoing a Cesarean section, on the ground that her religiously motivated refusal to accept the transfusion put the hospital and her doctors in “an untenable position.” Id. at 104, 485 N.Y.S.2d at 445. The court cited Georgetown for the proposition that her providers faced civil and criminal liability for respecting her refusal and suggested that health care providers have the right to treat a patient as they see fit. Id. at 103-04, 485 N.Y.S.2d at 445-46. For the reasons set forth earlier in this Article, neither of these arguments is persuasive. Again, as in In re Application of Jamaica Hosp., 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985), and In re Application of Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (N.Y. Sup. Ct. 1985), the patient was not represented by counsel and no reference was made to the patient’s constitutional right of privacy. See supra notes 225, 275.

283. Bartling v. Superior Court, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); accord Mercy Hosp. v. Jackson, 62 Md. App. 409, 489 A.2d 1130 (hospital’s religious values secondary to patient’s choice to refuse treatment), cert. granted, 304 Md. 47, 497 A.2d 484 (1985); In re Conroy, 98 N.J. 321, 352-53, 486 A.2d 1209, 1225 (1985) (“Indeed, if the patient’s right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.”).

284. The New York Court of Appeals has noted that a state which imposes civil liability on a doctor if he violates the patient’s right [to determine the course of his own medical treatment] cannot also hold him criminally responsible if he respects that right. Thus a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment. In re Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (footnote omitted), cert. denied, 454 U.S. 858 (1981). Similarly, a California court of appeal has held that a physician or hospital “could not have been criminally or civilly liable” for honoring a competent patient’s refusal of treatment. Bartling v. Superior Court, 163 Cal. App. 3d 186, 199, 209 Cal. Rptr. 220, 226 (1984).
The state's interest in protecting the lives and health of live-born children also does not justify the compelled treatment of pregnant women. Parents do not have the legal right to refuse medical treatment for their live-born children in all situations.\textsuperscript{285} It does not logically follow, as some have insisted,\textsuperscript{286} that a mother would also lack the legal authority to refuse treatment beneficial to her fetus. Treatment of a live-born child does not implicate the mother's rights to privacy and bodily integrity; treatment of a fetus inevitably does. Nonconsensual invasion of the mother's body is a much more fundamental and direct assault on her person than defying her will. Furthermore, a live-born child is unarguably a separate and independent being from its mother. Its legal and moral status as a person is recognized almost uniformly.\textsuperscript{287} The fetus does not now receive, and never has received, such recognition.\textsuperscript{288}

\textbf{Conclusion}

Fortunately, pregnant women only rarely refuse medical treatment that promises to benefit their fetuses and perhaps themselves as well. Thus, the ensuing conflict between the mother and her fetus when the mother refuses medical treatment will erupt only rarely. When mothers do refuse such treatment, the most appropriate response of physicians, nurses, and hospitals is to honor their wishes. Correspondingly, judges also should honor a mother's refusal and refrain from issuing orders that would compel her to receive treatment that she has decided, for her own reasons, to forego.

Physicians and judges may, on rare occasions, confront a situation in which a mother will refuse a simple, common form of medical treatment, such as a blood transfusion or an innocuous drug, that causes at most an insignificant and minimal invasion. They will, undoubtedly, be deeply troubled by the prospect of allowing the mother to make what would be considered the "wrong" choice by almost everyone, including the authors of this Article. Nevertheless, it is best to let the mother's wishes prevail. If physicians and judges intervene in a situation involving minimal intrusion and risk, there is no reason \textit{in principle} why they could

\textsuperscript{285} See \textit{e.g.}, \textit{In re Phillip B.}, 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), \textit{cert. denied}, 445 U.S. 949 (1980) (setting forth sound legal standards for evaluating parental refusals of treatment, but reaching a questionable result on the facts). \textit{See Myers, supra} note 4, at 212 n.44 for a variety of articles discussing this most difficult issue.

\textsuperscript{286} Myers, \textit{supra} note 4, at 32-52.

\textsuperscript{287} The philosopher Michael Tooley, in a now famous article, has argued that infanticide may be justified on the same grounds as abortion. Tooley, \textit{Abortion and Infanticide}, 2 \textit{PHIL. \& PUB. AFF.} 37 (1972).

\textsuperscript{288} \textit{See supra} notes 101-65 & accompanying text.
not intervene when the mother would be at more risk of harm, when the
treatment was more invasive, or when her reasons for refusing might
seem less "acceptable." It is impossible to meaningfully distinguish an
"acceptable" level of risk of physical harm from the "unacceptable," a
"minor" unobjectionable invasion of the mother's body from a "major"
objectionable invasion, or a "good" or "rational" reason for refusing the
treatment from a "bad" or "irrational" reason. It is far better simply
to avoid compelling pregnant women to live as seems good to a particular
physician, judge, or even to the rest of us than to force them to sacrifice
their wills and their bodies on the altar of someone else's notion of the
good.

Admittedly, this course of action may result in the birth of children
who will suffer from an injury or disease that might have been avoided
had their mothers chosen differently. It may also result in the death of
fetuses who otherwise might have lived.

This will be tragic, but it is likely to be rare. It is the price society pays
for protecting the rights of all competent adults, and preventing forci-
ble, physical violations of women by coercive obstetricians and judges.
The choice between fetal health and maternal liberty is laced with
moral and ethical dilemmas. The force of law will not make them go
away. The price to fetuses and to society of honoring maternal refusals of treat-
ment may seem high, but contrary policy would rob us of much more
and leave us far poorer as human beings.

289. The dissent in United States v. Crowder, 543 F.2d 312 (D.C. Cir. 1976) (en banc),
cert. denied, 429 U.S. 1062 (1977), mirrors this concern. After noting that the majority opin-
on gave no indication as to how to distinguish "minor" and "major" bodily intrusions, the
dissent wisely noted:

In sum, [the majority opinion allowing minor surgery] leaves to ad hoc determina-
tion, simply on the elastic and imprecise scale of reasonableness, the extent to which
the arm of government may reach inside the human body. That, I fear, starts us
down a slippery slope—on which there can be no stopping.

Id. at 324 (Robinson, J., dissenting).

290. One commentator has noted:

One must realize that the purchase price of a government which is party to no partic-
ular religious or metaphysical viewpoint, and therefore able to embrace peaceably
communities with widely divergent views of how citizens should live their private
lives, requires foregoing the temptation to impose by state force one's own view of
proper private morality. A peaceable pluralist society can be achieved only at the
price of toleration. One will need to be content with converting others by witness
rather than constraining conformity through force.

Engelhardt, supra note 227, at xix (emphasis in original).

291. Annas, supra note 4, at 45.